Discharge Planning Policy

Program: Behavioral Health Day Treatment / Partial Hospitalization Program

Effective Date: February 15, 2026

Review Date: February 15, 2027

Responsible Party: Clinical Director / Director of Medical & Clinical Services

Purpose

To ensure that all individuals served receive structured and coordinated discharge planning that supports continued recovery, stability, and transition to appropriate services following completion of the Day Treatment Program.

Policy

Discharge planning is an ongoing clinical process that begins at admission and continues throughout the course of treatment. The goal of discharge planning is to ensure continuity of care, support successful transition to a lower level of care, and maintain progress achieved during treatment.

Discharge planning must be individualized, person-centered, and aligned with the Individualized Service Plan and clinical progress of the individual served.

Scope

Discharge planning may include coordination with:

• Outpatient behavioral health providers

• Primary care providers

• Psychiatric medication providers

• Community support services

• Substance use treatment programs

• Housing or social service agencies

• Educational or vocational programs

• Legal or probation authorities when appropriate

Discharge Planning Process

1. Discharge planning begins during the initial treatment planning process.

2. The clinician identifies anticipated post-treatment needs and appropriate levels of care.

3. The individual served participates in discharge planning and identifies preferred providers and supports.

4. Staff coordinate referrals and appointments with external providers when appropriate.

5. The treatment team reviews discharge readiness and confirms continued supports.

6. A discharge summary and transition plan are completed and documented in the clinical record.

Discharge Criteria

Individuals may be discharged when:

• Treatment goals have been achieved or substantially met

• The individual no longer meets medical necessity for the level of care

• The individual transitions to a lower or higher level of care

• The individual withdraws from services

• Administrative discharge occurs due to non-participation or other program requirements

Required Discharge Documentation

The clinical record must include:

• Discharge summary

• Reason for discharge

• Summary of treatment progress

• Current diagnoses

• Medications at discharge when applicable

• Referrals and follow-up appointments

• Recommendations for continued care

Client Involvement

Whenever possible, the individual served participates in discharge planning. Staff should review the transition plan, provide education regarding follow-up services, and ensure the individual understands recommended next steps in care.

Continuity of Care

Staff should attempt to coordinate follow-up appointments prior to discharge when possible. Referrals and communication with receiving providers should be documented to support continuity of care.

Quality Monitoring

Discharge planning practices may be reviewed through chart audits, supervision, and quality improvement activities to ensure compliance with clinical standards and accreditation requirements.

Confidentiality

All discharge communications and referrals must comply with HIPAA, 42 CFR Part 2 (when applicable), and organizational confidentiality policies.