- In evaluating possible aftercare and residential arrangements, the team assesses the readiness of the providers to continue the interventions and the social learning model used on the unit, so as to build on the gains achieved.
- Skill transfer plans are provided to aftercare providers/systems. The plans will include:
  - Written plans and verbal handoff for all discharged patients.
  - Case/care manager, home health case manager, ACT, etc., visits on the units for patients at very high risk of rapid readmission.
  - Staff-accompanied visits to aftercare facilities/providers for patients at highest risk of rapid readmission.
- Assessments for other support services, e.g., care coordination, ACT and AOT are completed.
- Support system meetings (family, care coordinator, natural supports etc.) are conducted in order to assist the patient in the transition to outpatient status.
- Community exposure outings are arranged to assess discharge readiness and to assist the patient in making the transition.
- After discharge, patients and providers are called by the unit staff to ensure that all elements of the discharge plan were achieved and that any support required by the patient is provided.