

## DISCHARGE PLANNING

In general at BJC, social workers (MSW) handle placement of patients in facilities, including SNFs and rehab. Case coordinators handle discharges to home, including setting up equipment, home therapies and outpatient rehab.

General guidelines for d/c recommendations:  
(All bullets need not apply)

### INPATIENT REHAB:

- Pt. requires assistance with mobility with/without assistive device
- If ambulatory, pt walks  $\leq$  approximately 150ft
- Pt. requires at least 2 disciplines (PT/OT or PT/ST or all three)
- Pt. able to tolerate 3 hours of therapy per day. (Most of the time, pt. is allowed to work up to that amount.)

### SKILLED NURSING FACILITY (SNF):

- Pt. requires assistance with mobility with/without assistive device
- Pt. does not have adequate help at home
- Physically independent or supervised, but safety concerns
- ~~"The good" for inpatient rehab~~
- Unable to tolerate 3 hours of therapy per day
- Long term plan is for pt. to live in a nursing home
- Pt. unable to follow commands (it is o.k. if they follow even 25% of commands)

### HOME HEALTH:

- Pt. declines placement for rehab and has adequate help at home.
- Pt is independent with/without device in home.
- Cannot tolerate outpatient therapy.
- Home safety eval

### OUTPATIENT THERAPY:

- Higher level balance, cognitive or ADL/IADL needs.
- Transportation available.
- Can tolerate traveling to and from facility along with actual therapy.
- Day treatment: more intensive; BI pts.
- Specialty programs: driving eval, work hardening, vocational rehab.

Remember that d/c planning is often "gray" and not "black and white".  
It is best to decide as a team, with pt. and family input as well.

NOTES: