COMPREHENSIVE STROKE CENTER
UNIVERSITY OF MICHIGAN HEALTH SYSTEM

Discharge Planning for Stroke Survivors

Occupational Therapy (OT) and Physical Therapy (PT) assist with discharge planning recommendations. The recommendations may include the anticipated need for rehabilitation, durable medical equipment, home care services or adjustments be made to the home.

Common discharge recommendations are:

- **Home with Home Therapy (OT/PT):** Recommendations are to return home with current setup and family support and continued therapy **in the home.**
- **Home with Outpatient Therapy (OT/PT):** Recommendations are to return home with current setup and family support with continued therapy **outside the home**. It is important to find a physical therapist with neuro specialty training since stroke recovery is different from other therapies.
- **Inpatient Acute Rehab:** This recommendation is for patients who have had a significant change in functional status. These patients will need intensive skilled therapies such as PT, OT, Speech and Language Therapy, and/or Recreational Therapy. The patient can tolerate up to 3-5 hours of therapy over the course of a day and will be likely to return to home upon discharge. If the team recommends inpatient acute rehab they will place **a consult request** to Physical Medicine and Rehabilitation (PMR)
- **Subacute Rehab (SAR)/Skilled Nursing Facility (SNF) for ongoing therapy:** This recommendation is made when the patient is unsafe to return to their prior living situation due to a decline in functional status. The patient needs skilled therapy but cannot tolerate intensive rehabilitation. Subacute Rehab is slower paced than Inpatient Acute Rehab. The goal is to return home upon discharge. The patient will continue to receive OT and PT in SAR.
- **Extended Care Facility (ECF):** Recommendation for patients who have no skilled therapy needs. Skilled therapy is services provided by a qualified

professional for a patient that requires the expertise, knowledge, clinical judgment, decision making and abilities of a therapist (PT, OT, SLP) that assistants, qualified personnel, caretakers or the patient cannot provide independently

- **Assisted Living Facility:** Levels of assistance vary significantly at assisted living facilities. If the patient is safe to return to setup prior to admission, therapists can recommend outpatient or home therapy (PT/OT). Tenants can pay for additional assistance if needed. If a patient requires more assistance than what is available at the assisted living facility, or cannot afford to pay for more help, the team may recommend a Subacute Rehab stay (SAR) prior to returning to assisted living.
- **Return to Group Home:** Patient has current assistance available at the group home setup that was in place prior to admission. Therapists can recommend outpatient or home therapy (PT/OT) for people returning to a group home.
- **TBI Facility:** This recommendation is made for patients with a new traumatic brain injury (TBI) or a closed head injury (CHI) who need skilled therapies that are available at these facilities.
- **Long Term Acute Care (LTAC):** This recommendation may be made for patients with complex medical needs, such as being on a ventilator or requiring higher level of nursing or medical care. In such cases therapists may recommend SAR/SNF and the medical team including the case manager decides the level of medical care needed upon discharge. Patients continue to receive skilled therapies at Long Term Acute Care facilities.

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