A Qualitative Study of Clinical Decision Making in Recommending Discharge Placement From the Acute Care Setting

Background and Purpose. One of the roles of rehabilitation professionals in the acute care setting is making recommendations for patients' discharge placement. The purpose of this investigation was to explore the decision-making process of physical therapists and occupational therapists when recommending discharge destination for patients following acute care hospitalization. Subjects. Participants were 7 physical therapists and 2 occupational therapists in an acute care rotation at a large academic medical center. Methods. A grounded-theory strategy was used. Three interviews were conducted and guided by questions about participants' approaches to discharge decision making. Information from the interview transcripts was used to define constructs. A model was generated to explain the relationships among the constructs. Results. Decision making regarding discharge recommendations was guided by 4 constructs: patients' functioning and disability, patients' wants and needs, patients' ability to participate in care, and patients' life context. Information was filtered through therapists' experiences and modified by the health care team's opinions and by health care regulations. Discussion and Conclusion. The decision making of the rehabilitation professionals studied in recommending discharge placements for their patients reflects consideration of patients as individuals and the environments in which they live. Information about patients is filtered through the experience of therapists and influenced by health care regulations and opinions of other health care professionals, the patients, and their associates. The findings might be used in teaching clinical decision making to clinicians and students as they learn to make discharge recommendations. [Jette DU, Grover L, Keck CP. A qualitative study of clinical decision making in recommending discharge placement from the acute care setting. Phys Ther. 2003;83:224–236.]

Key Words: Decision making, Patient care planning, Patient discharge.

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Clinicians make judgments about a patient’s health status based on a variety of measurements and then choose what they believe is the best option for restoring health.\(^1\) Decisions about health care are based on many factors, particularly when there is uncertainty or ambiguity concerning the optimum intervention.\(^2\) These factors include characteristics of the patient as well as characteristics of the practitioner and characteristics of the organization in which he or she works.\(^2\) Models of decision making suggest that resource availability and accessibility, as well as clinicians’ beliefs about the effectiveness of interventions, affect decisions.\(^1\) Eisenberg\(^3\) suggested that a patient and clinician make up a social system and that decisions are made within a framework of the interactions within that system. Research suggests that, given similar data about a patient, resources, organizational structure, and so on, decisions made by different practitioners will vary.\(^1–3\)

For rehabilitation professionals in the acute care setting, including physical therapists and occupational therapists, decisions involve judgments about the patient’s ability to function in an environment and recommendations for the appropriate level of care after discharge (ie, determination of the setting that will lead to the patient’s optimum attainable, long-term function). Jensen et al,\(^4\) using qualitative research methods, have described the reasoning process of people believed by peers to be expert physical therapists. They contended that the therapist focuses on a patient’s function at the time the patient is seen in the clinic and on the patient’s previous level of function, setting mutual goals and recognizing the importance of a patient’s motivation. According to Jensen and colleagues, patients’ and their families’ interests have a strong influence on decision making, which they described as a “collaborative process.” Uili and Wood,\(^5\) in 1995, examined the decision making of physical therapists in skilled nursing facilities using a survey with both open-ended and closed-ended questions. Patient cases were presented to physical therapists for their recommendations for level of care required, including daily, less than daily, or no physical therapy. One purpose was to determine whether therapists made recommendations based on a patient’s prognosis for improvement. Results showed that the patient’s potential for meaningful, rapid, and measurable improvement; his or her prior level of function; and the

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acuity of the condition were all determinants of the level of care recommended by the therapists. Uli and Wood also demonstrated that in cases in which there was ambiguity about the potential for progress and recovery, decisions varied according to the therapist’s age and experience and whether the therapist was on staff or provided contractual services to the facility.

Factors predictive of discharge destination after acute care have been reported in the literature for patients with many types of conditions, including stroke, dementia, hip fracture, trauma, and total joint arthroplasty. Studies have shown a relationship of discharge destination with functional abilities at admission to and discharge from acute care. These abilities include transfers, walking, basic activities of daily living (ADL), cognition, socioeconomic status, caregiver support and wishes, and living situation. Pathology and impairments such as pain and comorbidities also have been shown to influence discharge destination. Some researchers have demonstrated the influence of finances and institutional policies on discharge destination, including a patient’s insurance, Medicare policy, and hospital procedures.

In many studies, researchers have used mathematical models, usually multiple regression models, to show how various factors influence choice of discharge destination. Scores from a variety of standardized tests of patients’ physical and cognitive functioning are used to build the models. The value of this approach is in reducing variability in decision making and possibly improving the quality and continuity of care provided to the patient by focusing the clinician on a defined set of factors to apply in making a decision. This approach, however, may have limited usefulness in the application to individual patients.

Models may be idiosyncratic when built from many variables that are uniquely defined for a study, and there are likely to be difficulties in measuring the patient’s and family’s wants and needs and the impact of third-party coverage on choice of discharge destination. Another problem is information reported in some studies have been derived based on models using data from a variety of measures of mental status or ADL. Because these measures may be specific to an institution or time consuming to implement in clinical care, they may not be readily or willingly transferred for use in another setting. Furthermore, most models fail to fully explain the variation in discharge destination, suggesting that discharge decision making relies on evaluation of factors that cannot be or have not been adequately measured. Using a qualitative approach, Potthoff et al interviewed discharge planners and described the discharge decision-making process used in 10 hospitals. They found that the process included determining the patient’s needs, preferences, prognosis, financial resources, prior use of services, and family support. Another step in the process was choosing, or recommending, the appropriate discharge setting based on the evaluation of information about the patient.

In our experience, the steps described by Potthoff et al may involve either physical therapists or occupational therapists. The actual process of decision making among these rehabilitation professionals has not been examined, and the nature of the data and the extent that the data are used in making discharge decisions across a wide variety of patients have not been reported. In 1997, Pottoff et al suggested that qualitative studies were needed to understand how decisions about discharge were being made. The purpose of our study, therefore, was to explore and describe using qualitative research methods the decision-making process engaged in by physical therapists and occupational therapists when making recommendations about the discharge of patients from the acute care setting.

**Method**

**Design**

We used a qualitative approach because we believed it would provide an understanding and overview of the clinical decision-making process used by physical therapists and occupational therapists in making recommendations about the discharge disposition of patients from the acute care setting. A grounded-theory strategy was used. Chenitz and Swanson described grounded theory as being based on a method of systematic collection and analysis of qualitative information to generate theory that explains a social or psychological phenomenon. The investigator attempts to understand and explain from the participants’ perspective the manner in which people in a specific setting understand, take action, manage, and interact in day-to-day situations. A guiding assumption of grounded theory is that there is a “basic social psychological process” that members of a group use in resolving a specific problem. The role of the researcher is to discover and describe this process.

We reviewed the literature to determine the presence or absence of studies related to the purpose of our study. Consistent with grounded theory, we initially reviewed the literature only to the extent necessary to determine whether there was a lack of literature that described the decision-making process of rehabilitation professionals in acute care discharge planning. Because results of
Qualitative studies may be influenced by the researcher, researcher biases can influence data analysis and interpretations. To limit our biases, we started with a relatively superficial literature review as suggested by Gla- ser.27 Following collection and analysis of data, we conducted a more thorough literature review in an attempt to find and explain links between the existing literature and the constructs we derived from our work.

All subjects signed informed consent forms prior to participation.

**Subjects**

We used a purposive sample of occupational therapists and physical therapists. There are several types of purposive sampling.28 We chose to use both convenience and comprehensive types of sampling. That is, we chose to ask for participation from all the therapists at an institution that was readily accessible, whom we believed would have knowledge of the topic under study. All therapists in the acute care service of a tertiary care, academic medical center of approximately 550 beds in the northeastern United States were asked to participate. We chose to ask both physical therapists and occupational therapists because the 2 professional groups were highly integrated in the rehabilitation services department in this institution. Additionally, both groups of therapists received referrals from physicians asking them to assist in the determination of the best discharge settings for their patients.

The participants were 3 occupational therapists and 7 physical therapists. One occupational therapist was excluded from the analysis due to a poor audiotape quality and inability of the transcriptionist to understand what was said. All participants were women. Their years of experience ranged from less than 1 year to 17 years (X=5.3, SD=5.9). Acute care experience in the facility where the study was conducted ranged from less than 1 year to almost 11 years (X=3.4, SD=3.9). Sixty percent of the staff therapists who participated in the study were hired directly out of their professional (entry-level) programs. The Table presents the characteristics of the acute care rehabilitation staff at the time of subject recruitment.

At the time we conducted the study, the average length of stay for patients in the acute setting in the institution was 4.5 days. The average number of rehabilitation treatment sessions per patient referred for therapy was 3.4. At the time of the study, occupational therapists and physical therapists in the acute care setting of this institution provided direct examination and evaluation of patients in order to contribute to the decision as to the setting to which the patient would be discharged. In most cases, following an initial examination of the patient and evaluation, the therapist noted in the record her recommendation for discharge setting. Discharge planning involved a wide variety of health care professionals, including rehabilitation professionals, nurses, physicians (both resident and attending), case managers for the medical center, and admissions screeners for the facility to which patients might be discharged.

**Procedure**

All participants were interviewed in person by 1 of the 3 investigators. Each interview with the investigator gathering demographic information such as degree earned, years in practice, and years in the current facility. We then used an unstructured format with open-ended questions to explore the participants’ general approach to their decision making related to discharge. All interviews were audiotaped and transcribed by a professional transcriptionist. We reviewed the transcripts after each interview and prior to the next interview. Our initial question to participants was, “How do you make decisions about where a patient should go when he or she is discharged?” We had a set of topics in mind that we wanted to explore relative to discharge decision making, and we questioned participants throughout the interview.

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<th>Participant No.</th>
<th>Professiona</th>
<th>Time Since Initial Licensure</th>
<th>Time in Acute Care at Current Facility</th>
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<th>Time in Acute Care at Current Facility</th>
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aPT=physical therapist, OT=occupational therapist.
to elicit the desired information. Topics included the most common decisions made; the hierarchy, if any, of factors considered in coming to a decision; how the final decision was derived; what were the most difficult aspects of decision making; and how the process of discharge decision making was learned. Using the technique of constant comparative analysis espoused by proponents of grounded theory, questions were altered, added, or deleted as data from each participant were analyzed. For example, when a participant said that she talked to the case manager, we made sure to add questions in each subsequent interview to determine how the relationship with the case manager worked in formulating the participant’s decision. After each interview, the transcript was reviewed together by all 3 researchers.

We listened to tapes to reconcile areas of the typed transcript that did not make sense or that the transcriptionist had left blank due to an inability to understand the participant. We also discussed our data as the data emerged from the interviews. Following the initial analysis, follow-up interviews were conducted to confirm, disconfirm, or add to the investigators’ interpretation of the interview. No attempt was made to have the same investigator who conducted the first interview conduct the second interview. Therapists also were asked to participate in a third interview. During this interview, we asked participants to bring with them a copy of an initial transcript. We then met to come to consensus on initial coding for the transcripts.

We then met to come to consensus on initial coding for the transcripts. Following our initial coding, we met again to discuss and derive a consensus about the relationships in the data that allowed us to group the initial codes into a smaller number of categories or constructs. A construct, in the context of our study, was an attribute (eg, optimism, professionalism) that cannot be directly observed or measured, but has effects that are determined indirectly. We labeled and defined the constructs, chose quotations from the transcripts that exemplified the constructs, and presented them to the participants during a second interview. Using this process and the third interview information, we modified or confirmed the existence of the constructs. Because physical therapists and occupational therapists may address the concerns of patients differently through their examinations and evaluations, we examined the information from the 2 groups together and separately in order to identify similarities and differences in their observations as they related to the constructs. Finally, we synthesized the data into a framework that we believed explained the decision-making process of our participants as they determined their recommendation for discharge disposition of their patients. We sought to enhance the scientific rigor of our study through the triangulation of data. Triangulation refers to seeking out and integrating data from several sources to enhance accuracy. We integrated data from both interviews and therapists’ written patient evaluations, used constant comparative analysis, invited participants to review the data to ensure accuracy and appropriate interpretation, and included an audit of our data by a colleague with expertise in grounded theory who had not participated in the data collection or analysis.

Results

The theoretical model shown in the Figure represents the major dimensions, as well as the relationships among those dimensions, in therapists’ decisions regarding recommendations for discharge for their patients from the acute care setting. These dimensions were identified through our data analysis processes and as a whole represent the process of clinical reasoning used to arrive at the best possible discharge decision for patients.

Patients’ Functioning and Disability

Both physical therapists and occupational therapists appeared to use a patient’s level of functioning and disability as the core dimension in their initial decision making. We defined functioning and disability as including impairments or meaningful deviations or loss in bodily functions or structure, as well as problems with involvement in life situations such as self-care, mobility, and domestic life. The physical therapists appeared to focus on the mobility aspects of functioning and disability, whereas the occupational therapists focused on the cognitive and ADL aspects: “. . . sometimes I feel like they might be safe from a mobility perspective but not from a cognitive perspective . . . so I would refer to OT [occupational therapy].” (Therapist 6)

The following statement by a physical therapist exemplifies this definition with a focus on impairment and mobility: “They have to have enough strength to carry out their ADL, to get out of bed by themselves, to go [from] sit-to-stand, to walk a functional distance, whatever that is for each person.” (Therapist 7) An occupational therapist’s statement revealed a focus on the
In determining recommendations for discharge placement, a therapist examines patients and collects information about their functioning and disability, wants and needs, ability to participate, and the context in which they live their lives. This information is synthesized and considered in light of the therapist's experience to derive an initial impression of what the recommendation should be based on the examination. The therapist then considers the effects the regulations imposed by the health care system place on options for recommendations and shares opinions with other team members before deriving a final recommendation.
self-care and domestic aspects of this construct: “Are they able to stand up and don their pants without losing their balance and falling over? Are they able to get in and out of the shower and on and off the toilet?” (Therapist 2) A physical therapist remarked, “I don’t really assess those things [ADL] as much [as activity tolerance]. I do worry about someone going home, doing a tub transfer, if I felt they were unsteady.” (Therapist 1)

Therapists said they gave consideration to the severity and duration of the problems as well as to the prognosis for improvement and the length of time and effort necessary to improve. One physical therapist’s comments demonstrated this consideration: “I compare them to what their baseline was. . . . I look generally at how bad of shape they’re in, what their diagnosis was, how long they’ve been in the hospital.” (Therapist 4) An occupational therapist similarly stated, “I would also look at their baseline function and how far they were from that status.” (Therapist 2) Therapists also considered the effect of the problems on the potential for individuals to harm themselves, particularly if there was a possibility of self-care and domestic activities. (Therapist 2) A physical therapist likewise voiced concern about safety, although she phrased this concern in terms of mobility, using a patient needing a walker as an example: “Do they have rugs all over the place? Is it very narrow, [so] they’re not going to be able to use it [the walker] in certain areas?” (Therapist 3)

The more severe patients’ conditions were, and the more deviant from their baseline functioning, the more clear the therapist was about a recommendation for a formal rehabilitation setting rather than home. This consideration is noted by one physical therapist in the following quotation with a focus on impairment: “Well, if a patient is just so impacted by a neurological event . . . their balance is really poor, they’re unable to maintain midline position . . . their motor control is poor . . . they’re unable to use their extremities . . . that’s the type of patient [for whom] you definitely develop the appropriate plan for rehab.” (Therapist 1)

One occupational therapist, while noting prognosis and cognitive ability as being related to her decision about a rehabilitation setting, also implied that patients with neurological deficits were somewhat easier to make decisions about than patients with other types of conditions: “…if they have a fairly good prognosis, are able to make decisions, [and] they’re able to carry over new[ly] learned tasks . . . obviously the neuro patients are going to need that . . . then I would [recommend placing] them in an acute [care] setting.” (Therapist 9)

**Patients’ Wants and Needs**

Additional dimensions, beyond impairment and disability, that were integral components of patients’ lives added information and augmented both occupational therapists’ and physical therapists’ decisions. One of these factors was the patients’ wants and needs. Patients’ wants included their goals for future functioning in their social, family, and work roles, and where they were willing or wanted to be following discharge. This dimension also included a family’s desire and willingness to either care for a patient’s needs at home or support the patient in another health care setting. A physical therapist stated, “…it depends upon what the patient wishes, obviously. If they want to go home and they have the appropriate support, then I would be more apt to send them home.” (Therapist 3) An occupational therapist was similarly concerned, remarking on the importance of: “. . . looking at patient goals in regards to what is important to them.” (Therapist 9) Therapists also shared their knowledge and opinions to influence the patient’s and family’s understanding about the setting that would best match the patient’s abilities. As one physical therapist explained, “Our job is to advocate for the patient, and so if we feel that a patient needs a certain level of care, we should try to educate the patient and family of that.” (Therapist 7) Similarly, an occupational therapist confirmed, “I’ll try and give a few options [so] that a family member can say, “This will be the best.”” (Therapist 9)

**Patients’ Ability to Participate**

A patient’s ability to participate in care was another important factor affecting therapists’ decisions. Participation was defined as the ability to actively take part in, direct, and share responsibility for one’s care and its outcomes. Occupational therapists and physical therapists considered a patient’s motivation, ability to learn and apply knowledge, confidence, and activity tolerance in terms of the patient’s ability to participate. An occupational therapist demonstrated her focus on motivation as it related to ability to participate: “If I feel that somebody is a motivated patient and they can actively participate in 3 hours of therapy a day, . . . then I would recommend an acute rehab.” (Therapist 9) A physical therapist voiced a similar focus on motivation: “Are they [patients] interested and participative in rehab or getting better, or are they not the least bit interested at all?” (Therapist 7)

**Context of Patient’s Life**

Therapists said they considered the context in which their patients lived in making decisions about discharge recommendations. We defined context as the physical,
social, and attitudinal environment in which the patient lived his or her life. Both occupational therapists and physical therapists said they considered the patient’s support network of family and friends and their ability to support a patient in a particular discharge milieu. As one physical therapist noted, “Definitely family support is involved. If I think that they’re kind of on the fence but they’re safe with supervision, I’m going to talk to the family and see if they can give the patient the amount of [support they need].” (Therapist 6) One occupational therapist stated, “I think probably the biggest factor I look at is the amount of social support that the patient has at home.” (Therapist 2) Therapists also considered the patients’ ability to live safely given the modifications, equipment, and architectural barriers in their homes and the supports of the community. An occupational therapist commented, “I’ll always get the big background...a very detailed home environmental setup and the equipment that they may own.” (Therapist 9) Physical therapists also paid attention to architectural barriers, although the focus seemed to be on mobility: “[Do] they have stairs, and if they have stairs, do they have a railing?” (Therapist 8)

The less sure the therapist was about the patient’s function and disability, ability to participate, and context, the more conservative the decision. For example, one physical therapist stated, “I tend to err on the side of sending them to rehab because I know that’s going to be safe for them, and if I have any doubt in my mind, then that’s the way I’m going to go.” (Therapist 6) This statement reflects a focus on functioning and disability. An occupational therapist demonstrated a focus on patients’ ability to participate and context when she noted that her hesitancy to recommend a home discharge was related to: “[knowing] that at home an OT [occupational therapist] might not get in there for 5 days to a week...that the patient may not follow up with outpatient therapy or that the patient may not basically adhere to recommendations.” (Therapist 2)

Therapists’ Experience

Both occupational therapists and physical therapists said they analyzed the data from their examinations, including information about the patient’s function, disability, wants and needs, and ability to participate in care and the context for his or her life. The therapists said they synthesized this information based on their experiences. We defined experience as practical knowledge or skill gained from formal education or direct observation, consultation, or participation in patient care as a rehabilitation professional. Experience was derived from the acute care setting in which the therapists were employed as well experiences in other acute care settings, rehabilitation settings, and home settings.

Experience included having participated in the care of a number of patients with similar conditions as well as patients with a variety of conditions of varying severities. As one physical therapist explained, “...after you see people over and over again, you can sort of learn to come to expect certain things, and certainly people surpass or are below your expectations, but it gives you a picture...more often than not, this happens with this type of patient.” (Therapist 3) An occupational therapist also discussed the effects of prior experience on her decisions: “That [experience working in the rehabilitation setting] gave me a good insight into even visualizing, planning, and figuring out what’s going to be safe for people.” (Therapist 9) Therapists with little experience tended to rely more on their colleagues to confirm or validate their recommendations.

One physical therapist with approximately 8 months of experience, all in an inpatient setting, stated, “...[case managers] tend to make the right decisions as far as having a better intuition about where the patient should go, so I usually like to get their opinion.” (Therapist 6) Physical therapists with little experience also tended to make more conservative decisions, recommending more formal supportive levels of care rather than discharge to home. A physical therapist with approximately 1.5 years total experience and 5 months in acute care stated, “I probably tend to err more on the conservative side...I would feel terrible if someone went home and failed or if they fell...” (Therapist 1) Physical therapists with little experience also reported having more difficulty than their colleagues with more experience with the time constraints imposed by regulations: “...the time constraint is very stressful.” (Therapist 6) The occupational therapists in our sample each had approximately 3 years of experience and did not discuss the issues related to lack of experience.

Therapists noted that their academic experience was not a major contributing factor in their learning to make discharge recommendations. As one occupational therapist noted, “I remember when I first started, I said I really wish I had a class on insurance and I really wish I had a class on discharge planning, 2 things, as great as my program was, we didn’t talk about. And I would say that about 40% of my job is discharge planning, if not more.” (Therapist 2)

In talking about how she learned to make decisions about discharge, a physical therapist noted the type of background that she was provided in school: “I can’t say I specifically learned [discharge planning]. I mean I think it was just over 5 years of the curriculum about assessing patients medically and assessing patients physically.” (Therapist 4) She went on to say, “Well, in school we learned about the different levels of rehab and the
different qualifications that you would need to get to the different rehab [settings].” One physical therapist noted of her affiliating students, “I think they can do [discharge planning] to an adequate level . . . still, very often by the time they leave, they still need help with that decision making.” (Therapist 7)

According to the therapists, following their analysis of patient data and synthesis of information through the filter of experience, they formed an initial impression of the best discharge destination for the patients. The initial impression was then modified through consideration of 2 additional dimensions, but in no obvious order. They said they considered the opinion of other team members and regulations within the health care environment.

Sharing of Opinions
We defined opinion sharing as seeking the opinion of others by engaging in a collaborative effort that aims to match one’s opinions with those of the other members of the health care team. This form of communication was both implicit and explicit. In the setting in which our study was conducted, the physical therapists and occupational therapists appeared to work closely together. One experienced physical therapist remarked, “If there’s no OT [occupational therapy] consult written and I think they [the patients] need it, I’ll advocate for the OT consult.” (Therapist 8) Accordingly, occupational therapists and physical therapists often first looked to each other for agreement about a patient’s discharge destination before seeking opinions of others. As one occupational therapist noted, “I don’t think I have ever recommended a certain discharge plan without contacting the physical therapist that’s working on a case. I think there’s always some sort of touching base with someone if there’s any question . . . making sure that this is the discharge plan that everyone recommends.” (Therapist 2)

Therapists seemed to seek either validation of or agreement with their discharge decisions, depending on their years of experience in the acute hospital setting. The following statement was made by a physical therapist with a little more than 1 year’s experience: “I hear other people saying the same thing I said, or the case manager is agreeing, or the attending physician is looking at it and agreeing. Sometimes that reassures me that I’m making the right decision.” (Therapist 4) The more complex the patient’s condition, the more opinion sharing seemed to play an explicit role in making decisions. As noted by one physical therapist, “. . . what I would do is . . . get a second opinion if I went in and saw someone and I just wasn’t sure.” (Therapist 3)

Health Care Regulations
Health care regulations appeared to affect the therapists’ decision-making processes in several ways. The therapists said they felt the need to consider their recommendations in light of the constraints placed on the patient’s options for discharge. These constraints included insurance coverage and regulations at the private and governmental levels and institutional issues related to the acute care length of stay and criteria for various discharge settings. As one occupational therapist related, “Unfortunately it also depends on insurance reimbursement. Not that that would change what I would recommend, but unfortunately we’re at times forced to send a patient home when they would benefit from rehab greatly because of lack of insurance.” (Therapist 2) Thinking by the physical therapists was similar, as exemplified by this statement: “I had a patient today who had no insurance, was from another country . . . . I still wrote that I recommended rehab . . . but unfortunately you have to look at the possibility that he might not be able to go, and then you have to have a back up plan.” (Therapist 4) Both statements suggest that therapists did not let insurance coverage and regulations limit their initial decisions. In cases where reimbursement was available (eg, patients with Medicare coverage), therapists stated that they did not consider this issue at all. Many final recommendations, however, were influenced by insurance or the structure of the setting to which they were to be discharged.

Institutional issues affecting decision making included practicing in an environment where the length of stay was quite short (ie, the acute care setting). Therapists were required to make recommendations for discharge during their initial visit with the patient. The effect of this environment on decisions was reported by one therapist with 17 years of experience: “Yes, you have to make the decision almost the first day that you see a patient, and that’s hard because you don’t always have all the information.” (Therapist 7)

Discussion

The Basic Social Process
Our results suggest that discharge decision making is a basic social process involving therapists and patients. Therapists appear to use clinical reasoning to arrive at what they believe are the best possible recommendations for discharge destinations for their patients. Barrows and Pickell have noted that the services provided within a particular setting in which a therapist treats patients impart an implicit contract. For example, an implicit contract between a patient and a rehabilitation professional might involve the expectation that the clinician will address the patient’s goals, that the patient will take part in the treatment plans, and that, in working
with the clinician, the patient will have less pain or better physical functioning. In the acute care setting in which the therapists involved in this study worked, an encounter with a patient implied a recommendation for discharge destination, and sharing of this recommendation with other decision-makers, including the patient, family, and health care team.

**Patients**

Barrows and Pickell\(^{30}\) suggested that decision making involves collecting data and synthesizing the data into an evolving mental image of a problem or solution. In our study, the data used in discharge decision making were collected and synthesized from 4 key areas: function and disability, needs and wants, ability to participate in therapy, and life context. Similarly, in a study by Unsworth et al.,\(^{31}\) the crucial information used by health care teams, including physical therapists and occupational therapists, to make decisions about the discharge of hypothetical patients with stroke from a rehabilitation setting was related to the patient’s mobility, ability to perform ADL, and level of social support. Morrow-Howell and Proctor\(^{32}\) demonstrated that medical factors, defined as the pathology, level of physical dependency, and cognitive state, were the most important factors in distinguishing among patients’ discharge destinations.

Our findings are also supported by Jensen et al.,\(^{4}\) who noted that physical therapists’ focus on a patient’s current and prior function, the patient’s interests and motivation, and goal setting with the patient.

Although studies examining the choice of discharge destination often focus on the use of standardized tests such as the Functional Independence Measure,\(^{6,9,10,16,20}\) the therapists in our study, for the most part, did not use standardized tests of function and disability, citing the limited time they had for examination of each patient. Unsworth et al.\(^{14}\) found that only 54.6\% of hospital discharge and rehabilitation admissions coordinators (including nurses, physicians, and “allied health” professionals) in the United States relied on standardized tests of function in making decisions for children with traumatic injuries. Similarly, Potthoff et al.\(^{24}\) found that none of the 10 hospitals across the 7 different cities that they surveyed had implemented standardized tests in decisions about discharge.

**Therapists**

Based on what we observed, the information about the patient’s life was synthesized and filtered through the therapists’ experience, and an initial impression was formed as to the discharge destination most compatible with the patient’s situation. Barrows and Pickell\(^{30}\) suggested that experienced clinicians’ evaluations are often more rapid and confident than those of their less experienced colleagues because they are able to draw on their memories about the characteristics of a particular patient problem. Similar to our findings, Curtis et al.\(^{33}\) reported that therapists with the least experience were most likely to report inadequate time to treat their patients.

Reich et al.\(^{25}\) found that occupational therapists were more likely than student occupational therapists to recommend discharge to a home setting. They hypothesized that students were likely more focused on the physical aspects of the patient and that the experienced therapists were more willing than the students to consider the wishes of the patient regarding home placement. We, too, found that therapists with lesser amounts of experience mentioned being conservative in their decisions. They were more likely to recommend a supported setting than home for patients, particularly if a patient’s life situation (eg, the patient’s family support or safety of the home environment) were not clear.

Unsworth et al.\(^{31}\) although they did not examine the effects of provider experience, also found that recommendations for discharge of hypothetical patients from a stroke rehabilitation unit were often conservative. That is, settings providing high levels of support, such as nursing homes, were frequently recommended. Their subjects included nurses, occupational therapists, physiatrists, social workers, physical therapists, and speech pathologists. This type of “discharge conservatism” has been addressed by Frost\(^{34}\) and is, in his opinion, related to the practitioner’s tendency to discount the decision-making ability of elderly patients, fear of the hospital’s risk should the patient fall at home soon after discharge, and an overemphasis on the burdens of caring for someone at home. We did not find these issues mentioned by our participants.

Most of the participants in our study noted that they had learned how to make discharge recommendations through clinical experience and through opinion sharing with their colleagues and health care team members. Osberg and Unsworth,\(^{15}\) in a study of discharge decisions for children, found that only about half of their hospital discharge and rehabilitation admission coordinators had training in discharge and admission planning. All of our participants remarked that they had not learned the process involved in discharge planning in school.

**Sharing of Opinions**

Opinion sharing was, according to our participants, another important dimension of decision making and apparently was used by the participants to focus and refine their final recommendation. Similarly, Dill\(^{35}\) found that discharge planners, in their case social workers, who were responsible for planning a patient’s discharge, sought consensus among professionals within
In a study in the United Kingdom, Gibbon found that the decision-making process.

In a study in the United Kingdom, Gibbon found that the greatest contributors to team conferences in the rehabilitation setting were physical therapists. They found that physical therapists supplied the most information and most frequently proposed the course of action. Similarly, in our study, for the more experienced therapists, sharing of opinions with the health care team about discharge disposition took the form of providing information to the team regarding their findings and recommendations rather than seeking confirmation.

Gibbon also found that occupational therapists spoke up to second physical therapists’ proposals. Physical therapists and occupational therapists in our study reported that they frequently sought to confirm information from one another.

**Health Care Regulations**

The model we observed in use suggests that constraints imposed by the health care system may cause therapists to reconsider and alter their initial recommendation to obtain the best possible match between the requirements of that system and the patient’s reality. Dubler has described the discharge process as blending the patient’s needs and wants, the provider’s suggestions, and the allowances of payers. Volland has suggested that the discharge planning process requires addressing system-specific and patient-specific concerns. One system-specific concern is that several groups participating in the decision outcomes, including the patient and family, practitioner, institution, and payer, each potentially have different goals. Another system-specific factor cited by Volland is the lack of time for decision making. The decision-making process of our participants mirrored these concerns. Volland described a sequential process of discharge planning as involving evaluation of the patient, talking to the patient and understanding his or her needs, developing a plan, determining obstacles to the plan, and implementing the plan. This process is reflected in our interviews and subsequently in the model developed based on them. The obstacles noted by our participants are largely related to health care regulations, and as a result therapists said they sometimes modify their initial impression of the best discharge destination. Similarly Dill, in an ethnographic study of discharge planning for elderly people, suggested that the use of institutional beds and payment for care can be as important as examination findings related to the patient’s needs in making discharge decisions.

Morrow-Howell and Proctor, using mathematical modeling, found that social support was the least important factor in discharge destination for elderly patients in an urban teaching hospital, ranking behind patients’ financial resources. In our theoretical model, therapists considered patients’ conditions and situations first, including their medical and functional status and support systems, in formulating an initial impression about the setting to which patients should be discharged. This initial impression, however, was sometimes altered by the realities of the health care system, which included financial resources. Thus, our model, in part, seems to be supported by the findings of Morrow-Howell and Proctor.

**Comparisons of Occupational Therapists and Physical Therapists**

The decision-making processes of the physical therapist and occupational therapists we studied are remarkably similar and reflected in the model that we propose. Some differences appear to exist in terms of the scope of their focus on patients’ functioning and disability in making their recommendations. Physical therapists seemed to focus on the impairment level and mobility-related functions such as muscle force, balance, and ambulation. Occupational therapists, however, tended to focus on ADL. Each group of professionals said they evaluated patient function and disability in terms of the severity of the patient’s condition, how far from his or her function prior to admission the patient is, and how safe the patient might be to return home. Each group’s decision making seemed to include concern for the patient’s wants and needs, ability to participate, and context for living, and the filtering of information about the patient through the lenses of experience and health care regulations was similar for both groups.

Our study is limited in its external validity by the nature of its design. We explored the decision-making process of rehabilitation professionals in one setting, and all of the participants were women. As noted by Hutchinson and Wilson, in qualitative research the issue is not so much generalizability, but the utility of the theoretical constructs in explaining the social process being described. In our case, this was the discharge decision making used by rehabilitation professionals. Although our design did not allow statistical comparisons among participants, we selected a group of therapists with a wide range of experience in the acute care setting in order to explore discharge decision making. A majority of our participants, however, had less than 5 years of experience in their profession and even less experience in the acute care setting. The social process we describe...
is limited to this group of relatively inexperienced therapists in this one setting.

A limitation may be that we chose to include both physical therapists and occupational therapists in our study. We made this decision due to the integrated and overlapping roles of physical therapists and occupational therapists on the inpatient service of their institution. Our data suggested that participants from each profession addressed similar themes. A related limitation is the inclusion of only 2 occupational therapists. The proportion of physical therapists and occupational therapists in our sample, however, reflected the makeup of the setting in which we conducted the study.

Another limitation is the lack of information about the actual discharge destination of patients in relationship to the physical therapists’ and occupational therapists’ recommendations. We asked therapists about their decision-making process in general, and we used one patient example to aid in data triangulation. We did not attempt to determine the actual discharge destination of any patients. In this respect, we were unable to determine whether the decision-making process actually had an impact on the final destinations of patients or whether their final destinations were the best choice for patients in terms of their physical and role-related outcomes. Such a determination was not our intent.

The clinical implications for our study rest with the utility of our theoretical model. We believe that the model might be useful for helping administrators, educators, students, and practitioners who are new to the acute care setting in thinking about the patient-related factors that may be important in making decisions about patients’ discharge destinations. Educators of rehabilitation professionals may take note of the role that these clinicians appear to play in providing information about the patient to the team for consideration in discharge planning in the acute care setting and in providing sufficient background through the curriculum. Clinical supervisory personnel might recognize the need to ensure some experienced staff are employed in the acute care setting to teach the process of discharge planning to new practitioners and to enhance the team’s efficiency and reliability in decision making. Those responsible for institutional operations might infer the importance of structuring care delivery to facilitate interdisciplinary opinion sharing by involving physical therapists and occupational therapists in discharge decisions.

Future research is necessary to test hypotheses suggested by the model such as the effect of experience on decisions, the differences between occupational therapists and physical therapists in their consideration of patients’ functioning and disability, the interaction of the patients’ needs and wants with their life context, and the hierarchy of the influence of factors overall on the recommendation for discharge destination. In addition, future research could determine whether therapists’ decision making plays a role in placement after discharge and whether different models of decision making are used in settings where the decisions are known to have an impact on discharge setting.

**Summary and Conclusion**

In this grounded theory study, we propose a model for discharge decision making. Discharge decision making is a basic social process involving therapists and patients in which therapists use clinical reasoning to arrive at what they believe are the best possible recommendations for discharge destinations. An encounter between a patient and therapist in the acute care setting implies that there was a rapidly determined recommendation for discharge destination; sharing of this recommendation with other decision-makers, including the patient, family, and health care team; and assuring the compatibility of the decision with the realities imposed by the health care system. The clinical reasoning process we describe necessitates collection and synthesis of information regarding patients’ life situations to formulate impressions of where patients would best be served. This initial impression appears to be affected by the therapist’s clinical experience. Finally, the impression initially achieved by the therapist may be refocused through sharing of opinions with other health care team members and knowledge of the constraints imposed on the ideal solution by institutional, private, and governmental regulations.

**References**


