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Building Rehabilitation Into Discharge Goals and Engagement (BRIDGE) Framework

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Abstract

Effective discharge planning is crucial for ensuring safe transitions and sustained occupational participation as clients transition from professional care to their desired community settings. Despite its importance, current discharge practices in occupational therapy remain inconsistent, often relying on informal communication, variable team coordination, and unstructured decision-making. These gaps contribute to client–caregiver unpreparedness, fragmented services, and increased readmissions. This manuscript presents the Building Rehabilitation Into Discharge Goals and Engagement (BRIDGE) Framework, a client-centered, occupation-focused conceptual model designed to structure and support the discharge planning process in occupational therapy.

The BRIDGE framework was developed through an iterative process of literature review, theoretical grounding, and integration of clinical experience. It synthesizes principles from the Canadian Practice Process Framework, Person–Environment–Occupation frameworks, the Kawa Model, and Bioecological Systems Theory. The framework outlines six discharge planning steps, ranging from goal and timeline setting to follow-up and monitoring, supported by four foundational pillars: patient and family factors, occupational therapy factors, interdisciplinary team factors, and environmental or system influences. Together, these components provide a comprehensive guide for clinical reasoning, collaborative planning, caregiver preparation, and transitional support.

The framework clarifies the role of occupational therapy, enhances interprofessional coordination, and promotes consistent transition planning. Future work should include empirical testing, case-based application, and population-specific adaptations.

Key Words*: Discharge planning, interprofessional collaboration, community reintegration*

BACKGROUND

The rehabilitation process typically involves a sequence of evaluation, intervention, and monitoring to achieve client outcomes. As they discontinue direct services, discharge planning is usually done to ensure continuity of care from one setting to another. It usually involves an interdisciplinary team that includes physicians, therapists, social workers, and other professionals, collaborating with the patient and caregiver to ensure safe transitions.[1,2] For occupational therapists, the client's continued participation in desired occupations is prioritized as they are reintegrated into the community.[3]

The importance of effective discharge planning is highlighted in both service delivery and client outcomes, as it has been linked to improved independence in occupations, reduced hospital stays, increased caregiver preparedness, and efficient and cost-effective service delivery.[1,3,4] However, due to the lack of an adaptable, evidence-based framework for discharge planning, the current discharge practices rely heavily on informal communication and disorganized execution of service transitions.[5] This problem limits the scalability and sustainability of effective discharge systems and promotes poor discharge, which is associated with unsatisfactory client outcomes and an

increased risk of readmissions or complications.[1,4,5]

With these in mind, the Building Rehabilitation Into Discharge Goals and Engagement (BRIDGE) Framework offers a structured, occupation-centred sequence of six discharge planning steps supported by four foundational pillars. It provides a coherent guide for clinical reasoning, collaborative decision-making, and safe, efficient transition from the current setting toward the client's desired setting.

Objectives

This framework aims to achieve the following objectives that address the limitations of current discharge planning practices in occupational therapy:

1. To identify and define the sequential steps of discharge planning in occupational therapy practice, clarifying roles, responsibilities, and decision points across the patient–community continuum.
2. To establish discharge parameters by identifying factors that inform safe and context-specific occupational therapy discharge planning decisions and processes.

To promote effective and sustainable community reintegration by guiding practitioners in implementing coordinated preparation, transition, and follow-up processes that support continued occupational participation.

DEVELOPMENT PROCESS

The development process began with an independent literature review on discharge planning across settings, identifying common challenges and stakeholder barriers. These findings informed group discussions that integrated evidence with clinical experience, revealing gaps in practice. Relevant models, frames of reference, and theories were selected to ground the framework. Collaborative brainstorming refined its components, structure, and visual mapping. To clearly present the framework, the authors generated an image (Figure 1) with the help of AI technology and a graphic artist. Ultimately, evidence, theory, and identified variables were synthesized into a cohesive discharge planning framework.

THEORETICAL BASES

The theoretical foundations of the BRIDGE framework integrate models that emphasize holistic, client-centered, and collaborative occupational therapy practice. The Canadian Model of Occupational Performance and Engagement (CMOP-E)[6] and the Canadian Practice Process Framework (CPPF)[6] inform the structure of discharge planning by adapting key action points relevant to the discharge process. These include assessment (understanding occupational status and potential for change), collaborative goal setting (aligning discharge priorities with individual needs), implementation (empowering clients, caregivers, and stakeholders through education and training), and monitoring and evaluation (providing follow-up and adjustments as needed). Together, they ensure that discharge extends beyond leaving the hospital and instead promotes meaningful re-engagement in everyday life.[6]

Complementing this, the Bioecological Theory highlights how interacting contexts shape outcomes.[7] Discharge planning, therefore, considers person factors, caregiver and family dynamics, and broader cultural, socioeconomic, and institutional influences. Within this lens, the microsystem reflects care settings such as wards, centers, and homes, while the mesosystem involves transitions to environments such as school, work, or home. Exosystem conditions, including caregiver burnout and financial burden, influence reintegration, while macrosystem forces such as stigma, limited funding, and structural inequities shape access and participation.[7] This systems-oriented view underscores the importance of communication and coordinated collaboration.

The Person-Environment-Occupation-Performance Model reinforces individualized planning by examining the interaction of personal capacities, environments, and daily roles.[8] Person factors span physical, cognitive, psychological, neurobehavioral, and spiritual dimensions,[8] with

evidence supporting the role of knowledge and self-management in reducing readmissions.[9] Environmental elements include social networks, culture, socioeconomic structures, and built surroundings,[10,11] while occupation emphasizes returning to meaningful roles and routines.[12]

Finally, the Kawa Model conceptualizes the discharge journey as a river, illustrating how environmental barriers, contextual conditions, and personal resources dynamically interact to influence occupational engagement.[13] Collectively, these models shape the BRIDGE framework to promote empowerment, sustained participation, and effective, contextually responsive discharge planning.

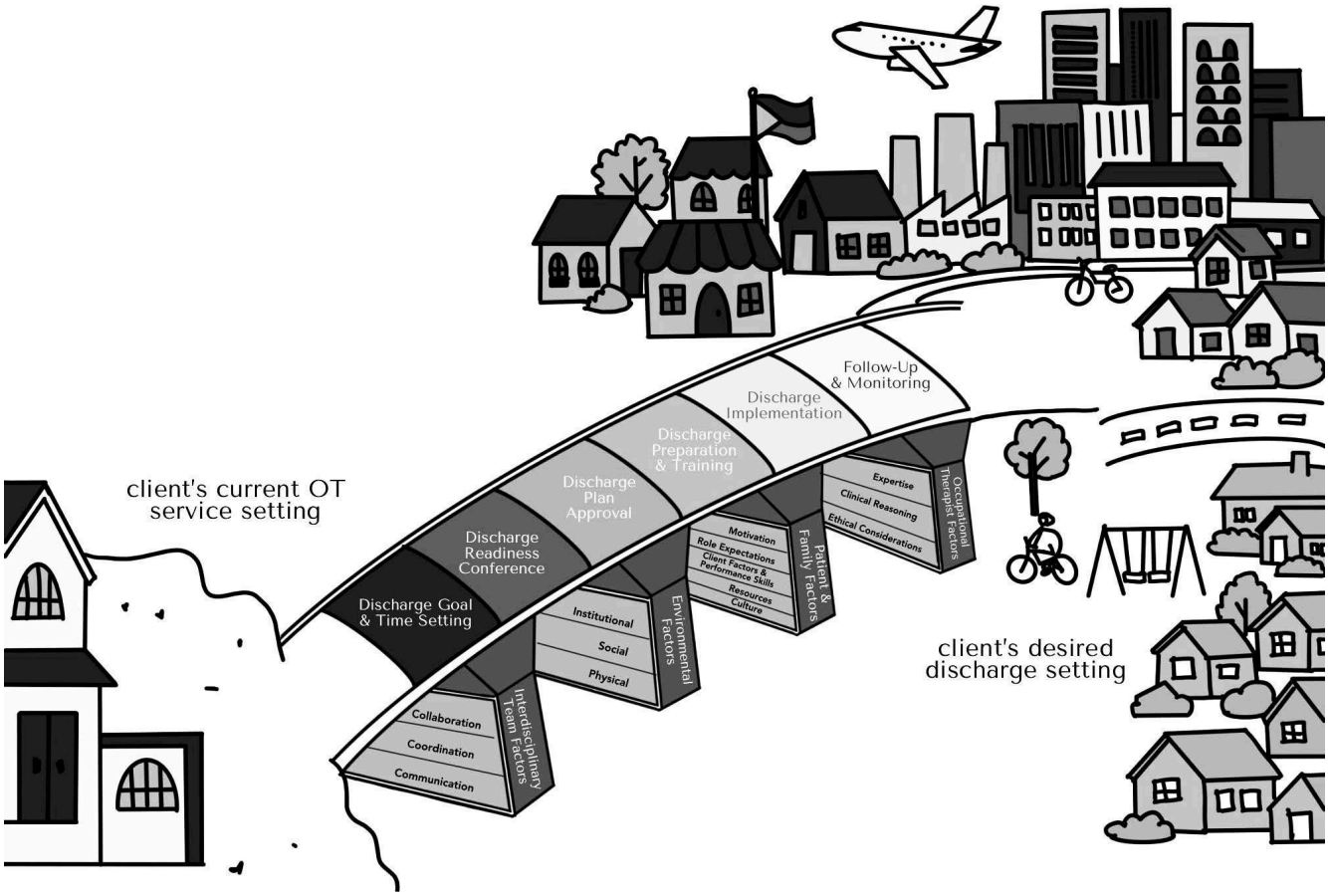

Fig. 1. Building Rehabilitation Into Discharge Goals and Engagement Framework

DISCUSSION

The following section provides a deeper look into the BRIDGE Framework, outlining how its steps and foundational factors work together to guide transitions between settings.

Left bank. This represents the client's current setting. Whether in- or out-patient departments of hospitals, private clinics, or community rehabilitation, the left bank represents where the client is currently and their status.

Right bank. The right bank represents the client's desired setting and end goal of occupational participation. Occupational participation refers to an individual's capacity to engage in essential and preferred occupations, demonstrated through functional independence and effective role performance. It also encompasses community reintegration, in which individuals are supported in resuming meaningful roles and routines within their daily environment.

Bridge Deck. This represents the six sequential steps of occupational therapy discharge planning, guiding the client's movement from the current to the desired setting.

Six Sequential Steps of Discharge Planning

Discharge Goal & Time Setting. This stage involves all stakeholders involved in the rehabilitation process communicating and determining their respective goals with the client and family, based on their desired outcomes, capabilities, and resources.[1,4] It ideally begins at the onset of therapy. It evolves over the course of care, since setting discharge timelines and goals early on prevents abrupt transitions and unprepared clients and families.[14]

Discharge Readiness Conference. This step is the formal convening phase, during which the interdisciplinary team, client, and family come together to discuss the client's current status, overall progress, and discharge readiness. Collaboration and coordination on the direction of the discharge plan, based on client, environmental, and social factors, ensure that outcomes are achieved and that the client and family are adequately prepared for the transition. It is generally conducted after intervention implementation and when the client demonstrates functional improvement and stability.[15]

Discharge Plan Approval. This phase is the formal decision-making or "green-light" phase, during which discharge plans informed by findings from the first two steps are planned and endorsed by the interdisciplinary team.[16] Formal endorsement is contingent upon a comprehensive assessment of the client's updated functional status, environmental readiness, and crucial caregiver preparedness,[17,18] alongside a thorough review of any remaining risks or requirements.[19]

During this phase, the team also confirms specific roles and responsibilities, finalizes timelines for final preparations, and identifies any conditional criteria needed for a smooth transition.[16] Coordination also extends to external stakeholders and community agencies (e.g., employers, school personnel, or home-health providers) whose involvement is essential for supporting the client's post-discharge roles and ensuring continuity of care.[18,20]

Ultimately, all stakeholders are aligned, prepared, and committed to proceeding safely and efficiently toward discharge in this phase.[20]

Discharge Preparation & Training. This stage is the action and teaching step, wherein the interdisciplinary team and the occupational therapist provide client and caregiver training and various stakeholders, such as teachers, employers, and volunteers, through discussion and a "demo-return-demo" of a personalized home instruction program (HIP) catering to the needs of the client before discharge implementation.

The HIP includes, but may not be limited to, the following: interventions that support occupations, occupations and activities, task and environment modification strategies, and caregiver-specific education topics (e.g., proper handling and positioning, grading of assistance in activities, environmental preparation upon discharge, etc.) that are related to discharge goals regarding occupational performance.[21] These will be tailored based on the data gathered from the previous steps.

Discharge Implementation (Exit). This stage is the transition step, focusing on the seamless transfer of the client from the current to the desired setting. It entails the execution of planned discharge interventions based on home instructions and the provision of guided support to facilitate a safe, coordinated, and client-centered transition.[21] This may be achieved through coordination with professionals involved in the community (e.g., social workers, barangay officials, volunteers) and stakeholders in the desired setting (e.g., teachers, employers, colleagues, etc.) to ensure a seamless transition towards community reintegration.

Follow-up & Monitoring. This stage is the sustenance step, in which the interdisciplinary team and the occupational therapist collaborate to provide support after discharge to ensure an effective transition and adjustment for the patient.[21] It aims to secure continued maximized function and optimal independence in valued and meaningful occupations through scheduled

check-ins, home or community visits, telehealth consultations, and communication with relevant stakeholders. This step also involves reinforcing client and caregiver education and training, and modification of goals, strategies, and care plans as needed. Timely referrals for additional support are also facilitated.

Factors in Columns

Patient and Family Factors. The patient and family are at the center of the OT discharge process, and their role is essential for a successful transition,[3] as their knowledge, attitudes and expections, involvement, motivation, skills, culture, and needs shape realistic goals, influence how well recommendations are followed at home, and guide therapists in creating smoother, safer, and more sustainable discharge outcomes.

Occupational Therapist Factors. The occupational therapist's role spans all stages of discharge planning, drawing on professional expertise and clinical reasoning to guide decisions from assessment through transition home, with higher hospital spending on OT linked to reduced readmissions and safer, more sustainable discharge outcomes.[3] OTs evaluate the person–environment–occupation fit, integrate ethical considerations that balance safety, autonomy, and negotiated risk,[19] and provide caregiver training, environmental adaptations, equipment recommendations, and home assessments to reduce fall risk and enhance participation.[17] Through occupation-focused planning and coordination with the interdisciplinary team, they advocate for goals centered on functional needs and meaningful occupational engagement.[16,22]

Interdisciplinary Team Factors. The interdisciplinary team is composed of healthcare professionals and community stakeholders whose involvement varies depending on the client's diagnosis, setting, and discharge goals. This team commonly includes physicians, nurses, occupational therapists, physical therapists, speech-language pathologists, social workers, psychologists, and dietitians, who work together to support the client's transition. It may also involve community-based partners such as teachers, employers, barangay health workers, volunteers, and representatives from community or non-government organizations, particularly when facilitating return to school, work, or meaningful community participation.

The components of the said factor include Collaboration, Coordination, and Communication, highlighting the importance of stakeholder alignment throughout the process. Collaboration refers to members of the interdisciplinary team working together toward shared discharge goals through decision-making, coordinated plans, and mutual respect and understanding of each profession's expertise. Coordination, on the other hand, involves the organization, sequencing, and integration of plans and interventions among the team to ensure a smooth and efficient service implementation. Meanwhile, Communication ties it together through the sharing of information, discussions, and decisions, and through maintaining mutual understanding during the process.[4,5]

Environmental Factors. Environmental factors are external components that influence the discharge process. First, institutional factors refer to elements within a healthcare institution that influence service delivery and discharge planning for both inpatients and outpatients. These factors encompass the services, systems, and policies established by the institution to meet patients' needs. However, challenges such as limited resources, infrequent or limited service availability, and inconsistent follow-up protocols can significantly affect both the discharge process and the continuity of care that follows.[23] Second, social factors pertain to the people or groups who provide practical, physical, or emotional support across different contexts. These may include families, religious organizations, care groups, friends, and other social networks that contribute to the patient's overall well-being and adjustment.[2] Finally, physical factors pertain to the built and natural environment that shape a patient's ability to access and engage in care. These include challenges such as limited physical space accessibility and inequities in the availability of adaptive tools, equipment, and devices.

In the Philippines, these barriers are evident in cases such as limited access to rehabilitation services, lack of availability for community-based

programs, and overreliance on caregivers. Such barriers can significantly influence the patient's independence, participation, and overall rehabilitation outcomes.[2]

Case Vignette. To illustrate application of the framework, this sample case is presented. Mr. R is a 68-year-old retired teacher recovering from a left MCA stroke with right-sided weakness, slowed processing, and mild expressive aphasia, resulting in decreased independence and safety at home. He requires assistance with self-care, medication management, mobility, communication, and household tasks and reports fear of falling.

1. Discharge Goal and Time-Setting: This entails collaboration with Mr. R, his family, and other stakeholders (i.e., members of the interdisciplinary team) to prioritize safe self-care, fall prevention, and home mobility within the expected discharge timeframe.
2. Discharge Readiness Conference: The interdisciplinary team reviews his physical, cognitive, and communication limitations, environmental risks, caregiver availability, and psychosocial concerns.
3. Discharge Plan Approval: The plan is formally approved by the interdisciplinary healthcare team after confirming functional status, home safety modifications, caregiver readiness, and remaining risks, with roles, timelines, and referrals clearly established.
4. Discharge Preparation and Training: A personalized program using a demo–return-demo approach trains Mr. R and his caregiver in safe transfers, self-care, medication routines, communication strategies, and environmental adaptations.
5. Discharge Implementation: Mr. R is transferred from the hospital setting to their home while ensuring that discharge plans and recommendations are in place
6. Follow-up and Monitoring: Scheduled home or clinic visits to reassess occupational performance, safety, and caregiver burden, reinforce training, and modify goals or referrals are arranges as needed.

Special Considerations

While the BRIDGE Framework offers a structured guide for strengthening discharge planning, several limitations should be recognized. Although it appears linear, real-world practice often requires revisiting earlier steps, adjusting timelines, and reevaluating goals as medical, functional, and social circumstances change. Because clients differ in their needs, resources, and team supports, strict step-by-step adherence is not always feasible; instead, the framework should be applied flexibly to support collaborative decision-making, goal-setting, and monitoring, rather than as a rigid pathway.

Furthermore, although Steps 1 (Discharge Goal & Time Setting) and 2 (Discharge Readiness Conference) are clearly presented, the framework does not visually capture the therapeutic, rehabilitative, and enabling processes that occur between them. In reality, this interval represents the core of occupational therapy work, which includes developing functional skills, enhancing the person–environment–occupation fit,[3,22] and preparing clients and families for transition. These processes, while not illustrated, are embedded throughout the framework.

CONCLUSION AND RECOMMENDATIONS

The BRIDGE Framework provides a practical roadmap that makes discharge planning more consistent, collaborative, and client-centered, helping ensure smoother transitions of care while minimizing missed steps and fragmented services. It prepares clients and families, reduces risks such as readmissions and prolonged hospital stays, and keeps stakeholders aligned through active involvement and collaboration. The framework also strengthens interprofessional practice by helping teams coordinate services, manage discharge plans effectively, and address physical, social, and organizational barriers for safer and more context-sensitive transitions.

Future development includes adding a standardized readiness protocol to support clearer decision-making, prevent premature discharge, and guide thresholds, red flags, and conditional approvals, as well as building

empirical evidence through pilot use and case studies to enhance practicality, adaptability, and flexibility across settings. Overall, BRIDGE advances occupational therapy by standardizing discharge planning into an occupation-centred sequence that clarifies the therapist's role in readiness assessment, caregiver preparation, environmental analysis, follow-up, and community reintegration, aligning practice with global rehabilitation standards and promoting measurable and collaborative discharge protocols.

Conflict of Interest

All authors declare no conflict of interest and have not received external funding.

Positionality and Disclosure Statement

The first five authors are students of the Master of Science in Occupational Therapy program of the University of Santo Tomas. The last author is a faculty member and is affiliated with the Independent Living Learning Center, Academia Progresiva de Manila, and the Rehabilitation and Empowerment of Adults and Children with Handicap Foundation, Inc. This paper was developed as a requirement for the Advanced Occupational Therapy Theoretical Foundations course.

Author's Contributions

All authors contributed equally.

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