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Care Transitions Between Hospitals and Skilled Nursing Facilities: Perspectives of Sending and Receiving Providers

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Abstract

Background—One in four Medicare patients hospitalized for acute medical illness is discharged to a skilled nursing facility (SNF); 23% of these patients are readmitted to the hospital within 30 days. The care transition from hospital to SNF is often marked by disruptions in care and poor communication among hospital and SNF providers. A study was conducted to identify the perspectives of sending and receiving providers regarding care transitions between the hospital and the SNF.

Methods—Hospital ($N = 25$) and SNF providers ($N = 16$) participated in qualitative interviews assessing patient transfers and experiences with unplanned hospital readmissions. Data were analyzed by a multidisciplinary coding team using the constant comparison method.

Results—Four main themes emerged: increasing patient complexity, identifying an optimal care setting, rising financial pressure, and barriers to effective communication. The data highlighted hospital and SNF providers' shared concerns about patient-level risk factors and escalating costs

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of care. It also identified issues that separate hospital and SNF providers, including different access to resources and information.

Conclusions—Hospital and SNF providers are challenged to meet the needs of complex patients. They are asked to establish comprehensive care plans for patients with significant medical and psychosocial issues while navigating tense relationships between healthcare institutions and rising financial pressures. The concerns of both hospital and SNF providers must be considered in order to develop practices that can improve the quality, cost, and safety of care transitions.

Keywords

care transition; hospital medicine; skilled nursing facility; health services research; qualitative research

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After hospitalization for acute medical illness, one in four Medicare patients is discharged to a skilled nursing facility (SNF) (1). Compared with patients discharged home, patients discharged to SNFs are older, have longer hospital stays, require more support for activities of daily living, and have increased co-morbidities, including cognitive impairment (2–5). Transitions between the hospital and SNF are often marked by delays in executing treatment plans (2, 6), poor communication among providers,(3, 6, 7) and perceptions by SNF clinicians that hospital clinicians are unwilling to address errors or concerns after patients leave the hospital (6–8). Twenty-three percent of patients discharged from a hospital to a SNF will be readmitted to the hospital within 30 days (9).

Quality improvement efforts designed to reduce unplanned 30-day readmissions from SNFs call for a multidimensional approach that considers organizational culture, financial risk, and policy implications, along with patient clinical acuity (10–12). There has been a call for health care leaders and providers to "go beyond the walls of the hospital"[10(pg. 1279)]to develop tailored care plans that match the patients with the appropriate level of services (13) and promote collaboration between hospitals and post-acute care facilities (2, 6, 14–17). Yet, there remains little research examining the factors involved in the care transition from hospital discharge to SNF admission. Previous research on hospital-to-SNF transitions has focused on the perspectives of a single type of facility (4, 6, 7, 12, 13, 15, 18), clinician (6, 13), or point in the transfer process (8, 12, 18, 19). The purpose of this qualitative study was to comprehensively examine both sending (hospital-based) and receiving (SNF-based) providers' perspectives on the care transitions of patients between the hospital and the SNF. Providers with direct experience with the transfer process participated in qualitative interviews, in which they were asked to assess the facilitators and barriers to safe patient transfers and describe their experience with unplanned hospital readmissions. The information generated from this study can be used to build collaboration across the health care continuum and improve the quality and safety of the care transition.

Methods

Research Design

In this qualitative study, data were collected through a combined quality improvement and research center. The Institutional Review Board at the first author's institution reviewed the protocol and provided an exemption for this study. The following methods and results are reported in accordance with the Consolidated Criteria for Reporting Qualitative Studies (COREQ) (20).

Setting and Participants

The study was conducted at a large, northeastern, urban, academic medical center and two local SNFs. The senior author [S.I.C.], a practicing physician at the hospital, identified two general medicine units for recruitment of hospital-based providers. Focusing on the general medicine services enabled the investigators to capture a complex and multi-morbid patient population. The final hospital study units included a house staff service and a hospitalist unit.

The SNF sampling frame consisted of SNFs that maintained at least a three-star quality rating from the Centers for Medicare & Medicaid Services (CMS) and were among the top ten volume sites for discharges received from the hospital. The CMS rating system incorporates information derived from health inspections, staffing data, and physical and clinical quality measures. Facilities awarded five stars, the highest number, are considered to have quality metrics that are above average. The lowest number of stars that a facility can receive is one (21). These criteria ensured that the SNFs were stable organizations (i.e., not in imminent danger of closing down) where SNF participants would have sufficient experience receiving patients from the academic medical center. In total, six SNFs were eligible for participation; two accepted. The final SNF study units included a suburban for-profit facility and an urban non-profit facility. At the time of the study, the suburban SNF had a five-star quality rating, and the urban SNF had a three-star quality rating (22).

The investigators used purposive sampling to identify participants ($N = 41$), including frontline staff and leadership from medicine, nursing, social work, and consult services (Table 1). All participants had direct experience with hospital-to-SNF care transitions, either through their involvement with discharging hospitalized patients to SNFs (n=25) or admitting SNF patients from the hospital (n=16). Providers were contacted directly (June 2015–October 2015) by e-mail or telephone, and interviews were scheduled at the respondent's convenience. Participation was voluntary and did not affect the respondent's relationship with the hospital, the SNF, or the affiliated university. No respondents dropped out or refused to participate. One interview was ended early and excluded from the study due to the respondent's lack of experience with hospital-to-SNF care transitions.

Data Collection and Analysis

Four qualitative investigators, including three authors (MCB, GO, KM), served as interviewers. Interviews were conducted from June through October 2015. Using a semistructured interview guide (Sidebar 1, interviewers asked respondents to describe the

transfer process, facilitators and barriers to safe patient transfers, and their experiences with unplanned hospital readmissions. The guide was developed by investigators from the center, including four authors (MCB, KM, BH, SIC), and was informed by ethnographic observations conducted by the first author. The guide included open-ended questions, such as “Can you walk me through the process of navigating the transition from the hospital to the skilled nursing facility?”, along with probes designed to elicit detailed information. Many probes were mirrored for senders and receivers. For example, a hospital provider might be asked “How, if at all, do you learn about any problems that occurred after the patient was discharged from the hospital?”, while a SNF provider would be asked “How, if at all, do you inform the hospital about any problems that occurred after the patient was discharged?”

Sidebar 1

Interview Guide*

1. **I have some brief demographic questions to provide context to the transcripts.**
   - **a.** What is your highest level of education?
   - **b.** Do you have any professional degrees?
   - **c.** How many years of clinical experience do you have?
   - **d.** How long have you been in your current position?
   - **e.** How many hours per week do you spend in direct patient care?
2. **Let’s start by having you briefly describe what you do at the hospital/ skilled nursing facility. Please describe your role and experiences with transitioning patients out of the hospital and into skilled nursing facilities.**
   - **a.** What role did you play in these transitions?
   - **b.** What are your responsibilities?
   - **c.** What does a typical transition look like?
3. **Can you walk me through the process of navigating the transition from the hospital to a skilled nursing facility?**
   - **a.** What is your role in this process?
   - **b.** Tell me about roles of other team members and how you coordinate with them.
   - **c.** What do you need to know to take care of your patients?
   - **d.** Could you give an example of a handoff or report you might give to a provider outside the hospital?*

*Main interview questions are in **bold**; probes are in Roman.

e. Tell me about your communication, if you have any, with the people who will care for the patient after he or she leaves the hospital.*

f. Tell me about your communication, if you have any, with the people who cared for the patient in the hospital.**

g. Can you give me an example of a handoff or report that might be helpful to receive from the hospital?**

h. Is there a difference process or experience for patients who have been readmitted?

4. What aspects of patient transitions have been going smoothly?

a. Who has contributed to that success?

b. What do you think has contributed to that success?

c. What makes the discharge process run smoothly?*

d. What makes the admission process run smoothly?**

e. Can you give me an example of a discharge to (a/your) skilled nursing facility that went well?

5. What aspects of patient transitions have been challenging?

a. How have you addressed these concerns? How did you go about it? Who were the key players?

b. If you have not addressed the issue, ideally, how would you go about fixing it?

c. Can you tell me about a patient who was difficult to discharge?*

d. Can you tell me about a patient whose discharge from the hospital went poorly?

e. What makes the discharge process challenging?*

f. . What makes the transition process challenging?**

g. How, if at all, do you learn about any problems that occurred after the patient was discharged from the hospital?*

h. How, if at all, do you inform the hospital about any problems that occurred after the patient was discharged?**

6. What has been your experience with patients who are readmitted to the hospital?

a. How do you make the decision to readmit a patient to the hospital? Who is involved?**

*Hospital only
SNF only **[Copyeditor: I added footnote above, so please make these daggar and double daggar]

b. What are some of the reasons that a patient may be sent back to the hospital?**

c. Could you give me an example of a patient who was recently sent back to the hospital?

d. Is there anything you can think of that would help to avoid sending patients back to the hospital?**

7. Is there anything else you could share with me that might help me better understand these transitions of care?

a. Do you see opportunities for improvement in the current process of transitioning care?

b. Do you see opportunities for improvement in communications with the clinicians who receive patients from the hospital?*

c. Do you see opportunities for improvement in communications with the clinicians who discharge patients from the hospital?**

Data were collected in quiet locations at respondents' workplaces, including offices, closed conference rooms, and private spaces in the university library. The interviews ranged in length from 14 to 51 minutes, with an average time of 32 minutes. Sessions were audio-recorded, with permission from the participants, and professionally transcribed. If an interview was interrupted by a non-participant or an urgent issue the interviewer paused the recording until the matter was resolved. Documents were imported into Atlas.ti (Scientific Software, Berlin, Germany, Version 7) for coding and retrieval.

The coding team was composed of four authors from diverse backgrounds (MCB: social work, GO: medicine, KM: health services research, MG: nursing). The constant comparison method (23, 24) was used to examine the data. Team members performed line-by-line reviews of transcripts, first working independently, then cooperatively. They met regularly, continuously updating the coding structure to reflect emerging data, refine code definitions, and organize findings. Disagreements were resolved through group discussion and memos were kept in Atlas.ti to document the analytic process. Interviews and coding continued until theoretical data saturation was reached. The final coding structure was reapplied to all transcripts. After all interviews were recoded the team met to develop and summarize themes.

To achieve member checking, an important technique for establishing credibility (25), the first and senior authors reviewed the findings in a feedback workshop with study participants and community stakeholders (26). The authors first presented the results, including the main themes that emerged from the interviews, along with supplemental quantitative data and a process map illustrating the transfer from the hospital to the SNF. The authors then moderated a follow-up discussion, wherein attendees affirmed the findings, elaborated on the results, and asked one another about their experiences sending and receiving patients.

Results

Four main themes emerged from the data: increasing patient complexity, identifying an optimal care setting, rising financial pressure, and barriers to effective communication. The findings are discussed from sending and receiving provider perspectives; all comments are provided in this section, as well as in Table 2.

Increasing Patient Complexity

Hospital and SNF providers considered patients discharged to SNFs to be medically and socially complicated. One SNF medical director observed, “What’s come out of the hospital now was always treated in the hospital years ago, to a large extent. People are coming out quicker. They’re coming out sicker.” Respondents described caring for patients with multiple co-morbidities whose conditions often required numerous medications and the use of specialized medical equipment. Many of these patients had significant burdens of disease that left them dependent on acute medical care; a hospital provider saw them as “…teetering on the verge of hospitalization all the time.” Respondents also detailed a long list of psychosocial issues affecting their patients, including substance abuse, homelessness, behavioral issues, poor social supports, and immigration status. **[**

This complexity contributed to tension among providers, who watched as patients cycled in and out of health care institutions with little improvement or change. Hospital respondents struggled to secure timely discharge plans that would safely address patients’ extended needs and prevent them from returning to the hospital. They attributed some unplanned readmissions to patients and family members who were reluctant to accept a poor prognosis. One care manager offered, “…a lot of people don’t like to hear about that…I still think most families, they don’t want to give – people don’t want to give up.” SNF providers questioned the rehabilitation expectations for patients with high illness burden. A SNF clinician stated, “They’re sending them here with the assumption, ‘You’re gonna get rehab. In a couple of weeks you’re gonna get stronger and you’re gonna go home.’ That is totally ridiculous.” SNF providers called for thoughtful discussions and documentation of goals of care during the hospital stay to help clarify the post-acute care plan for patients, caregivers, and providers.

Identifying an Optimal Care Setting

The transition process begins with the decision to send a patient to a SNF, rather than discharge to home. It also involves the identification of a specific facility to continue patient care. Hospital providers reported significant pressure to optimize length of stay and discharge patients who no longer required inpatient hospital services. Ustng a SNF helped them expedite safe discharges, especially for patients who had become deconditioned in the hospital or who had limited support available at home. A hospital physician said, “From the perspective of the medical team it is much easier, orders of magnitude easier to get someone to a facility than it is to get them home…. especially when they’re elderly, frail, and sick.”

SNF providers depended on these referrals to sustain volume, but often grappled with the complexity of the patients. They emphasized the structural differences between the hospital

and SNF, including reduced physician presence, lower nurse-to-patient ratios, and limited access to pharmacy and equipment services. A SNF director of nursing explained, "…we don't operate the same way as hospitals do. We don't have so much support. We don't have so many employees to do those extra tasks. We have one nursing supervisor for the entire house, and it's [more than 100] beds."

Hospital and SNF respondents also recognized the growing influence of quality improvement efforts on the disposition decision. These efforts, which included the adoption of the Interventions to Reduce Acute Care Transfers (INTERACT) communication toolkit (27) and the hospital's establishment of a preferred provider network with SNFs, focused on improving care processes and reducing unplanned hospital transfers, including 30-day readmissions. Hospital respondents found that these programs helped them distinguish between facilities by highlighting the differences in quality, safety, and patient satisfaction. A hospital transition coordinator explained, "…for me personally, the SNFs that don't send their patients back to the hospital, the SNFs that are able to get their patients home for me are the better ones. We have some SNFs that you send out a patient to, and they bounce right back, sometimes the next day, sometimes two days." SNF respondents saw participation in these efforts as crucial to maintaining a positive relationship with the hospital. A SNF director of nursing noted, "…if you really want to be the place that they'll send people to, you want your number of readmissions within 30 days to be very low, that you're able to care for what you take."

Rising Financial Pressure

Both hospital and SNF providers perceived the patient's care plan as intertwined with institutional-level financial factors, including payer sources and reimbursement. A leader from hospital care management explained, "We have to look at the insurances and what the insurance will either first, pay for, or if it's private insurance, of who are they on par with…. That also can affect patient's choice that it narrows down the number of facilities that they would have an option to go to." SNF providers carefully considered the potential financial gain or loss when assessing patient referrals for placement. One SNF provider candidly stated, "…if they are a money-making patient, a short-term patient, you don't want another facility to capture it before you do." Another SNF nurse worried about the recent acceptance of a patient currently undergoing chemotherapy, sharing, "I have a feeling in about 30 days there's gonna be a backlash. It's gonna be 'why did you say that patient could come. This patient just cost us $45,000.'" All respondents frequently noted that patients and family members were often unaware or mistaken about their insurance coverage and options for care, which complicated the process.

This emphasis on finance was often distressing for respondents. It fueled tension between hospital and SNF providers, with hospital providers frustrated by patient declinations, and SNF providers suggesting that payments drove discharges. One hospital nurse said, "I don't understand why they're allowed to refuse people…. We would never ever not take somebody in and care for them, and we, sometimes, just patients are left here for months because no one will take them, and that's sad." A SNF nurse commented, "The hospital gets paid, I believe, according to the diagnosis….the goal is to get this patient out so we get more bang

for our buck. Let's just get this patient out, get them to a different level." For other respondents, these issues raised larger concerns about providing safe, patient-centered care. A SNF social worker remarked, "We're all now scrambling around in a hurry trying to get the patient in and out quick…how come we're not focusing on the patient and meeting their needs?….I feel like we're helping the insurance companies. I don't feel like we're helping the patients."

Barriers to Effective Communication

When asked how to improve hospital-to-SNF care transitions, nearly every respondent identified communication. SNF providers were deeply concerned about the quality and consistency of the information sent from the hospital. They often received mismatched transfer forms and discharge summaries, with missing or inconsistent medication lists, instructions for care, and patient histories. A SNF medical director commented, "It's almost embarrassing when you have to ask the family what happened in the hospital." SNF providers felt that these discrepancies increased their workload and contributed to a sense of mistrust about the information received from the hospital.

Hospital providers recognized the importance of clear, accurate information during the care transition. However, they also spoke candidly about barriers that delayed or disrupted communication efforts, including frequent rotation of treatment teams and long wait times and multiple transfers when calling nursing report to SNFs. A hospital physician explained, "Some people are very detailed in their written word, but when you have 14 patients and you're trying to discharge half of them to a facility and you have that many discharge summaries to do, I would say most providers will not spend an hour on every discharge summary making sure that it is very detailed and really relays every aspect of the patient's hospital stay and their medical needs."

Respondents from both facilities recognized that provider communication was worsened by a lack of knowledge about SNFs, especially among patients and hospital frontline staff. Several hospital providers shared that they had never been to a SNF and only had a vague sense of the services available there. One hospital resident admitted, "I just don't have a good understanding of how medical care works at short-term rehab…. Are they seeing a doctor every day? Yeah, that's a black box for me." Hospital respondents who were knowledgeable about SNFs often encouraged their colleagues to consider the ease, or difficulty, of fulfilling care plans for complex patients. One hospital social worker observed, "If we are having difficulty discharging them to the community because we feel like they don't have the resources to support them, the skilled nursing facility is going to anticipate the same difficulty discharging them from their facility."

Discussion

This study highlights the complex challenges hospital and SNF providers face as they transition patients between facilities. These providers often struggled to identify a safe, appropriate care setting for patients with complicated medical and psychosocial needs. They grappled with financial policies that limited the availability of services for patients, including payer sources and reimbursement rates. Respondents emphasized the importance

of communication but encountered significant barriers when exchanging information, including hospital providers' poor knowledge about SNFs, inaccurate and incomplete documentation, and work flow challenges.

Numerous studies of care transitions suggest that including multiple perspectives not only strengthens data analysis but also fosters collaboration across facilities and systems, ultimately enriching quality improvement efforts (28–31). Researchers have previously used this multidisciplinary approach to examine care transitions between Canadian hospitals and post-acute care settings, identifying opportunities to improve communication and enhance the patient's transfer experience (19, 31). However, there were limitations to this work: one study did not include any physicians, while the other focused on emergency department utilization. In addition, the generalizability of these findings may be limited outside of a single payer health care system. In designing this study, the investigators sought to include sending hospital and receiving SNF providers in corresponding roles (e.g. hospital care managers who send referrals and SNF admissions directors who receive them), and inquired broadly about their experiences. This approach enabled the investigators to examine a wide range of issues affecting care transitions and compare similarities and differences in responses. The data revealed that while hospital and SNF providers shared many concerns about care transitions, they framed those issues differently, largely due to priorities and policies at their respective facilities. For example, all respondents stressed the importance of considering the information that the next provider needed to continue safe patient care. Hospital respondents, who were accustomed to working in the electronic health record (EHR), believed that SNF providers could easily retrieve this information. At the time of the interviews, however, SNF providers relied heavily on paper documentation and had limited access to the EHR. Identifying such facilitators and barriers is a critical step in fostering collaboration between hospitals and post-acute care facilities (2, 6, 14–17). Identifying these barriers also responds to calls from national quality improvement efforts for the building of meaningful, mutual health care partnerships that consider factors beyond clinical acuity, including facility culture (11), staff engagement and trust (11, 16), and the financial risks and benefits associated with cost reduction and quality improvement efforts (10). To our knowledge, this is the first time that this type of comprehensive approach has been applied to hospital-to-SNF care transitions in the United States.

Respondents eagerly offered ideas for improvement, many of which were aligned with recommendations from investigators focused on SNF care (6, 7, 12, 28, 30, 32, 33). These included a time-out at discharge to allow providers to complete transfer tasks and documentation without interruption, use of a throughput nurse to manage discharges, and tighter integration of social work into the general medicine service to better address patient care needs. Respondents encouraged innovative thinking about care transitions, praising novel solutions that broke down institutional barriers, like sharing the costs of expensive medications between facilities or utilizing SNFs for hospice care.

The findings demonstrate that optimal management of care transitions between hospitals and SNFs required more than just clinical assessment. Providers were tasked with piecing together support systems and payer sources for medically complex patients who often had limited resources and options for care. They were asked to do this amidst escalating financial

pressures within their institutions, the use of readmission rates to measure quality of care for complex patients, and an increasingly unwell patient population. At times, hospital and SNF providers seemed pitted against one another, as each institution remained primarily focused on addressing its own fiscal and performance metrics, with less consideration of the effectiveness or cost of the overall plan of care. This placed both hospital and SNF providers in near-impossible situations, as they were asked to establish comprehensive care plans that met patients' complex needs while simultaneously reducing health care utilization and lowering overall cost. This challenge will only grow as providers continue to encounter more patients who are increasingly dependent on hospitals and post-acute care services.

Implications

To positively affect patient care across the continuum, hospitals, SNFs, and research programs must work across institutional silos. Future interventions should focus on enhancing communication between clinicians, promoting provider understanding of post-acute care, and developing strategic opportunities to align facilities. This could include establishing direct communication channels between sending and receiving providers, working collaboratively on care plans that follow the patient from hospitalization through community discharge, instituting tours or visiting rotations through health care institutions, and identifying opportunities for facilities to manage costs across the continuum of care.

The study's host center has initiated several projects aimed at improving hospital-to-SNF transfers, including hosting an interactive demonstration of the electronic referral system, convening a multidisciplinary team to conduct root causes analyses of 30-day unplanned readmissions, administering a survey assessing SNF clinicians' experiences with hospital discharges, and implementing a telephone report between hospital and SNF clinicians before patient discharge. Investigators from the center also became regular presenters during bi-monthly meetings attended by hospital and post-acute care providers, and partnered with the hospital's newly developed SNF utilization committee and preferred provider network of SNFs to share information and resources. Implementation and evaluation of these efforts are currently underway.

Limitations

Because the study was localized within one geographic area, the findings may not be generalized to all hospitals or all SNFs. It also is limited to provider perspectives and does not include information from patients or unpaid caregivers.

Conclusion

Hospital and SNF providers are challenged to meet the needs of complex patients within a complicated and often fragmented health care system. They welcome opportunities to work collaboratively to improve the quality and safety of care transitions but are hindered by poor communication, competing priorities, and a lack of understanding about different health care settings. The findings speak to the importance of efforts to improve care transitions that address individual patient risk factors as well as the system-level policies that inform patient

disposition, facility relationships, and reimbursement for care. Future quality improvement efforts should consider solutions that can mutually improve the quality, cost, and delivery of care for all patients and providers.

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Table 1

Respondent Demographics ($N = 41$)

	Hospital Study Sites	SNF Study Sites
Staff nurses	5	4
Care management	6	0
Nursing leadership	2	2
Physician (physicians, residents)	6	2
Advanced practice providers (NP, APRN, PA)	2	2
Social work or Social services	3	3
Admissions personnel	0	3
Consult services	1	0
Total participants	**25**	**16**

Table 2

Major Themes and Illustrative Quotes

Theme	Hospital Provider	SNF Provider
Increasing Patient Complexity	[patients are] "…teetering on the verge of hospitalization all the time."	"What's come out of the hospital now was always treated in the hospital years ago, to a large extent. People are coming out quicker. They're coming out sicker."
	"…a lot of people don't like to hear about that…I still think most families, they don't want to give – people don't want to give up."	"They're sending them here with the assumption, 'You're gonna get rehab. In a couple of weeks you're gonna get stronger and you're gonna go home.' That is totally ridiculous."
Identifying an Optimal Care Setting	"From the perspective of the medical team it is much easier, orders of magnitude easier to get someone to a facility than it is to get them home…. especially when they're elderly, frail and sick."	"…we don't operate the same way as hospitals do. We don't have so much support. We don't have so many employees to do those extra tasks. We have one nursing supervisor for the entire house, and it's [more than 100] beds."
	"…for me personally, the SNFs that don't send their patients back to the hospital, the SNFs that are able to get their patients home for me are the better ones. We have some SNFs that you send out a patient to, and they bounce right back, sometimes the next day, sometimes two days."	"…if you really want to be the place that they'll send people to, you want your number of readmissions within 30 days to be very low, that you're able to care for what you take."
Rising Financial Pressure	"We have to look at the insurances and what the insurance will either first, pay for, or if it's private insurance, of who are they on par with…. That also can affect patient's choice, that it narrows down the number of facilities that they would have an option to go to."	"…if they are a money-making patient, a short-term patient, you don't want another facility to capture it before you do."
	"I don't understand why they're allowed to refuse people…. We would never ever not take somebody in and care for them, and we, sometimes, just patients are left here for months because no one will take them, and that's sad."	"I have a feeling in about 30 days there's gonna be a backlash. It's gonna be 'why did you say that patient could come. This patient just cost us $45,000.'"
		"The hospital gets paid, I believe, according to the diagnosis….the goal is to get this patient out so we get more bang for our buck. Let's just get this patient out, get them to a different level."
		"We're all now scrambling around in a hurry trying to get the patient in and out quick, when how come we're not focusing on the patient and meeting their needs? I feel like we're helping the insurance companies. I don't feel like we're helping the patients."
Barriers to Effective Communication	"Some people are very detailed in their written word, but when you have 14 patients and you're trying to discharge half of them to a facility and you have that many discharge summaries to do, I would say most providers will not spend an hour on every discharge summary making sure that it is very detailed and really relays every aspect of the patient's hospital stay and their medical needs."	"It's almost embarrassing when you have to ask the family what happened in the hospital."
	"I just don't have a good understanding of how medical care works at short-term rehab…. Are they seeing a doctor every day? Yeah, that's a black box for me." "If we are having difficulty discharging them to the community because we feel like they don't have the resources to support them, the skilled nursing facility is going to anticipate the same difficulty discharging them from their facility."	