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Stroke survivors' perspectives on the selection of a post-acute care setting, rehabilitation goal-setting, and satisfaction with post-acute care rehabilitation, and transition to home

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Abstract

Background and Purpose: Patients and caregivers have not typically been involved in the selection of a post-acute care (PAC) provider. In 2015, the Centers for Medicare and Medicaid Services (CMS) proposed the need to involve patients and their families during discharge planning. Engaging patients in rehabilitation decisions encourages shared decision-making among patients and their clinicians. The purpose of this study was to examine stroke survivors' perspectives on their involvement in selecting a post-acute care (PAC) provider and their goal-setting, and their satisfaction with the rehabilitation stay, and their discharge advice for stroke survivors, prior to 2015.

Methods: This qualitative study utilized semi-structured interviews. Thematic content analysis was performed on 18 stroke survivors' interviews (mean age=68 years) on their involvement related to their inpatient rehabilitation facility (IRF) or skilled nursing facility (SNF) stay, goal-setting, and discharge needs.

Results: More than half the participants were not involved in the selection of their PAC setting and believed that doctors made these decisions. Around two-fifths of stroke survivors reported they were not involved in rehabilitation goal-setting. Most patients were satisfied with their rehabilitation stay. When asked to recommend discharge topics for other stroke survivors,

participants recommended additional information on health care services, interventions, and insurance coverage.

Conclusion: Despite recommendations to include stroke patients in PAC selection and goal-setting, many former IRF and SNF patients report not being involved in either aspect of care.

Keywords

stroke; rehabilitation; patient-centered care; decision-making; health services for aged; continuity of patient care; patient discharge

Introduction

Approximately 48% of individuals with stroke receive rehabilitation in a post-acute setting.¹ Post-acute care (PAC) can be provided in many different care settings, including inpatient rehabilitation facilities (IRF), skilled nursing facilities (SNF), long-term acute care hospitals, home health services, and outpatient offices.² Stroke survivors (SS) with activity limitations who receive care in an IRF may achieve better outcomes and fewer complications compared to those receiving care in a SNF.^{3, 4} The decision about where an individual receives PAC, is made in the acute care hospital, and is often based on the individual's physical abilities, the severity of the stroke, health insurance coverage, the need to expedite discharge from acute care, and availability of a PAC bed.⁵⁻⁷

In 2015, the Centers for Medicare and Medicaid Services proposed that providers include patients and their family in discussions regarding PAC discharge planning and the selection of a PAC provider, and allow the patient to make the decision.⁸ The proposal focused on involving patients and caregivers as active partners in post-discharge care to support effective PAC transitions that could improve outcomes, such as reducing readmissions. In addition, the Patient-Centered Outcomes Research Institute promotes shared decision-making by involving patients and caregivers, for example, appropriate PAC provider, goal-setting.⁹ Acute care discharge planners indicate that patients and their families may have a more significant influence than clinicians or physicians on discharge decisions.⁶ While clinicians and case managers report involving patients and their caregivers in rehabilitation decisions,¹⁰ the level of involvement from the SSs perspective is unclear.

Including patients and caregivers in the selection of the PAC setting supports an appropriate discharge location and allow rehabilitation professionals to efficiently engage the patients in developing patient-centered SMART (specific, measurable, attainable, relevant, and time-bound) goals.¹¹ Rehabilitation services could be improved if they utilized patient-centered care to work towards increased autonomy.¹² While clinicians report they provide patient-centered care,^{13, 14} few studies address patients perceptions of involvement in selecting a PAC provider.^{15, 16} The purpose of this study was to explore SSs experiences prior to 2015 in PAC to understand both their involvement in choosing their PAC facility (i.e., SNF or IRF) and also their experiences while in rehabilitation. Questions specific to their time in rehabilitation included their involvement inclusion and satisfaction with rehabilitation goal-setting, satisfaction with the stay, and their recommendations to peers related to discharge planning needs.

Methods

The current study analyzed data from interviews conducted for the Patient Centered Outcomes Research in Elderly (PCOR-E) study. The PCOR-E study obtained approval from the University of Texas Medical Branch's Institutional Review Board (IRB) and Emory University's IRB approved a reliance agreement for this collaborative research.

Using convenience sampling from the Houston and Galveston, Texas area, we recruited former IRF and SNF patients from in-person, from support groups, and we recruited former SNF participants from SNFs and retirement living centers. Individuals recruited from support groups resided at home. The participants were stroke survivors, 18 years of age or older, and spoke English. The PCOR-E study had several significant aims: to identify stakeholder's needs related to several aspects of functioning and health care, including mobility limitations, visual impairments, cognitive limitations, discharge planning, and returning to work. For this study, we reviewed only the segments of participants' interviews that focused on their involvement in the selection of their PAC provider, and/or rehabilitation goal-setting, and/or their satisfaction with rehabilitation services, and/or their recommendations for peers. This part of the survey required respondents to respond to open-ended questions about an IRF or SNF stay. For this reason, we used an additional inclusion criterion, including receipt of PAC in a SNF or IRF. We excluded two participants who had aphasia, because the interviewers were not able to probe their involvement in selecting the PAC discharge planning and involvement in rehabilitation sessions using cue cards. One individual who received rehabilitation in an IRF was excluded because he did not discuss any discharge planning experiences. Three individuals were excluded from this analysis since their time since stroke was beyond ten years. All enrolled participants provided written consent and were interviewed in-person.

Research Design

We utilized a qualitative methodology, content analyses for this study to uncover the perspectives of stroke survivors following discharge to in-facility PAC setting following stroke hospitalization. The interviews were conducted to better understand what the stroke survivors experienced when selecting the PAC setting and during the PAC stay.

Data collection

Licensed physical (SK) and occupational therapists (CCH, TR) – male and female, with expertise in neurological rehabilitation, PAC discharge planning, and qualitative methodology – conducted the interviews between 2013 and 2015. The interview guide was pilot tested by TR on three individuals, which resulted in guide modifications. The final semi-structured interview included questions about the patient's perceptions of the stroke event and effects the stroke had, decisions surrounding the selection of the PAC setting, goal-setting in rehabilitation, and most important goals. For PAC selection and PAC rehabilitation experiences, participants were probed on various aspects of their involvement. For example, for participants who mentioned being involved in the PAC selection process, the interviewer followed up with probes such as: Could you explain how you were involved? Were you given options?

The face-to-face, semi-structured, open-ended, interviews were conducted in a location preferred by participants and were approximately 31 minutes long. Because most of the participants were recruited from support groups, we conducted these interviews in a meeting room next to the support group meeting. For the remaining participants, the location was their home or the health care facility where they were residing. The interview began with the interviewers disclosing their role in the study, including their affiliations with the organizations; the interviewers had no prior clinical experience with the participants. All interviews were audio-recorded and transcribed using a professional transcription service. Participants were compensated at study completion for their time with a \$25 gift card. To ensure an adequate sample size, we determined “saturation in silence”, where a sample size of about 12 will likely obtain the most salient items/responses.¹⁷ Data saturation was reached at the 12th interview.

Data Analyses

Because the interview questions were open-ended, each transcript was reviewed in its entirety to understand SSs perspectives on their involvement in PAC selection and rehabilitation goal-setting. The transcripts were carefully analyzed to ascertain the patients’ level of involvement in the selection of the PAC and rehabilitation goal-setting.

Two coders (SK and CCH), reviewed and analyzed the transcripts independently; and inductively and deductively coded the text using line-by-line coding technique with thematic content analysis.¹⁸

The data analysis was comprised of five steps. First, two reviewers independently reviewed all transcripts and coded four interviews. A codebook was developed from the interview topics and additional codes were generated from concepts that emerged from the transcripts (inductive coding). The codebook was refined with new codes as the concepts on PAC selection emerged from subsequent interviews.

In the second stage, the reviewers met to compare their initial codes for agreement of themes and subthemes. The two independent reviewers agreed upon six overarching categories and created a structured codebook that included: involvement in the selection of PAC provider (SS vs. others), satisfaction with PAC selection process, involvement in rehabilitation goal-setting, satisfaction with the rehabilitation goal-setting process, recommendation to peers on PAC selection, and discharge planning needs (deductive coding).^{18, 19}

Patient involvement in the selection of the PAC setting included three codes: not involved, somewhat involved and involved. Participants who mentioned that someone else made the decision and that they did not know the reason behind the decision were coded as “not involved.” Participants who mentioned that someone came in and discussed the options and explained the benefits of a selected PAC setting were coded as “involved.”

The third stage of analysis involved independently coding the remaining interview transcripts by the same two reviewers using the previously identified themes and subthemes.^{18, 19}

The fourth step included entering the themes and subthemes into *NVivo 10*.²⁰ This qualitative software was used to maintain and monitor the coded themes and subthemes systematically. Using NVivo for coding increases the accuracy of coding and makes the quality checking process efficient.²¹

The final step was a consensus-based decision-making process to check the agreement of the identified themes and subthemes and resolve any disagreements. In this step, the themes and subthemes along with their associated quotations were reviewed and discussed by the two original coders, along with other research team members. The transcripts were compared constantly for the trustworthiness of the themes and subthemes. When disagreements occurred, consensus was sought from all members of the multidisciplinary team, which included expertise in physical therapy (SK), occupational therapy (CH, TR), social work (MP), rehabilitation nursing (AD); and qualitative methods (SK, CH, MP, AD, TR), and health services research (SK, MP, AD, TR). Consensus coding is one of the most commonly used strategies to resolve disagreements in qualitative coding.²² The team members discussed the pros and cons of the divergent themes to arrive at a consensus. Using a multidisciplinary team should reduce the chance of bias.^{18, 23}

We used *NVivo 10*²⁰ software to systematically maintain and monitor the coded themes and subthemes. Using NVivo for coding increases the accuracy of coding and makes the quality checking process efficient.²¹

The results of the PCOR-E study were discussed in a local stroke support group meeting, which included study participants and their caregivers. In addition, participants were invited to the PCOR-E annual advisory group meeting (a stakeholder engagement lunch) where the results of the project were discussed. The participants shared their thoughts and feedback during these meetings.

Results

Participants

Eighteen community-dwelling SSs who received rehabilitation in either an IRF or SNF were included in this study, Table 1. Six of the individuals received rehabilitation in a SNF and 12 received rehabilitation in an IRF. The mean age of participants was 68±14 years. Those in the SNF group were older than those in the IRF group. Most participants were male, and more than half were Non-Hispanic White. Time since stroke ranged from one to ten years. Of these, 12 individuals (67%) having experienced the stroke within the last five years.

For the purposes of this analysis, the six categories have been clustered into three primary major themes: a) Patient involvement in PAC discharge planning, b) Patient involvement during rehabilitation goal-setting, c) Patient's discharge information needs; and two minor themes a) Patient satisfaction with rehabilitation and b) Recommendation to peers. Table 2 lists the distribution of participants across IRF and SNF for each theme.

Major Themes

Patient involvement in selection of PAC setting

Most of the participants reported that they were not involved in selecting their PAC provider during their acute hospitalization. One participant (61, F, Caucasian, SNF) stated, *“I don’t know. I just ended up here.”* Another participant (85, F, Caucasian, SNF) mentioned, *“I think [the selection of the PAC provider] was really just between the people in rehab and doctor.”* One (68, M, Caucasian, IRF) stated, *“Some 12-year-old sitting behind a damn desk at an insurance company made those damn decisions.”* Another participant (71, F, African-American, IRF) mentioned, *“Well, [the hospital] picked it.”*

Many participants mentioned someone else was involved in selecting their PAC facility. Six participants stated that their doctors made these decisions. One participant (Unknown age, M, African-American, IRF) mentioned, *“I think it was the doctor concerned because I was transferred from one section to another section.”* Another participant (86, M, African-American, SNF) mentioned, *“The doctor took the decision.”* Five participants had family members as informal caregivers who were involved in the selection of the PAC provider. One of them (86, M, African-American, SNF) stated,

“I was in there five days then they let me go, and they told me I could go back home. I couldn’t go back home by myself so then my daughter, I have three daughters, it wasn’t at the house, but they had one [skilled nursing facility] equipped for me. Check it out and see bedrooms and things. Why didn’t none of them live with me. They on their own, they don’t live with nobody. So anyway, they came looking for a place for me to live, my three daughters. They always do things together.”

Three participants mentioned involvement of both their family members and the clinicians. One participant (72, M, Caucasian, IRF) mentioned,

“They came and asked us all. My daughters were all there. I’ve got four of them. They were there practically the whole time, off and on. Our youngest one was there. She just stayed there.”

In addition, one participant (68, M, Caucasian, IRF) highlighted that the selection of the PAC provider is based on insurance coverage. He mentioned,

“The insurance companies, they make all the decisions with no knowledge at all of what goes on. That’s the way I feel about it.”

Although a few of the participants mentioned involvement in the selection of the PAC provider, their level of involvement may not demonstrate shared decision-making. For instance, one SS (50, M, Hispanic, IRF) mentioned, *“Yes, I was, cause they asked me if I wanted it, and I said yes.”* Another participant (72, M, Caucasian, IRF) mentioned,

“The doctors made all of the decisions on everything. They told us, they set it up. A representative came from [facility xx] over. They called me and told them they had a patient they need to see in there for rehab. They came over to the hospital in and talked with me. It was pretty well, between me and the doctors, I mean; I could

have gone anywhere I wanted to, as long as I went to a therapy place, in-house. That's how I ended up over there.”

Most participants were mostly not satisfied with the extent of their involvement in the selection of PAC setting, as one participant (85, F, Caucasian, SNF) mentioned, “*Well, if I would have known more, then I would have made myself do more...*” However, some participants were satisfied with their destination, as one participant (72, M, Caucasian, IRF) mentioned, “*I'm very satisfied [with my rehabilitation facility] ... They gave me my whole life back, as far as I'm concerned.*”

Patient involvement during rehabilitation goal-setting

When asked about the process of rehabilitation goal-setting, some participants mentioned that they were involved, some mentioned they were not involved, and others did not talk about their involvement during rehabilitation goal-setting. A participant (82, F, African-American, SNF) who was not involved mentioned, “*No they just gave me the exercises.*” Another (Unknown age, M, African-American, IRF) mentioned,

“I was involved in the doing but I was not involved in the decision-making... I would like to be [involved] because I knew where my weaknesses were, where they were. I would have loved to.”

Among the participants involved in goal-setting, some mentioned that they were asked to contribute only by way of asking questions or raising concerns. For example, one participant (55, M, Caucasian, IRF) stated, “*The goals are kind of discussed. I'm asked to contribute if I have specific concerns.*” While some mentioned that they the ability to make decisions about rehabilitation plan, one participant mentioned (68, M, Caucasian, IRF),

“She [therapist] gave me options of what I wanted to do, what I wanted to learn, and I wanted to learn it, and then she made a plan. She actually set down on [a] piece of cardboard and drew up a plan for me. The next time we met, she asked me is that [what] I wanted to do. It was exactly the course I wanted to take. She made me sign it and she stuck to it. It did wonders for me. It did wonders.”

Patient discharge information needs

Many participants revealed the need for specific information during their stay at the acute hospital or PAC before being discharged to home. Table 3 lists the subthemes and relevant quotations on the identified information needs. Ss expressed the need for information on rehabilitation services, medical interventions such as Botox® for spasticity, medications and equipment, and timely diagnosis. They also wanted to know more about their health insurance coverage (services covered by their insurance plan), be educated on what to expect following discharge, learn about the availability of resources such as support groups, and be informed of various psychological changes post-stroke such as depression.

Minor Themes

Patient satisfaction with rehabilitation

Most of the participants reported that they were satisfied with their rehabilitation experience, Table 2. A greater proportion of individuals receiving IRF care mentioned being satisfied than those who received SNF care. For instance, one participant (72, M, Caucasian, IRF) mentioned, *“Those people [therapists] are just great, what they did.”* Another participant (44, M, African-American, IRF) mentioned, *“Overall I’ve been pleased with it.”*

Recommendations to peers

Most participants were enthusiastic to give recommendations to peers based on their experiences. These recommendations can be categorized into three major areas: self-motivation, participation in services, and coping strategies. Table 3 lists the subthemes with relevant quotations associated with these major themes. For self-motivation, participants advised their peers to be involved, work as hard as they could, cooperate with their family and therapists, modify their lifestyle to control their blood pressure and improve nutrition, and pay attention to psychological health (e.g., depression). They also encouraged other SSs to participate in services, such as rehabilitation and support groups. Under the coping strategy category, participants encouraged other SSs to accept their condition, and have hope, faith, and patience.

Discussion

This study revealed that most SSs were not involved in selecting their PAC provider prior to 2015. Most SSs perceived their acute care physicians to be most involved in the selection of the PAC provider. Individuals in SNFs were more likely to report that they were not involved in the process, compared to those who underwent rehabilitation in IRFs; however, this difference could be associated with their differences in ages. Older adults usually consider that their physician knows the best approach and may have preferred that approach to themselves engaging in the decision-making process.²⁴ In contrast, another study reported that stroke discharge planners perceive patients and family as more influential than clinicians in selecting the appropriate PAC setting.⁶ In the current study, half the SSs mentioned that their family was involved the decision and only a fourth mentioned their own involvement in the selection of the PAC setting. The decisions were made in the absence of the SS partly because they may defer these decisions to their physicians or families.¹⁵

Patient-level factors are considered when selecting a PAC setting. For instance, individuals discharged to an IRF should be generally medically stable, need at least two modalities of therapy, be able to tolerate 15 hours of therapy per week, demonstrate potential benefit from intensive therapy, and require supervision by a physician.²⁵ Educating the patient/family about these criteria and communicating the benefits and any potential negative aspects of such decisions will promote the involvement of patients in shared decision-making during the transition to the appropriate PAC facility.²⁶ Although health care quality measures reports are publicly available, few patients and caregivers use this information to inform

their selection of a PAC provider, in part because they may not be able to interpret the information meaningfully.¹⁶

Various patient-level factors such as severity of injury, prognosis, age, anticipated length of stay, and family support influence PAC selection.^{6, 27} Clinicians may differ in their perceptions of the prognosis for a stroke patient, as it may be difficult to discern in the early stages which patients will benefit from rehabilitation.⁵ In addition to patient-level factors, facility-level factors such as internal referrals, staffing concerns, facility location with respect to the patient's residence, availability of PAC facilities, and the facility's ability to provide services for the patient play an important role in PAC selection.^{6, 27, 28} In addition, the PAC may favor admission patients with less complex needs to minimize the number of patients at risk for poor outcomes.^{5, 29}

There was more patient involvement during rehabilitation. In addition, participants revealed that they were mostly satisfied with their overall rehabilitation experience; this finding is consistent with those of a previous study.³⁰ As patients learn about their disease and recovery, they gradually take a more active role in goal-setting and treatment planning.^{31, 32}

Under the Bundled Payment Care Improvement Initiative, health care providers must be accountable for the quality of care for each patient. Under this initiative, the Centers for Medicare and Medicaid Services reimburses the providers at a target amount for related services (e.g., acute care, rehabilitation, readmission) for a particular diagnosis.³³ This model would encourage care coordination and the healthcare facilities could benefit from involving patients in their care early to implement these initiatives successfully. In spite of substantial health care costs, the health care system in the U.S. does not rank well compared to other countries related to patient satisfaction and health outcomes.³⁴ The U.S. can benefit from investigating the innovations across other countries such as the U.K. and Switzerland, and investing in cross national research.

SSs expressed the need for information on various factors before being discharged to home. In this study, SSs wanted information about their health insurance coverage, which may have enabled them to have continued therapy. Individuals also expressed the need for information on rehabilitation services following discharge to home. Participants stressed the importance of self-advocacy and various coping strategies. Rebuilding SSs resilience is known to improve both their attitudes and function positively.³⁵ Clinicians must provide appropriate patient-centered information while accounting for the individual's cultural background, language, and any current functional or communication deficits.^{10, 36}

Multiple clinicians are involved in the PAC discharge planning process and may have differing levels of knowledge about PAC discharge planning, depending on their clinical expertise and experiences. In addition, not all physicians involved in discharge planning have the experience to execute a patient-centered plan.³⁷ Having authorized clinicians lead and set standards to share information with patients could standardize this process.³⁸ A "Stroke Navigator" can initiate a post-discharge follow up and identify and resolve any issues that the patient/family member may have with the transition and connect them to services they need. Physical therapists involved in the patient's treatment are aware of the

patient's comorbidities and resources available, and can incorporate functional assessment during discharge planning. Increased rates of readmission can be associated with inadequate involvement of physical therapists during discharge planning.³⁹ In addition, involving caregivers would benefit in the care transition process, as they play a significant role in the SSs care and can identify unique needs.⁴⁰⁻⁴²

We acknowledge several study limitations, including that the participants were from one geographical location (Texas) of one country (U.S.). Individuals with aphasia were excluded from our analysis as we were not able to explore their experiences in PAC discharge planning and satisfaction with PAC rehabilitation using cue cards, which limits the generalizability of the results to this population. Only one participant with limited English-language proficiency, a Spanish-speaker, was included in this study. We utilized various recruitment strategies to include a diverse sample. Many individuals with stroke received their PAC outside Houston/Galveston. It is important to further explore age, gender, ethnic, educational, and geographical variations in SSs involvement in PAC discharge decisions.

The study interview questions were open-ended, and we used standard probes to ascertain the experiences of all SSs on their level of involvement; however, the probes were not all the same. The time since the stroke and PAC varied among participants; therefore, some participants may have had difficulty with recalling information about their involvement. It is important to consider that the participants' cognitive dysfunction (e.g., depression and memory) may have affected their responses or their interpretations of their experiences.

To build on the current research, future studies should recruit SSs during discharge or early in their rehabilitation in PAC to understand their level of involvement. Future studies must explore additional strategies to explore experiences of individuals with aphasia and those who speak languages other than English. Including caregivers' perspectives could be beneficial to understanding experiences among individuals with aphasia.

In order to increase the involvement of patients and caregivers in the selection of a PAC setting future research should focus on the effectiveness of specific strategies such as motivational interviewing or shared decision-making aids. In addition, there is a need for future studies that explore the impact of shared decision-making in PAC discharge planning among SSs/caregivers and their clinicians where the clinicians provide a framework for understanding rehabilitation quality in language helps individuals choose a PAC facility that matches their needs.^{15, 16, 36} Another area of exploration is the effectiveness of the "Stroke Navigator" role in producing better rehabilitation outcomes, especially among vulnerable populations. Future studies must also explore the influence of caregiver support and involvement on PAC discharge destination. Future studies must consider the impact of cognitive function while assessing patients' experiences with PAC discharge planning. In addition, it is important to explore how participants' personality and beliefs may influence their memory recall of their involvement in and satisfaction with the process.

Conclusion

Current findings suggest an inadequate involvement of SSSs during their PAC discharge planning prior to 2015. SSSs should be involved in selecting the PAC setting and setting rehabilitation goals during the PAC rehabilitation process. Practicing shared decision-making, involving stroke survivors in discussions during PAC discharge planning and providing them options for various PAC facilities is key to delivering patient-centered care.

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Table 1:

Sample characteristics

Sample Characteristics	Total (n=18)	Inpatient Rehabilitation Facility (n=12)	Skilled Nursing Facility (n=6)
<i>Age (years) Mean±SD</i>	68±14	61±10	81±10
<i>Gender</i>	Male = 14, 78% Female = 4, 22%	Male = 11, 92% Female = 1, 8%	Male = 3, 50% Female = 3, 50%
<i>Race/Ethnicity</i>	Non-Hispanic White =11, 61% African-American, n=4, 22% Hispanic, n=2, 11% Asian-American, n=1, 6%	Non-Hispanic White = 7, 58% African- American = 2, 17% Hispanic = 2, 17% Asian-American = 1, 8%	Non-Hispanic White = 4, 67% African- American = 2, 33% Hispanic = 0 Asian-American = 0
<i>Time since stroke</i>	1–2 years: n=7, 39% 3–5 years: n=5, 28% 6–10 years: n=6, 33%	1–2 years: n=7, 58% 3–5 years: n=2, 17% 6–10 years: n=3, 25%	1–2 years: 0 3–5 years: n=3, 50% 6–10 years: n=3, 50%

Table 2:

Distribution of IRF and SNF participants across themes

Themes	Total (n=18) N, %	IRF (n=12) N, %	SNF (n=6) N, %
Major Themes			
Involvement in selection of PAC setting			
<i>Patient involvement with someone else in selection of PAC setting</i>	4, 22%	2, 17%	2, 33%
<i>Only someone else was involved in selecting their PAC</i>	11, 61%	8, 67%	3, 50%
<i>No one was involved in selecting PAC setting</i>	1, 6%	0	1, 17%
<i>Unknown</i>	2, 11%	2, 17%	0
Patient involvement in rehabilitation goal-setting			
<i>Involved in rehabilitation goal-setting</i>	8, 44%	5, 42%	3, 50%
<i>Not involved in rehabilitation goal-setting</i>	8, 44%	5, 42%	3, 50%
<i>Unknown</i>	2, 11%	2, 17%	0
Discharge information needs (yes)	9, 50%	7, 58%	2, 33%
Minor Themes			
Patient satisfaction with rehabilitation (yes)	13, 72%	11, 92%	2, 33%
Offered recommendation to peers (yes)	14, 78%	9, 75%	5, 83%

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Table 3:

Discharge information needs and recommendation during post-acute discharge planning

Themes	Representative Quotations
Discharge information needs	
Rehabilitation Services = 4 (%)	<i>"I wish I was visited even by any of the therapists [after IRF discharge] but this never happened until I discovered something [exercises] in the YouTube."</i> (Unknown, M, African-American, IRF)
Medical interventions = 4 (%)	<i>"One thing they wanted me to do in order to help with the spasticity in my arm was to get the Botox shots. I would've set those up a lot earlier, like when I was in the hospital, so that way there would be no interruption and I could just go straight into outpatient therapy and get that rehab and get that done."</i> (44, M, African-American, IRF)
Insurance coverage= 3 (%)	<i>"I wanted to go back to therapy. I want to call my insurance. The woman, she was telling me, she said, "Well, right now we don't have it approved, but you can pay for it out ofpocket." I said, "I'm sorry, but I can't pay that." It just stressed me out because I really, really wanted to go back to therapy."</i> (61, M, Asian-American, IRF)
Training and education = 2 (%)	<i>"I think they need to spend a little time either talking or showing or whatever, a little bit more about, when you get out in life, this is what we'll expect, or this is what we'll do. I think that's what they need to do."</i> (74, F, Caucasian, IRF)
Support group = 2 (%)	<i>"I learned about the stroke support group from one of the people who also signed up. I didn't actually learn about it from other sources, which is quite surprising to me."</i> (55 M, Caucasian, IRF)
Psychological = 2 (%)	<i>"This depression here lately, the last couple weeks ...I don't know what brought it on. I really don't because I wasn't upset ...happy in my life you know. I don't know what brought it on."</i> (Unknown, M, Caucasian, IRF)
Recommendation	
Self-motivation = 7 (%)	<i>"I would tell them to definitely go for it, and work as hard as they could."</i> (85, F, Caucasian, SNF)
Participate in services = 5 (%)	<i>"Tell them to go through as much physical therapy as possible."</i> (70, M, Caucasian, IRF)
Coping strategy = 4 (%)	<i>"Faith. Yes, my faith. I say that's what got me through it all."</i> (71, F, African-American, IRF)