Supplemental Digital Content 2

Free-Text Survey Results

: 1	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Access to follow up appts	1	0.49	1	0.49
Acuity of Medical Condition	1	0.49	2	0.98
Acuity of clientele	1	0.49	3	1.46
Age	1	0.49	4	1.95
Alcoholism	2	0.98	6	2.93
Chronic diagnosis, such as heart failure	1	0.49	7	3.41
Chronic illness	1	0.49	8	3.90
Co morbidities unrelated to illness	1	0.49	9	4.39
Cognitive status of patient or primary caregiver	1	0.49	10	4.88
Communication defocits	1	0.49	11	5.37
Compliance of the patient	2	0.98	13	6.34
Cultural opposition to institutionalizing family members, e	1	0.49	14	6.83
D/c destination does not match with PT's recommended option	1	0.49	15	7.32
DC'd too early from acute care hospital	1	0.49	16	7.80
Dc before medically stable due to pressure from insurance co	1	0.49	17	8.29
Decreased ability to comply with medical discharge instructi	1	0.49	18	8.78
Decreasing Length of stay without looking at continuum	1	0.49	19	9.27
Did not transition to the first best care setting	1	0.49	20	9.76
Discharge to soon	1	0.49	21	10.24
Discharge to the wrong location	1	0.49	22	10.73
Discharge too early/fast	1	0.49	23	11.22
Discharged too soon due to trying to decrease length of stay	1	0.49	24	11.71
Disposition home when post-acute Rehab was recommended	1	0.49	25	12.20
Early discharge from hospital on initial admit	1	0.49	26	12.68
Economic status	1	0.49	27	13.17
Elderly	1	0.49	28	13.66
Emphasis to reduce LOS	1	0.49	29	14.15
Facilities dcd to don't/can't enforce restrictions(fluid, di	1	0.49	30	14.63
Falls	2	0.98	32	15.61
Falls at home	1	0.49	33	16.10
Follow up with primary care physician	1	0.49	34	16.59
Gait ability	1	0.49	35	17.07
Gap in service between hospital D/C and HHC services	1	0.49	36	17.56
High level of patient acuity	1	0.49	37	18.05
Impaired functional mobility	1	0.49	38	18.54

: 1	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Inadequate follow up	1	0.49	39	19.02
Inadequate handoffs	1	0.49	40	19.51
Inadequate post-acute care	1	0.49	41	20.00
Inappropriate (inadequate) discharge plan	1	0.49	42	20.49
Inappropriate D/C disposition - pt refuses recommended D/C	1	0.49	43	20.98
Inappropriate d/c location	1	0.49	44	21.46
Inappropriate discharge destination	1	0.49	45	21.95
Inappropriate discharge locations	1	0.49	46	22.44
Inappropriate discharge setting	1	0.49	47	22.93
Incorrect discharge location	1	0.49	48	23.41
Lack of access to resources	1	0.49	49	23.90
Lack of adequate medical f/u	1	0.49	50	24.39
Lack of assurance that PT has received HHPT.	1	0.49	51	24.88
Lack of care planning	1	0.49	52	25.37
Lack of communication to sub acute settings	1	0.49	53	25.85
Lack of competent social support	1	0.49	54	26.34
Lack of discharge information re: mobility	1	0.49	55	26.83
Lack of family support	1	0.49	56	27.32
Lack of patient and caregiver education	1	0.49	57	27.80
Lack of prescribed meds at home	1	0.49	58	28.29
Lack of resources in community	1	0.49	59	28.78
Limited caregiver assistance in homes	1	0.49	60	29.27
Medical acuity	1	0.49	61	29.76
Medically indigent population	1	0.49	62	30.24
Medication management	1	0.49	63	30.73
Medication non-compliance	1	0.49	64	31.22
Medication noncompliance	1	0.49	65	31.71
Medication reconciliation concerns	1	0.49	66	32.20
Meds	1	0.49	67	32.68
Multiple comorbidities	1	0.49	68	33.17
No follow up after discharge	1	0.49	69	33.66
Non-compliance	1	0.49	70	34.15
Non-compliance with prescribed medications	1	0.49	71	34.63
Not accessing services (medical f/u, pharm, edu, DME, rehab,	1	0.49	72	35.12
Not following therapists discharge recommendations	1	0.49	73	35.61

The FREQ Procedure

: 1	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Observation Status limiting patients from d/cing to SNF (esp	1	0.49	74	36.10
PCP follow up	1	0.49	75	36.59
PT discharge recommendations not followed	1	0.49	76	37.07
Patient Education (lack of)	1	0.49	77	37.56
Patient Non-compliance	1	0.49	78	38.05
Patient Noncompliance	1	0.49	79	38.54
Patient compliance	1	0.49	80	39.02
Patient compliance to recommendations and directions	1	0.49	81	39.51
Patient compliance with medical team recommendations	1	0.49	82	40.00
Patient discharged before being medically optimized	1	0.49	83	40.49
Patient discharged to location other than recommended by PT	1	0.49	84	40.98
Patient does not go to appointments	1	0.49	85	41.46
Patient non compliance medications or regimen	1	0.49	86	41.95
Patient noncompliance	3	1.46	89	43.41
Patient noncompliance with instructions	1	0.49	90	43.90
Patient noncompliance with meds	1	0.49	91	44.39
Patient refusal to go to recommended level of care	1	0.49	92	44.88
Patient was not medically ready	1	0.49	93	45.37
Patient's "non-acceptance" of PTs recs	1	0.49	94	45.85
Patient's cognition	1	0.49	95	46.34
Patient/family non-compliance with DC instructions	1	0.49	96	46.83
Patients being discharged too early against PT recommendatio	1	0.49	97	47.32
Patients disagree with DC recommendation	1	0.49	98	47.80
Patients getting discharged too soon - cost saving technique	1	0.49	99	48.29
Patients noncompliance with recommendations	1	0.49	100	48.78
Patients not following medical advice	1	0.49	101	49.27
Patients not regularly mobilized by nursing staff during adm	1	0.49	102	49.76
Patients refusing PT recommendations for SNF or cont care	1	0.49	103	50.24
Patients with complex, chronic needs need more follow up	1	0.49	104	50.73
Polypharmacy	1	0.49	105	51.22
Poor communcation post discharge with the patient	1	0.49	106	51.71
Poor communication	1	0.49	107	52.20
Poor follow up after discharge	1	0.49	108	52.68
Poor follow up with PT after DC	1	0.49	109	53.17
Poor medical followup after discharge (e.g. medication compl	1	0.49	110	53.66

: 1	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Poor patient adherence to plan	1	0.49	111	54.15
Poor patient and caregiver education	1	0.49	112	54.63
Poor patient compliance with discharge instructions	1	0.49	113	55.12
Poor patient followup	1	0.49	114	55.61
Poor relationship with pcp	1	0.49	115	56.10
Poor support systems for meals, meds, CPAP, diabetes care, e	1	0.49	116	56.59
Premature discharge	1	0.49	117	57.07
Progression of disease process	1	0.49	118	57.56
Pt being easily DC from hospital	1	0.49	119	58.05
Pt funding status does not allow for appropriate discharge l	1	0.49	120	58.54
Pt non-compliance	2	0.98	122	59.51
Recommended services not received	1	0.49	123	60.00
Rush to get patients discharged	1	0.49	124	60.49
Short initial LOS	1	0.49	125	60.98
Socioeconomic factors	1	0.49	126	61.46
Socioeconomic status of our population (i.e. can't afford pr	1	0.49	127	61.95
Surgical Site infection	1	0.49	128	62.44
Un or underinsured with lack of access to medication	1	0.49	129	62.93
Unfunded patients, those who use the ED as their primary car	1	0.49	130	63.41
age	1	0.49	131	63.90
appropriate dicharge location	1	0.49	132	64.39
chronic disease management	1	0.49	133	64.88
chronic dx exacerbations	1	0.49	134	65.37
chronic illness not managed well at home	1	0.49	135	65.85
co-morbidities	1	0.49	136	66.34
complex medical problems and lack of follow-up with medicati	1	0.49	137	66.83
discharge destination fails to continue progress/education	1	0.49	138	67.32
discharge home (family/pt insistance) rather than SNF if rec	1	0.49	139	67.80
discharge prior to meeting independent and/or safe mobility	1	0.49	140	68.29
discontinuity in communication among providers	1	0.49	141	68.78
early discharge	1	0.49	142	69.27
education for safety at home	1	0.49	143	69.76
failure of patients to have access to programs to assist the	1	0.49	144	70.24
falls	1	0.49	145	70.73
general mobility throughout the day before/after therapy int	1	0.49	146	71.22

: 1	Frequency	Percent	Cumulative Frequency	Cumulative Percent
immobility	1	0.49	147	71.71
inadequate resources for patients at discharge for f/u care	1	0.49	148	72.20
inadequate support at home	1	0.49	149	72.68
incorrect discharge plan	1	0.49	150	73.17
insufficient resources in community health outside the hospi	1	0.49	151	73.66
lack of adequate mobility	1	0.49	152	74.15
lack of communication between acute and post acute settings	1	0.49	153	74.63
lack of communication by health providers from acute care to	1	0.49	154	75.12
lack of continuity of care within hospitalization, especiall	1	0.49	155	75.61
lack of coordination with post acute provider	1	0.49	156	76.10
lack of follow up with primary care physicians	1	0.49	157	76.59
lack of mobility as an inpatient	1	0.49	158	77.07
lack of mobility in the hospital	1	0.49	159	77.56
lack of patient follow up of recommendations	1	0.49	160	78.05
lack of payor source and social support	1	0.49	161	78.54
lack of pt resources to follow up-meds, specialists, appts..	1	0.49	162	79.02
lack of social support	1	0.49	163	79.51
lack of support in home	1	0.49	164	80.00
limited availability to timely follow up appointments	1	0.49	165	80.49
med management	1	0.49	166	80.98
medical complications, including DVTs/PEs, PNA, transplant r	1	0.49	167	81.46
medical decline after discharge	1	0.49	168	81.95
medical diagnoses	1	0.49	169	82.44
medical issues not completely resolved	1	0.49	170	82.93
medication access	1	0.49	171	83.41
medication management	1	0.49	172	83.90
non compliance	2	0.98	174	84.88
non compliance with medication due to cost	1	0.49	175	85.37
non-compliance	2	0.98	177	86.34
non-compliance w/meds and/or follow-up	1	0.49	178	86.83
non-compliance with discharge recommendations	1	0.49	179	87.32
non-compliance with medications	1	0.49	180	87.80
non-compliance with medicine	1	0.49	181	88.29
not following PT recommendation	1	0.49	182	88.78
not following discharge recommendations	1	0.49	183	89.27

: 1	Frequency	Percent	Cumulative Frequency	Cumulative Percent
patient compliance	1	0.49	184	89.76
patient demographic	1	0.49	185	90.24
patient non-compliance with diet and meds and follow up with	1	0.49	186	90.73
patient non-compliance with medication	1	0.49	187	91.22
payor source--we have a high population of indigent patients	1	0.49	188	91.71
poor communication between diciplines (mostly physicans)	1	0.49	189	92.20
poor coordination of services in the home environment	1	0.49	190	92.68
poor follow up	1	0.49	191	93.17
poor health literacy	1	0.49	192	93.66
poor medical follow up	1	0.49	193	94.15
poor medication management	1	0.49	194	94.63
premature discharge	1	0.49	195	95.12
pressure to discharge pts regardless of their status	1	0.49	196	95.61
primary care follow up not timely	1	0.49	197	96.10
pt adherence	1	0.49	198	96.59
pt's lack of social support	1	0.49	199	97.07
recommendations for snf, inpt rehab rejected by patient/ fam	1	0.49	200	97.56
shortened length of stay in hospital	1	0.49	201	98.05
social issues	1	0.49	202	98.54
subsequent exacerbation of disease	1	0.49	203	99.02
undiagnosed psyciatric illness	1	0.49	204	99.51
unrelated secondary illness	1	0.49	205	100.00

:	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Access to continued therapy	1	0.49	1	0.49
Access to services	1	0.49	2	0.99
Acquire new infection in the snf setting	1	0.49	3	1.48
Adherance to medications	1	0.49	4	1.97
Age	1	0.49	5	2.46
Being Discharged too Soon	1	0.49	6	2.96
Complications at sub-acute facility	1	0.49	7	3.45
Confusing discharge instructions	1	0.49	8	3.94
Declining health	1	0.49	9	4.43
Delay in home care services starting up.	1	0.49	10	4.93
Dementia or altered mental status	1	0.49	11	5.42
Did not understand discharge instructions provided	1	0.49	12	5.91
Discharge before patients are ready	1	0.49	13	6.40
Discharge from hospital to home before pt is functionally ready	1	0.49	14	6.90
Discharge plan by PT not followed	1	0.49	15	7.39
Discharge quicker than patient stabilizes	1	0.49	16	7.88
Discharge to location other thatn that which was recommended	1	0.49	17	8.37
Discharge too soon	2	0.99	19	9.36
Discontinuity of physical therapy care after discharge	1	0.49	20	9.85
Dislocation	1	0.49	21	10.34
Don't follow PT recommendations for discharge location	1	0.49	22	10.84
Early discharge	1	0.49	23	11.33
Easy to admit complex patients	1	0.49	24	11.82
Facilities not will to take pt's with marginal social history	1	0.49	25	12.32
Fall risk	1	0.49	26	12.81
Falls	3	1.48	29	14.29
Families overestimating their ability to provide care at home	1	0.49	30	14.78
Families/caregivers unrealistic expectations of how much work it is to care for the	1	0.49	31	15.27
Family doesn't follow recommendations of assist level/ recommended dc destination	1	0.49	32	15.76
Family respite needed	1	0.49	33	16.26
Financial constraints guiding discharge	1	0.49	34	16.75
Financial resources	2	0.99	36	17.73
Follow up after DC	1	0.49	37	18.23
Getting and taking medication	1	0.49	38	18.72
HF exacerbation	1	0.49	39	19.21

:	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Hospital aquired Pneumonia	1	0.49	40	19.70
Inability to receive help at home	1	0.49	41	20.20
Inadequate education/patient and family teaching	1	0.49	42	20.69
Inappropriate D/C disposition - insurance will not cover	1	0.49	43	21.18
Insufficient family support in context of mobility and/or cognitive deficits	1	0.49	44	21.67
Insufficient patient and family education	1	0.49	45	22.17
Lack of communication between healthcare providers	1	0.49	46	22.66
Lack of communication in d/c planning process	1	0.49	47	23.15
Lack of education to patient	1	0.49	48	23.65
Lack of education to patient/family	1	0.49	49	24.14
Lack of education to patients and more importantly family members regarding both med	1	0.49	50	24.63
Lack of follow-up	1	0.49	51	25.12
Lack of general functional mobility with Nursing staff	1	0.49	52	25.62
Lack of home support	1	0.49	53	26.11
Lack of insurance approval for discharge recommendations	1	0.49	54	26.60
Lack of management of medical co morbidities	1	0.49	55	27.09
Lack of outpatient follow up	1	0.49	56	27.59
Lack of reinforcement by LIPs to patients re PT recs for safe D/C dispo	1	0.49	57	28.08
Lack of resources in community	1	0.49	58	28.57
Lack of social support outside hospital	1	0.49	59	29.06
Lack of social supports	1	0.49	60	29.56
Limited access to care	1	0.49	61	30.05
Limited access to community health programs	1	0.49	62	30.54
Medication Mismanagement	1	0.49	63	31.03
Medication errors	1	0.49	64	31.53
Mismatch between health literacy and instructiob	1	0.49	65	32.02
Mismatch between recommendations of therapists and patient's wishes (don't consent t	1	0.49	66	32.51
No insurance	1	0.49	67	33.00
Non compliance with follow up	1	0.49	68	33.50
Non-compliance	1	0.49	69	33.99
Noncompliance	2	0.99	71	34.98
Not enough patient education about importance of followup	1	0.49	72	35.47
Not following therapists plan of care for length of stay	1	0.49	73	35.96
Outside network providers	1	0.49	74	36.45
Overuse of ER	1	0.49	75	36.95

:	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Patient did not understand and follow recommendations	1	0.49	76	37.44
Patient discharged before medically ready	1	0.49	77	37.93
Patient education	1	0.49	78	38.42
Patient has organ failure that is nearly end stage (CHF, CKD, etc.) and medical mana	1	0.49	79	38.92
Patient initially refused a SNF placement but was not safe to be at home.	1	0.49	80	39.41
Patient non compliant with recommendations	1	0.49	81	39.90
Patient non-compliance	1	0.49	82	40.39
Patient non-compliance with recommendations	1	0.49	83	40.89
Patient noncompliance with follow up	1	0.49	84	41.38
Patient noncompliance with post acute care medications or treatments	1	0.49	85	41.87
Patient not getting prescriptions filled/taking meds	1	0.49	86	42.36
Patient refusal of d/c recommendations	1	0.49	87	42.86
Patient's ability to understand their own medical condition	1	0.49	88	43.35
Patient's insurance dictating discharge placement	1	0.49	89	43.84
Patient's lack of resources	1	0.49	90	44.33
Patient/family going against therapy disch recommendations	1	0.49	91	44.83
Patients not dosed effectively with exercises in subacute rehabs	1	0.49	92	45.32
Patients not following recommendations	1	0.49	93	45.81
Patients not following up with recommended providers	1	0.49	94	46.31
Patients not getting exercise via nursing assistance once they are cleared from PT b	1	0.49	95	46.80
Patients refusing the level of care recommended by PT/OT	1	0.49	96	47.29
Patients unable to pay for medications	1	0.49	97	47.78
Patients with complex, chronic needs not understanding recommendations for homegoing	1	0.49	98	48.28
Physician and system practice patterns	1	0.49	99	48.77
Physicians disregard recommendations of PT and OT	1	0.49	100	49.26
Poor cognitive function	1	0.49	101	49.75
Poor coomunication of instructions of d/c instuctions	1	0.49	102	50.25
Poor family support	1	0.49	103	50.74
Poor family support- just want patient resources	1	0.49	104	51.23
Poor follow post-discharge	1	0.49	105	51.72
Poor follow up	1	0.49	106	52.22
Poor patient adherence	1	0.49	107	52.71
Poor patient compliance with recommendations	1	0.49	108	53.20
Poor social support	1	0.49	109	53.69
Population without PCP	1	0.49	110	54.19

:	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Practice of defensive medicine	1	0.49	111	54.68
Premature discharge	1	0.49	112	55.17
Private physicians that are not on board with continuu of care	1	0.49	113	55.67
Pts initial plan was to go home but after few days got SOB even if it is coordinated	1	0.49	114	56.16
Pts not using equipment appropriately	1	0.49	115	56.65
Push for decreased length of stay (patients d/c too soon)	1	0.49	116	57.14
Quick Discharges	1	0.49	117	57.64
Refusal of patient to accept recommended discharge	1	0.49	118	58.13
Self care ability	1	0.49	119	58.62
Social support	1	0.49	120	59.11
Socioeconomic status (homeless population)	1	0.49	121	59.61
Staff/patient/caregiver communication	1	0.49	122	60.10
Too early discharge initially	1	0.49	123	60.59
Unavailability of caregiver	1	0.49	124	61.08
Uninsured or underinsured (post-acute services not covered)	1	0.49	125	61.58
access to primary care physicians following discharge	1	0.49	126	62.07
acknowledging therapy's recommendations for discharge	1	0.49	127	62.56
chronic conditions	1	0.49	128	63.05
co-morbidity	1	0.49	129	63.55
cognition	1	0.49	130	64.04
cognitive impairment	1	0.49	131	64.53
community acquired infections	1	0.49	132	65.02
complications/recurrence of symptoms (e.g., CHF)	1	0.49	133	65.52
compromise d/c plan b/c of insurance constraints	1	0.49	134	66.01
decreased patient motivation	1	0.49	135	66.50
decreased understanding of patient how to manage themselves at home	1	0.49	136	67.00
delay in home care services (both nursing and PT	1	0.49	137	67.49
discharge home and not to recommended discharge location (eg subacute rehab, acute r	1	0.49	138	67.98
discharge to inappropriate level of care based on functional status of pt	1	0.49	139	68.47
discharge to non- recommended level of care	1	0.49	140	68.97
early discharge	1	0.49	141	69.46
failure to heed PT recommendations	1	0.49	142	69.95
falls	1	0.49	143	70.44
families / patient not following recommendations	1	0.49	144	70.94
family/social support	1	0.49	145	71.43

: 2	Frequency	Percent	Cumulative Frequency	Cumulative Percent
follow up by the physician or a primary care provider after dc	1	0.49	146	71.92
generic d/c instructions - no room for PT activity recs.	1	0.49	147	72.41
health literacy	1	0.49	148	72.91
improving- but not discharging from ED	1	0.49	149	73.40
inappropirate post acute care	1	0.49	150	73.89
inappropriate discharge	1	0.49	151	74.38
incomplete medical management	1	0.49	152	74.88
inconsistent compliance with medications	1	0.49	153	75.37
insurance denials/pre-certification process when therapy recommends IP rehab and pt	1	0.49	154	75.86
insurance limitations on LOS and care post d/c	1	0.49	155	76.35
knowledge deficit of post acute providers	1	0.49	156	76.85
lack of access to medical providers/clinics	1	0.49	157	77.34
lack of communication with discharge destination	1	0.49	158	77.83
lack of coordination of care	1	0.49	159	78.33
lack of exercise/education programs like cardiopulm rehab	1	0.49	160	78.82
lack of follow through on meds	1	0.49	161	79.31
lack of patient compliance	1	0.49	162	79.80
lack of patient education	1	0.49	163	80.30
lack of patient resources	1	0.49	164	80.79
lack of resources	1	0.49	165	81.28
lack of understanding of medication use	1	0.49	166	81.77
long term chronic conditions that patient's "handle at home" without adequate servic	1	0.49	167	82.27
malnutrition	1	0.49	168	82.76
medical literacy deficits	1	0.49	169	83.25
medication (mis-)managment	1	0.49	170	83.74
medication management	1	0.49	171	84.24
medication non-adherence or mal-adherence	1	0.49	172	84.73
medication not available	1	0.49	173	85.22
multiple medical issues--one team decices the patient is ready, but another may not	1	0.49	174	85.71
non compliance with medications or follow up	1	0.49	175	86.21
non compliance with recommended diet	1	0.49	176	86.70
non-compliance with follow up with primary physician	1	0.49	177	87.19
non-compliance with medications	1	0.49	178	87.68
noncompliance	1	0.49	179	88.18
not following discharge recommendations due to insurance limitations	1	0.49	180	88.67

: 2	Frequency	Percent	Cumulative Frequency	Cumulative Percent
not quite medically ready to be discharged	1	0.49	181	89.16
not understanding discharge plan	1	0.49	182	89.66
over treatment by the medical community; COPD/CHF/CRF treated way beyond capacity fo	1	0.49	183	90.15
patient compliance and co-morbidity factors	1	0.49	184	90.64
patient preference and request to return	1	0.49	185	91.13
patient refusal to go to recommended level of post-acute care (ie SNF, LTC)	1	0.49	186	91.63
patientS very ill relatively near death could be hospice but still at home full code	1	0.49	187	92.12
patients identified who should no longer be in home environment alone but who are ow	1	0.49	188	92.61
physician insistence on a discharge setting despite recommendation	1	0.49	189	93.10
poor education from MD and nursing regarding medical problems	1	0.49	190	93.60
poor functional status at time of d/c	1	0.49	191	94.09
poor initial D/C plan/placement	1	0.49	192	94.58
poor patient compliance	1	0.49	193	95.07
poor support systems to patients/families	1	0.49	194	95.57
pt / CG cognition (ability to follow directions/make good choices)	1	0.49	195	96.06
pt non-compliance with tx recommendations	1	0.49	196	96.55
re-occurring illness	1	0.49	197	97.04
recommendations not followed	1	0.49	198	97.54
rush the discharge to the first accepting facility, not the best fit for the patient	1	0.49	199	98.03
shortened length of stay (esp post-op backs)	1	0.49	200	98.52
socioeconomic situation	1	0.49	201	99.01
unclear/limited resources at home for pt	1	0.49	202	99.51
wound infection	1	0.49	203	100.00

: 3	Frequency	Percent	Cumulative Frequency	Cumulative Percent
"observation status"	1	0.53	1	0.53
Ability to share documentation outside organization	1	0.53	2	1.06
Access to PCP	1	0.53	3	1.59
Actual discharge location does not equal recommended discharge location	1	0.53	4	2.12
Admission diagnosis not optimally managed prior to discharge	1	0.53	5	2.65
Appropriate access to medications	1	0.53	6	3.17
At risk comorbidities	1	0.53	7	3.70
Bias v. Drug abusers, homeless and obese	1	0.53	8	4.23
COPD exacerbation	1	0.53	9	4.76
Chronic conditions	1	0.53	10	5.29
Chronic illnesses that some patients have difficulty managing at home (i	1	0.53	11	5.82
Chronic medical issues/comorbidities	1	0.53	12	6.35
Chronicity and instability of medical condition (ETOH, COPD and CHF)	1	0.53	13	6.88
Communication PT-patient regarding discharge education	1	0.53	14	7.41
Comorbidity	1	0.53	15	7.94
Complications from lack of mobility(pneumonia, ulcers)	1	0.53	16	8.47
Conservative care in snfs	1	0.53	17	8.99
D/c Recs from therapy being ignored	1	0.53	18	9.52
Discharged prior to being medically stable	1	0.53	19	10.05
Discharged to destination other than that which was recommended by PT	1	0.53	20	10.58
Drug abuse	1	0.53	21	11.11
Drug and alcohol-related complications	1	0.53	22	11.64
Drug interactions	1	0.53	23	12.17
Dvt	1	0.53	24	12.70
Early discharge	1	0.53	25	13.23
Exacerbation of chronic illness	1	0.53	26	13.76
Facilities not willing to take pts with jx of substance abuse	1	0.53	27	14.29
Failure to follow up with physician	1	0.53	28	14.81
Fall	1	0.53	29	15.34
Fall risk	1	0.53	30	15.87
Falls	1	0.53	31	16.40
Family preferences/ belief systems	1	0.53	32	16.93
Hidden Medical information in complex charting systems	1	0.53	33	17.46
Inability of family to provide enough care/assistance	1	0.53	34	17.99
Inability to see PCP for follow up and further med adjustments	1	0.53	35	18.52

: 3	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Inadequate follow up post discharge	1	0.53	36	19.05
Insurance denial of appropriate level of post-DC care	1	0.53	37	19.58
Insurance denial of post acute care rehab forcing patients home	1	0.53	38	20.11
Lack of access to services	1	0.53	39	20.63
Lack of adequate insurance	1	0.53	40	21.16
Lack of appropriate medical follow up post-DC	1	0.53	41	21.69
Lack of communication between disciplines prior to discharge	1	0.53	42	22.22
Lack of continuum of care	1	0.53	43	22.75
Lack of education regarding safety at home	1	0.53	44	23.28
Lack of family etc.support post discharge	1	0.53	45	23.81
Lack of family support	3	1.59	48	25.40
Lack of follow through of recommendations made by Rehab team -e.g. going	1	0.53	49	25.93
Lack of followup information	1	0.53	50	26.46
Lack of housing	1	0.53	51	26.98
Lack of insurance (CMS) coverage	1	0.53	52	27.51
Lack of insurance coverage	1	0.53	53	28.04
Lack of patient accountability with d/c plan... Noncompliance	1	0.53	54	28.57
Level of education of patient i.e. ability to discern need to pursue tre	1	0.53	55	29.10
Loss of information to other providers after discharge	1	0.53	56	29.63
Low health literacy	1	0.53	57	30.16
MD's not listening to our recommendations	1	0.53	58	30.69
Medical complexity of patients	1	0.53	59	31.22
Medical discharge too soon	1	0.53	60	31.75
Medically complex patients	1	0.53	61	32.28
Medication errors	1	0.53	62	32.80
Medication mismanagement	1	0.53	63	33.33
Minimal doctor and nursing respect for therapist input in patient assess	1	0.53	64	33.86
No support system at home	1	0.53	65	34.39
Non compliance with dc recs	1	0.53	66	34.92
Non compliant with medications	1	0.53	67	35.45
Non-compliance (i.e. COPD, HF)	1	0.53	68	35.98
Noncompliance	1	0.53	69	36.51
Not following therapist discharge recommendations (i.e. sending patients	1	0.53	70	37.04
PCP does not follow discharge recommendations	1	0.53	71	37.57
PT & OT discharge recommendations not followed	1	0.53	72	38.10

: 3	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Patient compliance	1	0.53	73	38.62
Patient discharged with suboptimal education on readmission risk	1	0.53	74	39.15
Patient financial means to pay for care	1	0.53	75	39.68
Patient noncompliance with oxygen needs, medication instructions, etc.	1	0.53	76	40.21
Patient was recommended inpatient rehab or skilled nursing facility. Pat	1	0.53	77	40.74
Patient's financial status	1	0.53	78	41.27
Patient's low health literacy	1	0.53	79	41.80
Patient/Caregiver Not Always Understanding Instructions Despite Being Ed	1	0.53	80	42.33
Patients disregarding discharge disposition recommendations	1	0.53	81	42.86
Patients prefer hospital more than home- like a hotel	1	0.53	82	43.39
Patients resistance to rehab	1	0.53	83	43.92
Patients unwilling to recognize that home is not the safest option for t	1	0.53	84	44.44
Physicians are not held financially accountable, so they don't care abou	1	0.53	85	44.97
Physicians not able to fix problem	1	0.53	86	45.50
Physicians select poor candidates for surgeries/interventions, and the p	1	0.53	87	46.03
Poor compliance w meds	1	0.53	88	46.56
Poor d/c option	1	0.53	89	47.09
Poor family support	1	0.53	90	47.62
Poor follow through by pt's re overall medical care/ recs	1	0.53	91	48.15
Poor follow up after discharge from hospital - to MD. many contributing	1	0.53	92	48.68
Poor functional endurance/ limited functional reserve in context of medi	1	0.53	93	49.21
Poor identification of social factors (finances, housing, transportation	1	0.53	94	49.74
Poor patient adherence to plan	1	0.53	95	50.26
Poor wound management	1	0.53	96	50.79
Post hospital syndrome	1	0.53	97	51.32
Post-op infection/PNA/DVT	1	0.53	98	51.85
Progression of other Medical comorbidities	1	0.53	99	52.38
Recommeded services not set up	1	0.53	100	52.91
Recurrence of chronic medical conditions such as CHF, COPD	1	0.53	101	53.44
Remote program for CHF monitoring ("Heartlink") failed due to financial	1	0.53	102	53.97
Repeat falls	1	0.53	103	54.50
SNF providing too low an intensity of PT such that pt regresses from the	1	0.53	104	55.03
Sepsis	1	0.53	105	55.56
Short length of stay	1	0.53	106	56.08
Social issues	1	0.53	107	56.61

: 3	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Social support	2	1.06	109	57.67
Too many cooks at the kettle	1	0.53	110	58.20
Treatment non-compliance	1	0.53	111	58.73
Volume to process patients	1	0.53	112	59.26
access to resources	1	0.53	113	59.79
accessible housing to come and go	1	0.53	114	60.32
acuity at admission	1	0.53	115	60.85
availability of SNF and IRF beds	1	0.53	116	61.38
care to high for at home caregivers	1	0.53	117	61.90
chronic health issues/co-morbities	1	0.53	118	62.43
compliance	1	0.53	119	62.96
d/c plan not followed, usually pt refusal	1	0.53	120	63.49
daily weights with CHF	1	0.53	121	64.02
decline in status due to multiple medical conditions/co-morbidities	1	0.53	122	64.55
deconditioning	1	0.53	123	65.08
decreased ability to get medications or lack of understanding of medicat	1	0.53	124	65.61
decreased functional mobility	1	0.53	125	66.14
decreased intensity of rehab	1	0.53	126	66.67
decreased understanding of medication changes	1	0.53	127	67.20
discharge prior to managing medical problem causing admission	1	0.53	128	67.72
discharge to inappropriate level of care based on medical issues	1	0.53	129	68.25
education level	1	0.53	130	68.78
expected progression of chronic illness/disease process	1	0.53	131	69.31
failure to consult PT	1	0.53	132	69.84
failure to thrive	1	0.53	133	70.37
financial	1	0.53	134	70.90
financial barriers	1	0.53	135	71.43
following recommendation to reduce risks	1	0.53	136	71.96
high % of low economic clients	1	0.53	137	72.49
high acuity of patient at d/c	1	0.53	138	73.02
high density chronic disease	1	0.53	139	73.54
home care doesn't show up	1	0.53	140	74.07
horrible continuity of care; one hand doesn't know what the other is doi	1	0.53	141	74.60
illness not being well managed before leaving	1	0.53	142	75.13
inadequate therapy frequency and intensity while in the acute hospital f	1	0.53	143	75.66

: 3	Frequency	Percent	Cumulative Frequency	Cumulative Percent
inappropriate discharge placements	1	0.53	144	76.19
increasing safety with mobility while inpatient so the patient is better	1	0.53	145	76.72
insurance issues/lack of benefits	1	0.53	146	77.25
lack of access to care	1	0.53	147	77.78
lack of adequate follow-up services	1	0.53	148	78.31
lack of carry over from hospital to home in multiple areas--activities,	1	0.53	149	78.84
lack of family support	1	0.53	150	79.37
lack of follow up	1	0.53	151	79.89
lack of insurance	1	0.53	152	80.42
lack of medical follow up/resources	1	0.53	153	80.95
lack of proper follow up (patient factor)	1	0.53	154	81.48
lack of pt education how to prevent readmission	1	0.53	155	82.01
lack of social support	1	0.53	156	82.54
lack of support/education to facilitate change in habits for those deali	1	0.53	157	83.07
limitations in resources	1	0.53	158	83.60
limitations to post-d/c medical management	1	0.53	159	84.13
limited understanding of underlying medical issues	1	0.53	160	84.66
medication management	1	0.53	161	85.19
multiple medical issues under the control of too many MDs--nobody lookin	1	0.53	162	85.71
need for more community navigators	1	0.53	163	86.24
no follow up calls	1	0.53	164	86.77
non compliance with medications	1	0.53	165	87.30
non-compliant with use of assistive devices	1	0.53	166	87.83
nonadherence	1	0.53	167	88.36
not following PT d/c recommendations	1	0.53	168	88.89
patient doesn't have support system	1	0.53	169	89.42
patient knowledge deficit re medications	1	0.53	170	89.95
patient motivation and goals	1	0.53	171	90.48
patient non-compliance	2	1.06	173	91.53
patient/family anxiety, mental health	1	0.53	174	92.06
patients are very ill. Too expensive to provide adequate support for all	1	0.53	175	92.59
patients who have difficulty with eating/ swallowing issues who do not f	1	0.53	176	93.12
poor access to community nursing	1	0.53	177	93.65
poor ccordination services	1	0.53	178	94.18
poor compliance with discharge recommendations	1	0.53	179	94.71

: 3	Frequency	Percent	Cumulative Frequency	Cumulative Percent
poor discharge planning not listening to therapists family refusal to fo	1	0.53	180	95.24
poor follow with PCPs	1	0.53	181	95.77
poor insight on part of pt/caregivers about what will be required to car	1	0.53	182	96.30
poor/inconsistent follow through by pt at home	1	0.53	183	96.83
poverty	1	0.53	184	97.35
shorter LOS	1	0.53	185	97.88
sickly pts	1	0.53	186	98.41
social issues	1	0.53	187	98.94
specialization of medicine with lack of gatekeeper who can thoroughly in	1	0.53	188	99.47
the nature of chronic diseases	1	0.53	189	100.00

: 4	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Admitted for inappropriate reasons	1	0.65	1	0.65
All medical issues not addressed as IP	1	0.65	2	1.30
Cardiac issies	1	0.65	3	1.95
Caregiver education regarding red flags	1	0.65	4	2.60
Cognition	1	0.65	5	3.25
Comorbidities	1	0.65	6	3.90
Confusion	1	0.65	7	4.55
Decline in function	1	0.65	8	5.19
Decline of pt to agree to go to the recommended di	1	0.65	9	5.84
Delay of home health services seeing Pt. after d/c	1	0.65	10	6.49
Discharge to streets or shelter	1	0.65	11	7.14
Discharged from hospital too early	1	0.65	12	7.79
Don't follow up with pts after discharge	1	0.65	13	8.44
Drug and alcohol abuse, or mental health/addiction	1	0.65	14	9.09
Dumping by NH	1	0.65	15	9.74
Failure at home	1	0.65	16	10.39
Failure to follow d/c recs	1	0.65	17	11.04
Fall risk with decreased balance not addressed	1	0.65	18	11.69
Falls	1	0.65	19	12.34
Families overwhelmed	1	0.65	20	12.99
Family/caregivers do not follow discharge recommen	1	0.65	21	13.64
Habitual patients	1	0.65	22	14.29
Homelessness	1	0.65	23	14.94
Huddle on a case when it becomes difficult vs bein	1	0.65	24	15.58
I work at a military hospital where patients pay n	1	0.65	25	16.23
Inadequate support at home	1	0.65	26	16.88
Inappropriate services available at home to assist	1	0.65	27	17.53
Insurance issues - pt's come to ER unnecessarily	1	0.65	28	18.18
Lack of adequate health insurance	1	0.65	29	18.83
Lack of attendance at f/u appointments	1	0.65	30	19.48
Lack of consideration by provider of ALL the patie	1	0.65	31	20.13
Lack of family support	1	0.65	32	20.78
Lack of family/community support	1	0.65	33	21.43
Lack of functional standardized tests in acute car	1	0.65	34	22.08
Lack of home safety evaluation	1	0.65	35	22.73

: 4	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Lack of resources	1	0.65	36	23.38
Lack of resources at home	1	0.65	37	24.03
Lack of resources for patient after d/c	1	0.65	38	24.68
Lack of therapists in Home health	1	0.65	39	25.32
Limited access to home health/outpatient services	1	0.65	40	25.97
MDs going against rehab recs for DC	1	0.65	41	26.62
Medical complication	1	0.65	42	27.27
Medical noncompliance	1	0.65	43	27.92
Medication errors by patient	1	0.65	44	28.57
Medication mismanagement/ polypharmacy	1	0.65	45	29.22
Misdiagnosed	1	0.65	46	29.87
Misunderstanding of amount of care that family wil	1	0.65	47	30.52
No support in community	1	0.65	48	31.17
Non- referrals for PT/OT/ST	1	0.65	49	31.82
Not following recommended discharge plan- refusal	1	0.65	50	32.47
Not sure	1	0.65	51	33.12
Nutrition issues	1	0.65	52	33.77
Ongoing chronic medical problems	2	1.30	54	35.06
Overly cautious staff at SNF/rehab/home care refer	1	0.65	55	35.71
Overstate available assist at home	1	0.65	56	36.36
Pain	2	1.30	58	37.66
Patient anxiety	1	0.65	59	38.31
Patient did not keep follow up appt	1	0.65	60	38.96
Patient discharged without follow up care plans in	1	0.65	61	39.61
Patient doesn't understand or doesn't follow disch	1	0.65	62	40.26
Patient feels they cannot take care of themselves	1	0.65	63	40.91
Patient fell at home	1	0.65	64	41.56
Patient non-compliance	1	0.65	65	42.21
Patient non-compliance, not following recommendati	1	0.65	66	42.86
Patient preference	1	0.65	67	43.51
Patient/caregiver noncompliance with discharge rec	1	0.65	68	44.16
Patients being discharged sooner than advisable (e	1	0.65	69	44.81
Patients do not take responsibility for their heal	1	0.65	70	45.45
Patients doctors and staff pushed to get patient o	1	0.65	71	46.10
Patients refusing best DME for them	1	0.65	72	46.75

: 4	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Paucity of out-patient support for patients with c	1	0.65	73	47.40
Physical therapy d/c recom not followed	1	0.65	74	48.05
Physician follow up- a part of #1	1	0.65	75	48.70
Physicians get paid more when patients are readmit	1	0.65	76	49.35
Poor PT- physician communication	1	0.65	77	50.00
Poor communication between providers	1	0.65	78	50.65
Poor health of our community (many chronic conditi	1	0.65	79	51.30
Pt's sycho-social issues/ home support (or lack of	1	0.65	80	51.95
Pt's with limited health literacy	1	0.65	81	52.60
Recurrence of disease/disease not well managed	1	0.65	82	53.25
Renal failure	1	0.65	83	53.90
Rural status	1	0.65	84	54.55
SNF "milking" the patient's days in SNF and not pr	1	0.65	85	55.19
Secondary complications (pneumonia, etc)	1	0.65	86	55.84
Stay active	1	0.65	87	56.49
Unaddressed pysch issues	1	0.65	88	57.14
Underinsured	1	0.65	89	57.79
Unfollowed D/C recommendation placement	1	0.65	90	58.44
Very Sick Patients With Complex Medical History	1	0.65	91	59.09
Waiting times to see a primary care physician	1	0.65	92	59.74
When patients do not follow up with their physicia	1	0.65	93	60.39
aspiration Pneumonia	1	0.65	94	61.04
assist at home or lack thereof	1	0.65	95	61.69
being discharged too early	1	0.65	96	62.34
complicated chronic problems	1	0.65	97	62.99
decreased communication overall with care team	1	0.65	98	63.64
decreased compliance w/ d/c recs (e.g., meds)	1	0.65	99	64.29
dehydration	1	0.65	100	64.94
depression due to functional dependence	1	0.65	101	65.58
drug issues	1	0.65	102	66.23
drug seeking behavior	1	0.65	103	66.88
external locus of control (the doctor will fix me	1	0.65	104	67.53
failure to thrive	1	0.65	105	68.18
family noncompliant with our recommendations	1	0.65	106	68.83
fragile patients	1	0.65	107	69.48

: 5	Frequency	Percent	Cumulative Frequency	Cumulative Percent
health knowledge of caregiver	1	0.65	108	70.13
high % of elderly clients	1	0.65	109	70.78
inadequate direct follow up with the patient after	1	0.65	110	71.43
inadequate management of chronic conditions	1	0.65	111	72.08
inadequate mobility in acute	1	0.65	112	72.73
ineffective patient involvement in directing their	1	0.65	113	73.38
insurance barriers	1	0.65	114	74.03
insurance coverage of d/c recommendation	1	0.65	115	74.68
insurance problems	1	0.65	116	75.32
lack of appropriate follow up care for medicaid pa	1	0.65	117	75.97
lack of behaviorial modification	1	0.65	118	76.62
lack of education	1	0.65	119	77.27
lack of family involvement/support	1	0.65	120	77.92
lack of family/patient to provide care	1	0.65	121	78.57
lack of follow-through with home program	1	0.65	122	79.22
lack of home support	1	0.65	123	79.87
lack of patien education	1	0.65	124	80.52
lack of physician over-sight	1	0.65	125	81.17
lack of proper post acute management of patient	1	0.65	126	81.82
lack of resources- community/social/financial- onc	1	0.65	127	82.47
lack of social support using hospital as a social	1	0.65	128	83.12
lack of staff--RNs, CM, MSW, rehab	1	0.65	129	83.77
lack of support(family dynamics/social issues)	1	0.65	130	84.42
limitations to post-d/c therapy services	1	0.65	131	85.06
limited value in therapy opinion for some high ris	1	0.65	132	85.71
medical complexity	1	0.65	133	86.36
medical noncompliance	1	0.65	134	87.01
mental health issues	1	0.65	135	87.66
multiple doctors do not communicate with each othe	1	0.65	136	88.31
outside facility care	1	0.65	137	88.96
palliative care, end of life issues without plan,	1	0.65	138	89.61
patient knowledge deficit re self care	1	0.65	139	90.26
patient non-compliance with outpatient physician o	1	0.65	140	90.91
patient/family anxiety	1	0.65	141	91.56
patients cannot afford meds	1	0.65	142	92.21

: 5	Frequency	Percent	Cumulative Frequency	Cumulative Percent
patients identified as fall risk but who decline u	1	0.65	143	92.86
physicians not following PT recommendations for di	1	0.65	144	93.51
poor access to primary care physicians	1	0.65	145	94.16
poor social support at home	1	0.65	146	94.81
primary care physicians	1	0.65	147	95.45
psycho-social issues (esp. chronic mental health p	1	0.65	148	96.10
risky behaviors by pts	1	0.65	149	96.75
social issues/homelessness	1	0.65	150	97.40
socioeconmic factors at home	1	0.65	151	98.05
support at home	1	0.65	152	98.70
transition out of acute care prematurely	1	0.65	153	99.35
various types of electronic medical records that d	1	0.65	154	100.00

: 5	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Access to EMR by caregivers and patients	1	0.85	1	0.85
Bad Luck	1	0.85	2	1.71
Breathing issues	1	0.85	3	2.56
Caregiver support	1	0.85	4	3.42
Change in status	1	0.85	5	4.27
Chf	1	0.85	6	5.13
Chronicity of Disease	1	0.85	7	5.98
Complete discharge plan not established prior to discharge	1	0.85	8	6.84
Complications That Occurred at the OSF	1	0.85	9	7.69
Dec funding for certain facilities	1	0.85	10	8.55
Discharged too early from acute care	1	0.85	11	9.40
Disease progression/ Functional decline progression	1	0.85	12	10.26
ED processes that promote admission rather than treat and release.	1	0.85	13	11.11
ED used by patients as primary care / urgent care	1	0.85	14	11.97
Early DC due to push for decreased length of stay	1	0.85	15	12.82
Falls	1	0.85	16	13.68
Family not equipped skill-wise or with right ancillary services at dc	1	0.85	17	14.53
Follow up appt should have been scheduled in 3-7 days vs two weeks.	1	0.85	18	15.38
HMO discharges that are premature	1	0.85	19	16.24
Huge variability of skill and competence of home care providers	1	0.85	20	17.09
Illiteracy/low education level of patients	1	0.85	21	17.95
Immobility	1	0.85	22	18.80
Inadequate medication reconciliation/planning	1	0.85	23	19.66
Insurance issues	2	1.71	25	21.37
Intensity of PT intervention not matching needs of patient while admitted	1	0.85	26	22.22
Lack of "norms" to compare one patient's progress to another	1	0.85	27	23.08
Lack of carryover of education to familly	1	0.85	28	23.93
Lack of family/care-giver involvement	1	0.85	29	24.79
Lack of medical follow-up	1	0.85	30	25.64
Lack of sufficient patient education	1	0.85	31	26.50
Length of stay of initial admission	1	0.85	32	27.35
Limited family support	1	0.85	33	28.21
Limited pt u defeat ding of condition and home management	1	0.85	34	29.06
Medical Errors	1	0.85	35	29.91
Multiple comorbidities	1	0.85	36	30.77

: 5	Frequency	Percent	Cumulative Frequency	Cumulative Percent
New illness	1	0.85	37	31.62
No caregiver	1	0.85	38	32.48
Non-compliance by patient	1	0.85	39	33.33
Not able to get transportation for follow up care	1	0.85	40	34.19
Not sure	1	0.85	41	35.04
Out of network insurance in season (FL)	1	0.85	42	35.90
Patient & family understanding of prognosis and management at home	1	0.85	43	36.75
Patient decisions	1	0.85	44	37.61
Patient non-compliance	1	0.85	45	38.46
Patient non-compliance with follow up care plan	1	0.85	46	39.32
Patient's lack of understanding of their disease	1	0.85	47	40.17
Patients not feeling ready to be discharged	1	0.85	48	41.03
Patients not following HEP/home safety recommendations	1	0.85	49	41.88
Patients not understanding disease process	1	0.85	50	42.74
Patients refuse rehab	1	0.85	51	43.59
Polypharmacy	2	1.71	53	45.30
Poor communication within the continuum of care.	1	0.85	54	46.15
Poor follow-up after discharge re: equipment, therapy, recommendations	1	0.85	55	47.01
Poor quality therapy in SNF	1	0.85	56	47.86
Poor understanding and ownership of how to manage disease process.	1	0.85	57	48.72
Poor understanding of the role of a hospital in managing things like dement	1	0.85	58	49.57
Psychosocial status	1	0.85	59	50.43
Pt's insurance declining to approve the recommended discharge destination	1	0.85	60	51.28
Pts. refusing to DC to anywhere but home	1	0.85	61	52.14
Recieve post acute therapy	1	0.85	62	52.99
SNF decision making -- send to ER	1	0.85	63	53.85
Secondary complications	1	0.85	64	54.70
Unable to obtain medications	1	0.85	65	55.56
Unrealistic expectations of patients and families regarding how they will p	1	0.85	66	56.41
Use of the ED	1	0.85	67	57.26
altered mobility	1	0.85	68	58.12
co-morbidities	1	0.85	69	58.97
cognition issues plus poor social support	1	0.85	70	59.83
cognitive status	1	0.85	71	60.68
communication	1	0.85	72	61.54

: 5	Frequency	Percent	Cumulative Frequency	Cumulative Percent
complex medical conditions	1	0.85	73	62.39
complex medical patients	1	0.85	74	63.25
complications of alcohol/drug abuse	1	0.85	75	64.10
decrease in health status	1	0.85	76	64.96
delay in follow-up services	1	0.85	77	65.81
drug and alcohol abuse by patients, non-compliance for pyschiatric conditio	1	0.85	78	66.67
falls	1	0.85	79	67.52
falls and frequent hospitalizations without rehab	1	0.85	80	68.38
family/patient refusing recommendations	1	0.85	81	69.23
high % of clients with multiple comorbidities	1	0.85	82	70.09
high volume of patients and turn over daily	1	0.85	83	70.94
immobility post-d/c	1	0.85	84	71.79
inadaquete psychosocial support	1	0.85	85	72.65
inadequate emphasis on wellness and prevention	1	0.85	86	73.50
inadequate supervision of patients when a certain level of adult supervisio	1	0.85	87	74.36
infection	1	0.85	88	75.21
infections	1	0.85	89	76.07
infrequent homecare visits	1	0.85	90	76.92
lack of collaboration/communication by acute care team	1	0.85	91	77.78
lack of intervention by MD at SNF or rehab	1	0.85	92	78.63
lack of mobility	1	0.85	93	79.49
lack of resources(financial issues)	1	0.85	94	80.34
lack of social support	1	0.85	95	81.20
limited follow up with pt once home	1	0.85	96	82.05
medical issues being incompletely managed in acute setting	1	0.85	97	82.91
mental health issues	1	0.85	98	83.76
n/a	1	0.85	99	84.62
no lifestyle change	1	0.85	100	85.47
not discharging to recommended post acute level of care	1	0.85	101	86.32
observation/outpatient admission status	1	0.85	102	87.18
patient compliance/finances	1	0.85	103	88.03
patient lack of resources to remain well	1	0.85	104	88.89
patients with cognitive impairments who improperly take medications, forget	1	0.85	105	89.74
poor communication	1	0.85	106	90.60
poor health insurance- going straight to the ER	1	0.85	107	91.45

: 5	Frequency	Percent	Cumulative Frequency	Cumulative Percent
poor health literacy	1	0.85	108	92.31
poor patient edcuation in hospital	1	0.85	109	93.16
pressure to reduce the length of stay	1	0.85	110	94.02
pt non compliance	1	0.85	111	94.87
pt's not discharging to recommended level of care - especially those who ne	1	0.85	112	95.73
pt's will poor social support	1	0.85	113	96.58
pt/ family non compliance w/ d/c instructions both medical and functional/	1	0.85	114	97.44
push for rapid discharges and in some areas of the hospitals- late therapy	1	0.85	115	98.29
relunctance to discuss end of life wishes/plans	1	0.85	116	99.15
secondary complication - infection/cellulitis/etc.	1	0.85	117	100.00