# What is this tool?

A document to collect a list of the clinical and social service resources available at the skilled nursing facilities with which you are partnering. The list is an opportunity for hospitals to identify SNF staff to provide a warm handoff and promptly meet the transitional care needs of patients to help reduce readmissions.

# Who should use this tool?

The care transitions team at your hospital.

# How to use this tool?

Use this document to gather contact information and establish available services of your SNF partners. Having this information in a comprehensive list facilitates timely post-discharge follow up and monitoring.

| **Skilled nursing facility** | **Admission coordinator** **(name/phone #, email)** | **Post-admission contact** ***(for circle back for*** ***hospital to SNF)*** | **Physician(s)**  | **Pharmacist** | **Rehab/Physical therapist**  |
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# References

The elements included in this tool were modified from:

Designing and Delivering Whole-Person Transitional Care. Content last reviewed June 2017. Agency for Healthcare Research and Quality, Rockville, MD. <https://www.ahrq.gov/patient-safety/settings/hospital/resource/guide/index.html>

Berkowitz, Bill, and Eric Wadud. “Section 8. Identifying Community Assets and Resources.” *Chapter 3. Assessing Community Needs and Resources | Section 8. Identifying Community Assets and Resources | Tools | Community Tool Box*, The University of Kansas, 2022, <https://ctb.ku.edu/en/table-of-contents/assessment/assessing-community-needs-and-resources/identify-community-assets/tools>

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