

# Transitions in Care Long Term Care Facility Survey

**September 2011**

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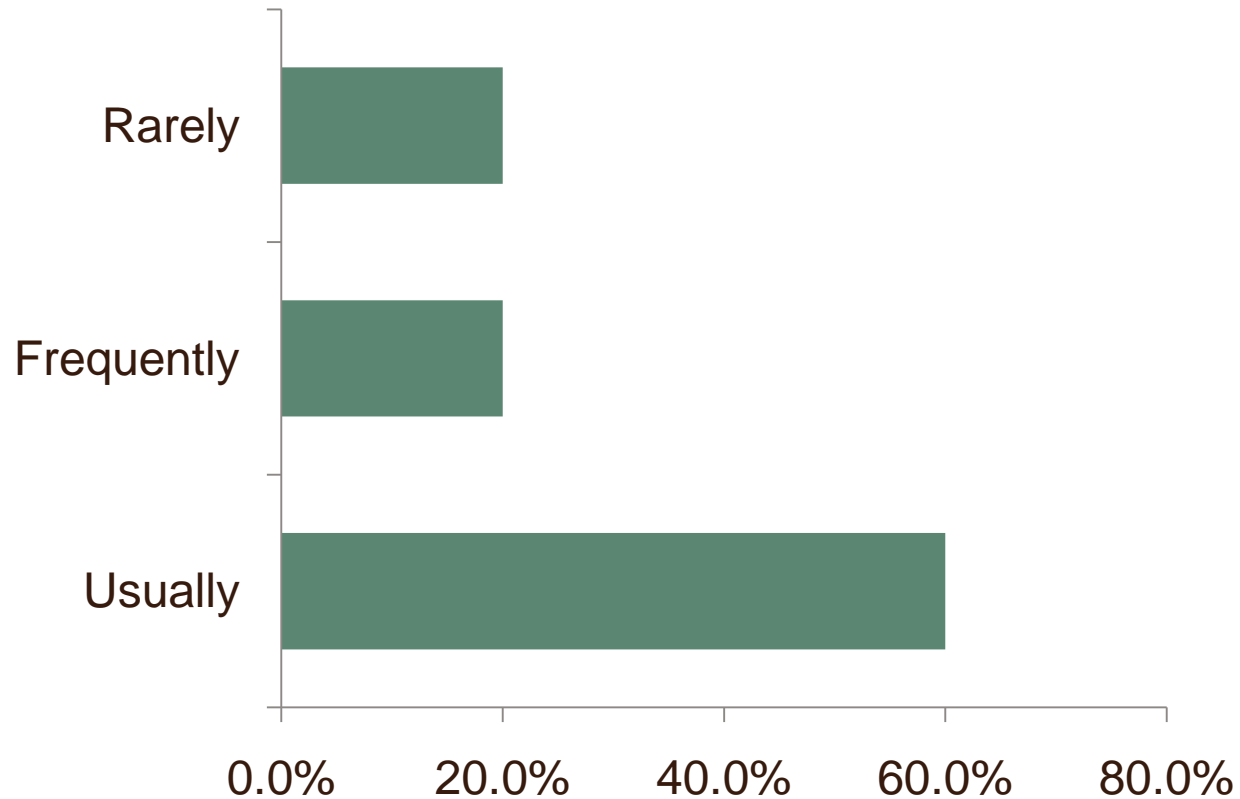
# Survey Parameters

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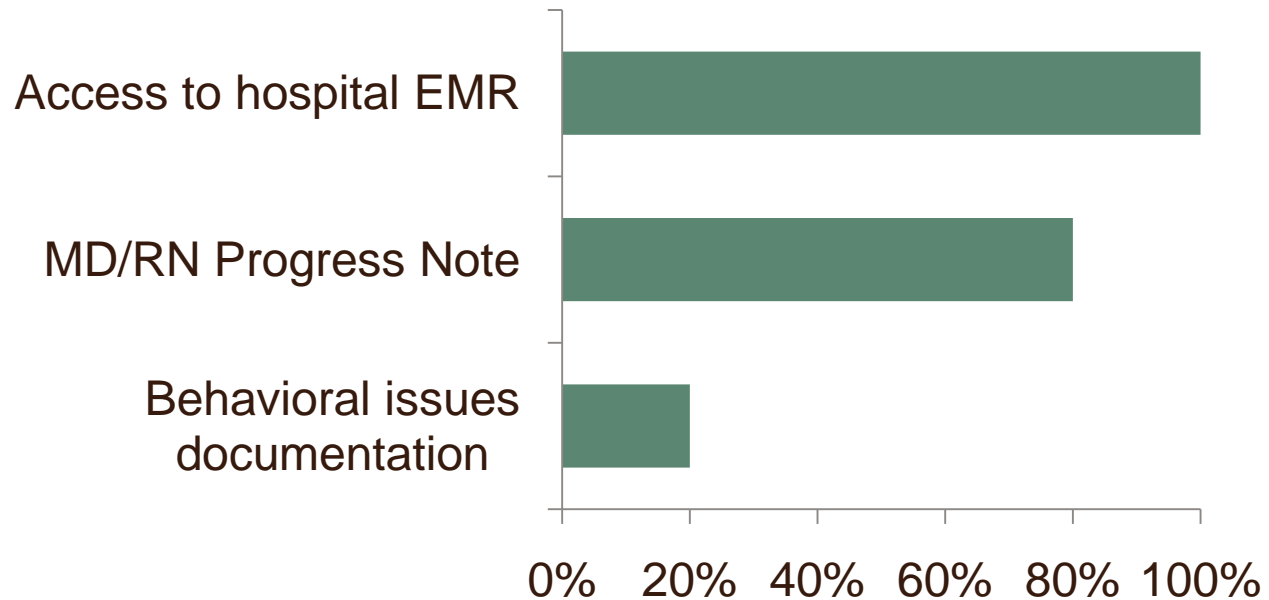
- 14 questions created by multi-disciplinary team
- Survey administered by phone interview (courtesy of Frances Hanckel, Steering Committee member)
- N=5 unique responses
- Sample includes SNF units, daycare units, Alzheimer care units, extended care units

# #1: When you admit a patient from a hospital, is the information you receive adequate to initiate and maintain care?



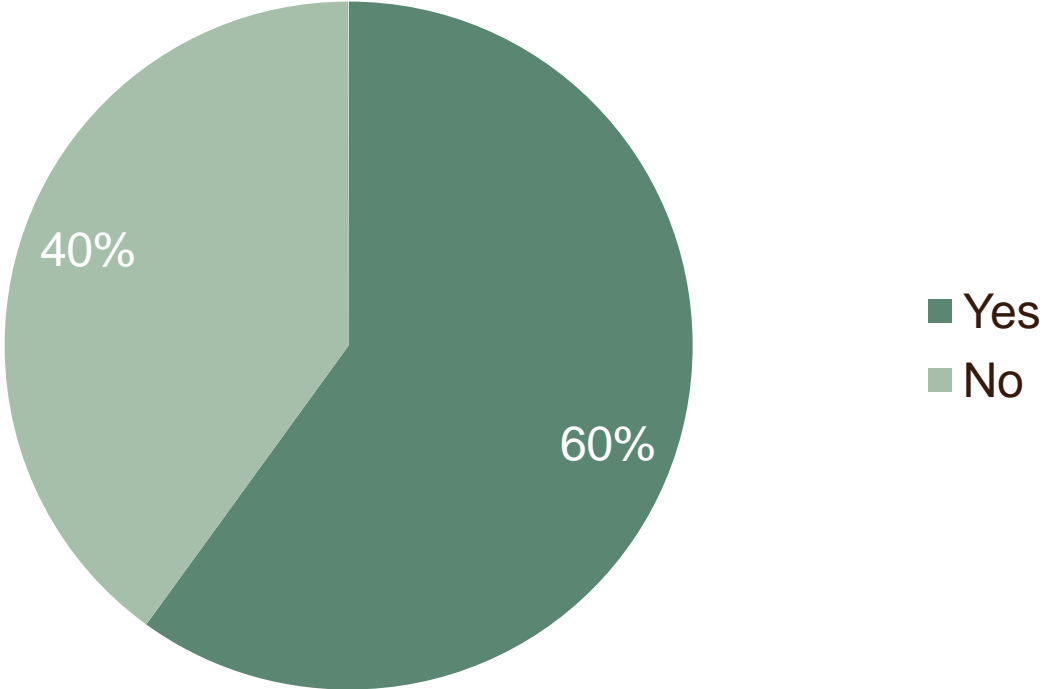
## #2: Is there information not usually sent that would be extremely helpful in the provision of care? ◆

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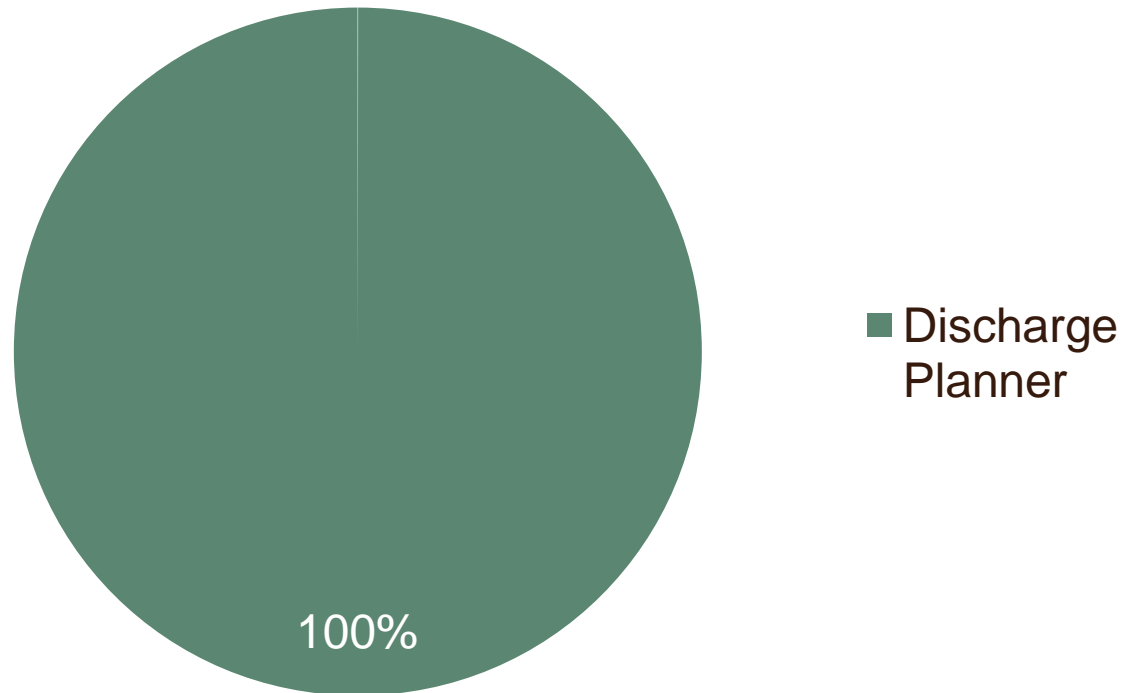
### #3: Do you receive a prompt discharge summary from the hospital?

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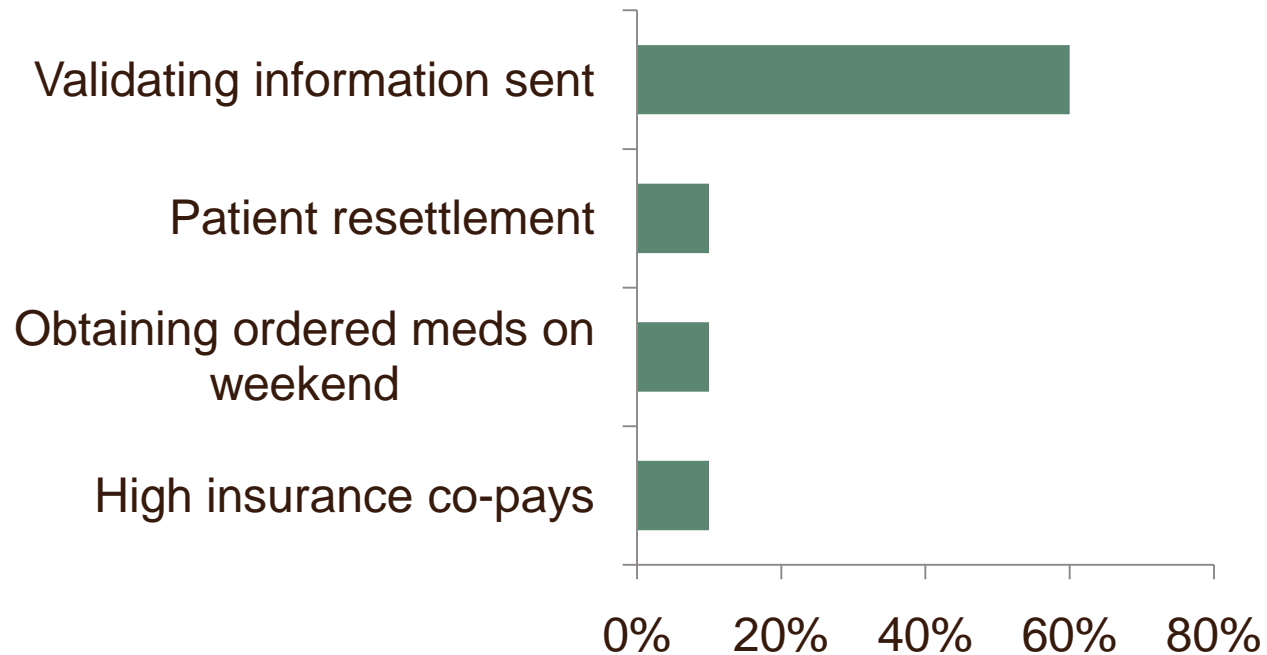
## #4: Is there someone at the discharging hospital you can contact if you have questions?

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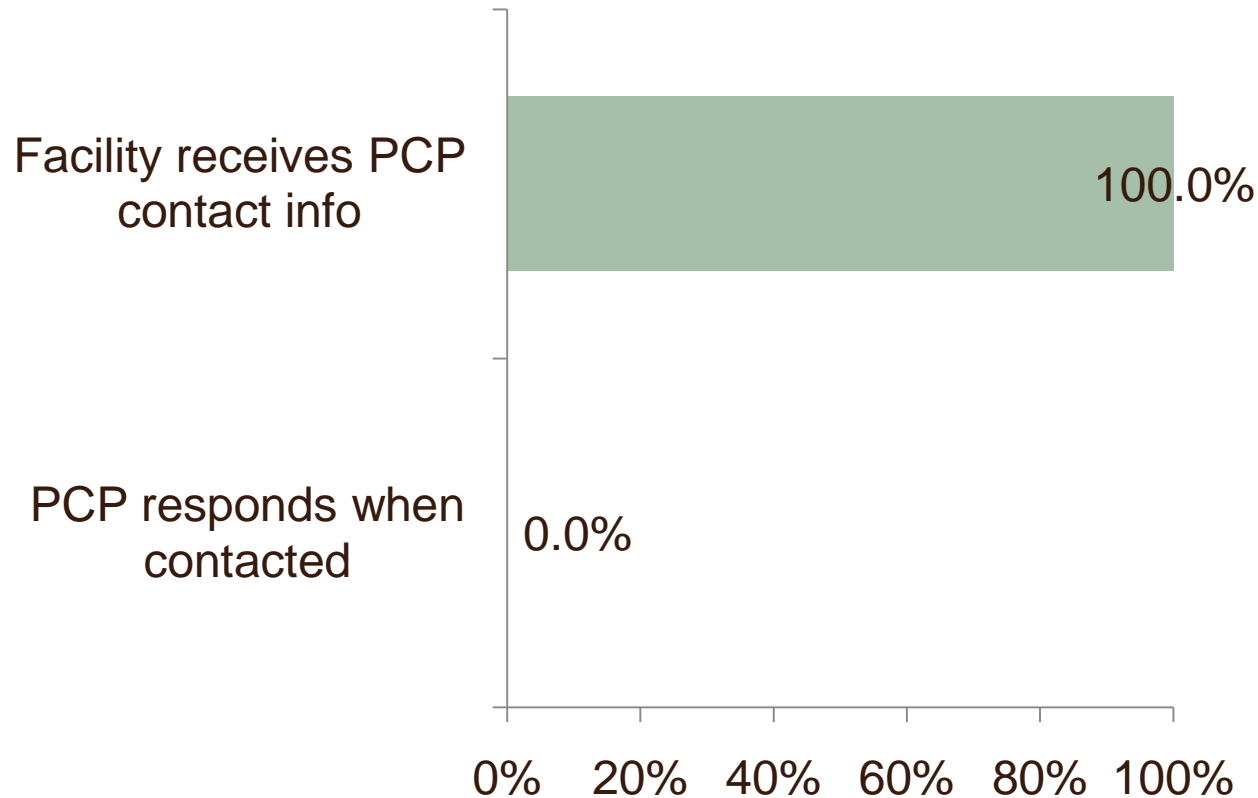


## #5: What is the most challenging or frustrating issue you face when a patient is discharged to your facility from a hospital?

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## #6: Do you receive contact information for the patient's PCP or specialist upon admission?

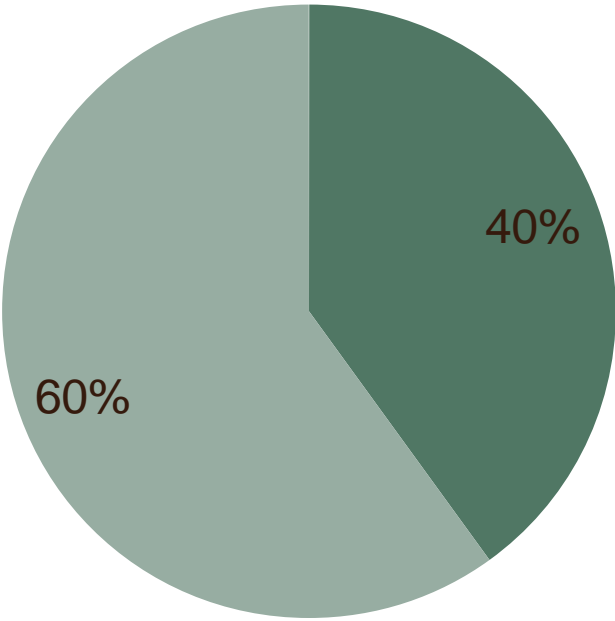




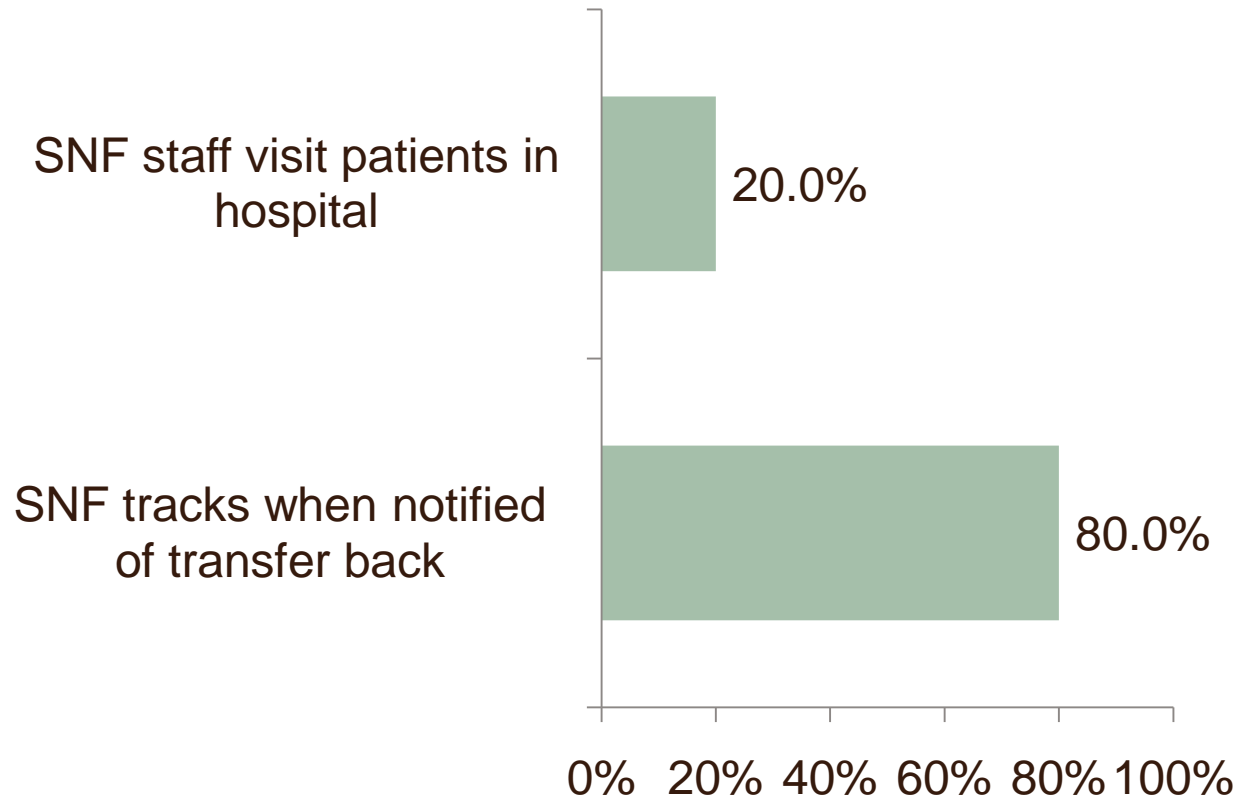
# #7: Do you have a hospitalist or SNF-ist on staff that sees some or all of your patients?



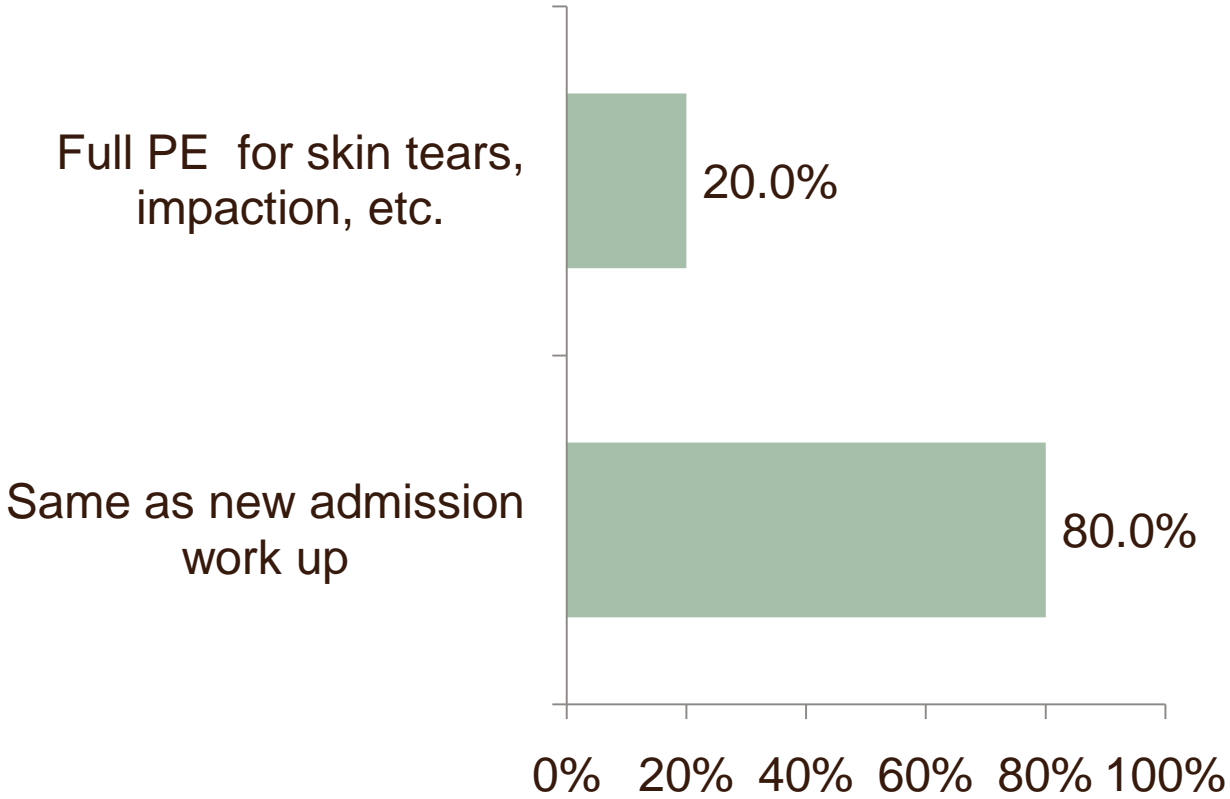
■ No ■ Yes



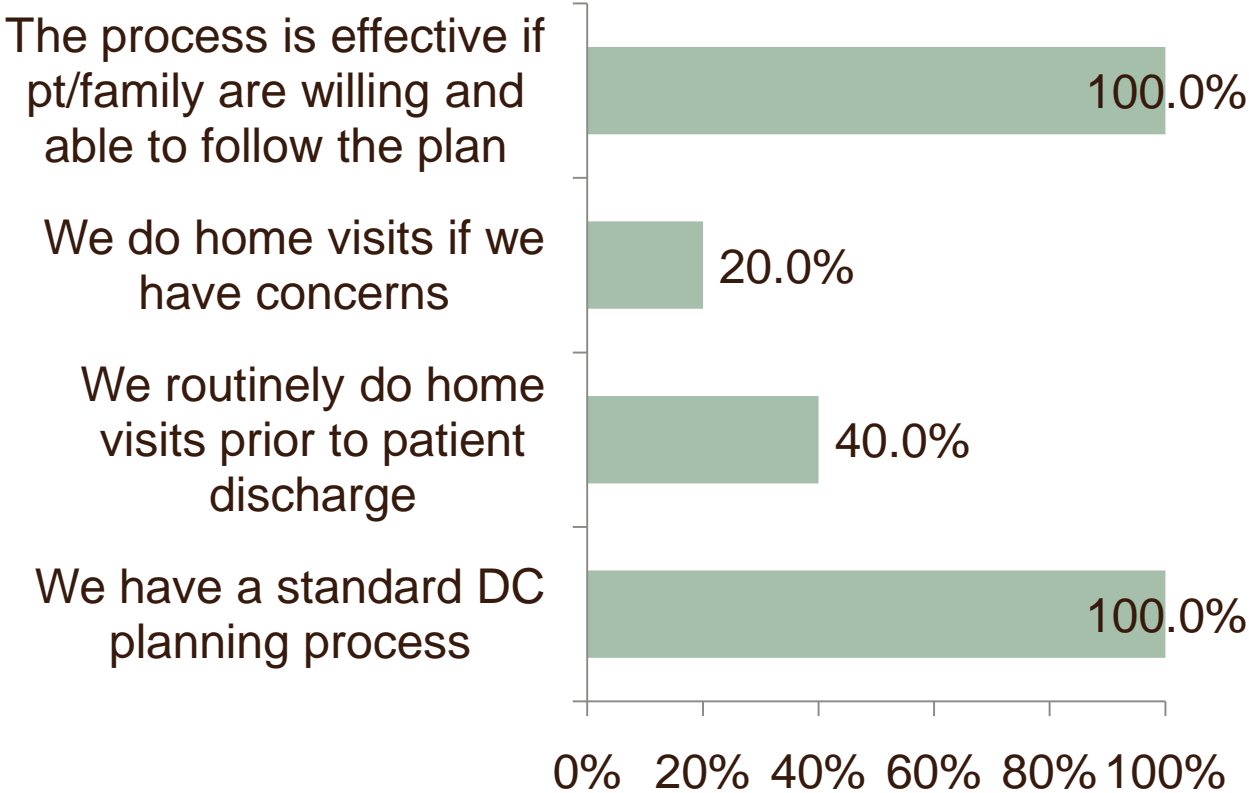
## #8/9: Who in your organization tracks when one of your patients is readmitted to the hospital?



# #10: Do you have a standard process for re-evaluating a patient after readmission to your facility?



# #12/13: Regarding your discharge planning process:



## #14: What is the most difficult or frustrating issue when a patient is discharged from your facility to home?

