

# Patient Readmission Interview Tool

A readmission interview offers an opportunity for the care team and for the patients and families/caregivers to share their perceptions about the hospitalization and post-discharge experience. Use these questions as a springboard for discussion, and as a way of identifying opportunities to improve the system and to engage the patient to be an active partner on his-her care team. This document serves as a guide only; depending on the interview, it may not be necessary to ask all the listed questions.

Date \_\_\_\_\_

Name of patient \_\_\_\_\_

Interviewer \_\_\_\_\_

## Reason for returning to the hospital:

1. What prompted you to return to the hospital? \_\_\_\_\_
2. Were you able to talk to your doctor or the doctor's office before you came back to the hospital?  
 Yes.
  - Which doctor or doctor's office did you talk to? \_\_\_\_\_
  - What instructions did your doctor's office provide? \_\_\_\_\_
- No. Why not? \_\_\_\_\_

## Self-Care and Assistance

Tell me about your time at home after being discharged from the hospital this last time.

3. What arrangements were made for you when you went home?

<input type="checkbox"/> Does not know	<input type="checkbox"/> Medical Equipment	<input type="checkbox"/> Medication assistance
<input type="checkbox"/> Home Health	<input type="checkbox"/> Home IV Therapy	<input type="checkbox"/> Home Delivered Meals
<input type="checkbox"/> Nursing Home	<input type="checkbox"/> Hospice	<input type="checkbox"/> Homemaking/errand services
<input type="checkbox"/> Rehabilitation	<input type="checkbox"/> Follow-up appointments	<input type="checkbox"/> Transportation
<input type="checkbox"/> Personal care	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____
4. How did these arrangements meet your needs?  
 Needs not met     Somewhat     Needs met     Too much
5. If no arrangements were made, did you have any difficulty caring for yourself at home?  Yes  No  
If yes, can you tell me more about that and what type of assistance you feel would be helpful?  
\_\_\_\_\_
6. While at home, did you have any questions about how to care for yourself?  Yes  No  
If yes, how were you able to get those questions answered?  
\_\_\_\_\_

## Discharge Instructions Review

7. Upon discharge, were the instructions given to you provided in the language you prefer?  Yes  No

8. In your own words, can you please tell me what you remember from your discharge instructions.

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9. Were there any instructions that were confusing or difficult to do?  Yes  No

If yes, which ones?

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10. What if any additional information could have been helpful to prevent this hospital visit?

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## Medications

11. Did you have any new prescriptions when you were last discharged?  Yes  No

If yes, were you able to obtain your new prescription without difficulty?  Yes  No

If no, what can you describe any problems or barriers you experienced?

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12. Do you have questions about any of your medications, new or existing?  Yes  No

If yes, what questions do you have?

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13. Since being home, have you missed any medication doses or taken more than the usual dose?

Yes  No

If yes, which medication(s) and how have you taken it differently than prescribed?

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## Social Factors

Social Determinants of Health (SDOH) can impact a person's health, which can lead to readmissions. Please refer to your organization's SDOH Screening tool to further assess the patient's needs. If your organization does not have a standard SDOH screening tool see below for tools, you can utilize. Based on your findings from the SDOH screening, initiate your organization's internal process to connect your patient to the resources needed to address the identified SDOH barriers.

- [The PREPARE Screening Tool](#)

- [AAFP Social Needs Screening Tool](#)

## Questions for Care Team Members

1. Could this readmission have been avoided?  Yes  No  
If yes, what could have been done differently upon discharge to set this person up for success once at home?

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2. Was this person's self-care or assistance needs addressed and met prior to discharge?  Yes  No  
If no, what could have been done differently?

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3. Were the person's cultural and linguistic needs met when providing discharge instructions?  Yes  No  
If no, what could have been done differently?

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4. Did medication adherence contribute to this readmission?  Yes  No  
If yes, what could have been done differently regarding medications?

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5. Are there social factors contributing to this readmission?  Yes  No  
If yes, what can be done to address these?

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Date

Care Team Members Interviewed

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