Patient Readmission Interview Tool

A readmission interview offers an opportunity for the care team and for the patents 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.

The Patient and Family Centered Care Partners (PFCCP) developed this comprehensive readmission Interview Guide to facilitate the development of effective strategies that minimize hospital readmissions for patients.

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.
     - o Which doctor or doctor's office did you talk to? _____
     - o 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?

☐ Does not know	☐ Medical Equipment	☐ Medication assistance
☐ Home Health	☐ Home IV Therapy	☐ Home Delivered Meals
☐ Nursing Home	☐ Hospice	☐ Homemaking/errand services
☐ Rehabilitation	☐ Follow-up appointments	☐ Transportation
☐ Personal care	☐ Other_____	☐ 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.

_____

_____

_____

9. Were there any instructions that were confusing or difficult to do? ☐ Yes ☐ No
   If yes, which ones?

   _____

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

_____

_____

_____

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?

    _____

    _____

    _____

12. Do you have questions about any of your medications, new or existing? ☐ Yes ☐ No
    If yes, what questions do you have?

    _____

    _____

    _____

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?

    _____

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?

   _____

   _____

   _____

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?

   _____

   _____

   _____

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

   _____

   _____

   _____

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

   _____

   _____

   _____

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

   _____

   _____

   _____

Date	Care Team Members Interviewed
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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