# What is this tool?

In the case of a multiple-admission patient or readmission within 30 days of last discharge, this tool helps hospitals gather information from the patient, care partner and/or family member on non-medical factors that may have contributed to the admission or readmission. The questions are designed to gain a deeper understanding of the patient’s and care partner’s perspectives, challenges and barriers. With this information, hospitals can identify commonly recurring opportunities for improvement in current discharge processes and better optimize discharge plans.

# Who should use this tool?

This tool should be used by designated readmission team members, such as quality improvement, nursing, case management or other designated staff.This tool is *not* designed to be given to a patient or care partner to complete and return to staff; it should be completed by a hospital team member.

# How to use this tool:

* Identify patients in the hospital who have been readmitted within 30 days of discharge from the hospital and/or patients that meet your facility’s readmission criteria.
* Ask the patient and/or care partner if they are willing to have a short (10- to 15-minute) discussion about their recent admission or readmission.
* The interviewer will ask the below questions and record the answers.
* Analyze responses for insight into why patients have returned to the hospital so soon after their discharge.
* EQIC encourages you to conduct the interview when the patient’s care partner or family member is present to provide more robust information.

# FOR INTERNAL USE ONLY

Patient Name:

Medical record number:

Date of admission (current admission):

If applicable, admitted from which community-based organization?

Who is responding to this survey or being interviewed?









If other, please explain:

Name of the care partner, family member or other person present:

Relationship to patient:

Name of interviewer:

Date:

# Section 1: General admission or readmission

1. Why did the patient return to the hospital? (Hospital to categorize readmission based on observed patterns. Examples: Concerns related to transportation, medication, social determinants of health or community-based organization support.)
2. Did the physician managing your care outside of the hospital, such as your primary care provider, see or speak to you before sending you to the hospital?







1. Was your return to the hospital:









If other, please explain:

1. Have any community-based organizations been involved in your care? Examples are skilled nursing facility, home health care, nutritional support agency, physical/occupational/respiratory therapy, social services, etc.





If yes, what organization(s) have been involved in your care?

1. Did you contact any staff of the community-based organization(s) identified in question #4 to discuss what was happening before coming back to the hospital?





If yes, what were you told?

# Section 2: Discharge instructions and patient education

1. When you were discharged from your last hospital stay, did the staff provide you with information in a way you could understand about the kind of care you would receive post discharge?









1. Overall, how prepared were you to manage your care when discharged from the hospital?











1. What, if anything, could have better prepared you and/or your care partner/family member to feel more comfortable about your discharge?

# Section 3: Medication

1. Did you have any problems with your medication? Examples: were you able to access medications, afford the medications prescribed, were there any discrepancies in medication dosage and did you know how to take the medication?





If yes, please describe:

1. Did you understand the instructions about your medications and its side effects, including over-the-counter drugs, vitamins, supplements and prescribed medications?





If no, please state the reason why:

1. Are you still taking all your medications as prescribed at the time you left the hospital?





If no, please state the reason why:

# QUESTION FOR INTERVIEWER ONLY – DO NOT READ TO PATIENT

1. Root cause(s) of admission or readmission: *Interviewer’s impression of the primary reason(s) for the readmission (Choose all that apply):*

Complication from the previous admission

Medication non-compliance

Non-adherence to diet/exercise recommendations

Inadequate understanding of the level of care available at the next transition

The patient and/or care partner did not understand what care could be managed away from the hospital or in the home

The facility the patient was discharged to was not equipped to handle the patient’s condition

The patient’s palliative care needs were not met

Other (specify):

# References

The elements included in this tool were modified from:

Herndon L., Bones C., Bradke P., Rutherford P., How-to Guide: Improving Transitions from the Hospital to Skilled Nursing Facilities to Reduce Avoidable Rehospitalizations. Cambridge, MA: Institute for Healthcare Improvement; June 2013. Available at [ihi.org/resources/Pages/Tools/HowtoGuideImprovingTransitionHospitalSNFstoReduceRehospitalizations.aspx](http://www.ihi.org/resources/Pages/Tools/HowtoGuideImprovingTransitionHospitalSNFstoReduceRehospitalizations.aspx)

