



New York State  
Partnership  
for Patients



Preventable Readmissions Initiative  
Patient and Care Partner Interview Tool:  
Readmission from SNF

**What Is This Tool:**

This tool is designed to help hospitals gather information from the patient and family care partner on non-medical factors that may have contributed to the readmission. The questions are designed to provide deeper understanding of the patient and care partner’s perspectives and challenges to help hospitals better optimize discharge plans so they address patient concerns and identify commonly recurring opportunities for improvement in current discharge processes.

**How To Use It:**

- Identify patients in the hospital who have been readmitted from a skilled nursing facility (SNF) within 30 days of being discharged from the hospital
- Ask the patient and/or family care partners if they are willing to have a 10- to 15-minute discussion about their recent readmission to the hospital
- The interviewer will ask the below questions and record the answers
- Analyze responses for insight on “why” patients have returned to the hospital so soon after their discharge
- This tool is not designed to be given to a patient or care partner to complete and return to staff

**Tips:**

- We recommend you select at least five to 10 patients readmitted to your organization within the past 30 days to include in the group of patients and/or family care partners to interview
- We suggest you identify cases from your high-volume readmission SNF partners, services, or other areas of concern
- We suggest you identify cases from your high-volume readmission SNF partners, services, or other areas of concern
- Ensure that you interview enough patients to observe trends and opportunities for improvement. NYSPFP encourages you to interview the patient when the patient’s care partner or family member is present to provide more robust information

Patient Name (for internal use only): \_\_\_\_\_ Medical Record #: \_\_\_\_\_

Date of Admission (current admission): \_\_\_\_\_

SNF Admitted From: \_\_\_\_\_

Who Is Responding to This Survey or Being Interviewed?

Patient  Care Partner or Family Member  Both  Other

Relationship to Patient: \_\_\_\_\_

Name of Interviewer: \_\_\_\_\_ Date: \_\_\_\_\_

# Preventable Readmissions Initiative

## Patient and Care Partner Interview Tool: (Continued)

### Section 1: General Readmission

1. Why did you return to the hospital? (Free text – hospital to categorize based on observed patterns)

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2. Did the physician managing your care at the SNF see you before sending you to the hospital?

Yes  No, I did not see my physician at the SNF prior to returning to the hospital

3. Were the risks and benefits of going to the emergency department or hospital versus staying at the SNF explained before your transfer?

Yes  No

4. Did a physician, nurse practitioner, or nurse at the SNF tell you they could safely manage your care without transferring you to the hospital?

Yes  No

If yes, did they advise you to stay at the SNF?

Yes  No

If yes, do you know why you were returned to the hospital now?

Yes  No

If yes, please state the reason: \_\_\_\_\_

5. Was your return to the hospital (select from below options):

- Unexpected and caused by a new medical problem
- Unexpected, but related to what I was treated for in the SNF
- A result of the SNF not meeting my expectations for care or services

# Preventable Readmissions Initiative

## Patient and Care Partner Interview Tool: (Continued)

### Section 2: Discharge Instructions and Patient Education

6. When you were discharged from your last hospital stay, did the hospital staff provide you with information (in a way you could understand) about the kind of care you would receive at the SNF (e.g., how often a physician would see you)?

Yes  No  Don't Know  Doesn't Apply

7. Overall, how prepared did you feel to go to the SNF from the hospital?

1	2	3	4	5
<i>Not at all prepared</i>				<i>Well prepared</i>

8. What else, if anything, could have better prepared you and/or your care partners to feel more comfortable about going to the SNF? (Free text)

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### Section 3: Medication

9. Were your medications available when you arrived at the SNF?

Yes  No

10. Did you understand the instructions about your medications and their side effects (including over-the-counter drugs, vitamins, supplements, and prescribed medications)?

Yes  No

If no, please state the reason why: \_\_\_\_\_

11. Are you taking all your medications as prescribed when you leave the hospital?

Yes  No

If no, please state the reason why: \_\_\_\_\_

## Preventable Readmissions Initiative

### Patient and Care Partner Interview Tool: (Continued)

#### QUESTION FOR INTERVIEWER ONLY – DO NOT READ TO PATIENT

12. Root Causes of Readmission: Interviewer's impression of the primary reason(s) for the readmission  
(Choose all that apply):

- Complication from previous admission
- Medication non-compliance
- Non-adherence to diet/exercise recommendations
- Inadequate understanding about the level of care at the SNF
- Patient and/or care partner did not understand care could be managed in the SNF
- SNF or rehab unit was not equipped to handle the patient's condition
- Patient's palliative care needs were not met
- Other (specify): \_\_\_\_\_

#### References

The elements included in this tool were modified from components of the following tools:

- 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 <http://www.ihl.org/resources/Pages/Tools/HowtoGuideImprovingTransitionHospitalSNF-toReduceRehospitalizations.aspx>
- NYSPFP Preventable Readmissions Initiative: Patient and Family Caregiver Interview Tool. Available from: <https://www.nyspfp.org/Members/Initiatives/Readmissions/Tools.aspx>