Time 1: Demographics

Record ID

_____

COMPLETE THE SECTION BELOW FROM THE PATIENT'S MEDICAL CHART

Study ID Assigned by Medication Safety Research Team

_____

Medical Record Number (MRN)

_____
(Type medical record number from the EHR)

Patient's Sex

◯ Female ◯ Male

Date of Birth

_____
(Type year of birth here (mm/dd/yyyy))

Is the patient of HISPANIC, Latino, or Spanish origin? [ENTER FROM MEDICAL CHART]

◯ Yes ◯ No

Enter patient's race from medical chart [CHECK ONE OR MORE BOXES THAT APPLY]

☐ White
☐ Black/African American
☐ American Indian/Alaskan Native
☐ Asian
☐ Native Hawaiian/Other Pacific Islander
☐ More than one race
☐ Unknown or unreported
☐ Other

PLEASE COMPLETE THE SECTION BELOW BY ASKING THE PATIENT

What transportation do you use OR is available for you to use?
IF A CAREGIVER IS ANSWERING, ASK: What transportation does [PATIENT'S NAME] use?

☐ Your own car
☐ Public transit
☐ Walk
☐ Family/Friend
☐ Taxi/Uber/Lyft
☐ Other

If using other types of transportation modes, type responses below:

_____

What is your education level?

☐ Below high school
☐ Completed some high school
☐ High school graduate
☐ Completed some college
☐ Associates degree
☐ Bachelor's degree
☐ Master's or above

Presently, how many people live in your house, including you?

_____

What is your approximate yearly household income?	☐ Under $10,000 ☐ $10,000 - $14,999 ☐ $15,000 - $24,999 ☐ $25,000 - $34,999 ☐ $35,000 - $49,999 ☐ $50,000 - $74,999 ☐ $75,000 and above
Do you have a primary care provider?	◯ Yes ◯ No
If No, who do you see for majority of your healthcare?	_____
In the past ONE year, how many doctors wrote you prescriptions?	_____
Do you have insurance, including Medicare and Medicaid?	◯ Yes ◯ No
If Yes, can you tell me which types of insurance you have?	☐ Medicare ☐ Medicaid ☐ Commercial/Private Insurance ☐ Other
Who do you live with?	_____

COMPLETE THE SECTION BELOW ONLY IF A CAREGIVER IS AVAILABLE AND CONSENTED TO BE INTERVIEWED

IS CAREGIVER PRESENT AND CONSENTED TO BE INTERVIEWED?	◯ Yes ◯ No
What is the caregiver's sex?	◯ Female ◯ Male
What is the caregiver's age?	_____
Are you of HISPANIC, Latino, or Spanish origin?	◯ Yes ◯ No
What is your race? [CHECK ONE OR MORE BOXES THAT APPLY]	☐ White ☐ Black/African American ☐ American Indian/Alaskan Native ☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐ More than one race ☐ Unknown or unreported ☐ Other
What is your relationship to [NAME OF PATIENT]?	☐ Spouse ☐ Partner ☐ Daughter/Son/Grandchild ☐ Neighbor ☐ Friend ☐ Hired for a cost ☐ Other

How long have you been taking care of [NAME OF PATIENT]?

_____
(Type number of years, months, or days)

In the past three months, on average how many hours per week did you spend on care-giving for [NAME OF PATIENT]?

_____

COMPLETE THE NEXT SECTION FROM A CHART REVIEW

Type All Admission Diagnoses

_____

Type All Discharge Diagnoses

_____

Does the patient have a document allergy information in the medical record?

◯ Yes ◯ No

If Yes, please type allergy information

_____

Date of Admission

_____

Date of Discharge

_____

Length of hospital stay during current admission [IN DAYS]

_____
(Type number of days)

Number of hospital admission(s) in the last 12 months, including the current admission.

_____

Time 1: Interview with Patients and Caregivers in Hospital Room

Record ID	_____
Date of Interview (Time 1)	_____ (mm/dd/yyyy)
Do you have a caregiver at home to help you manage your medications?	◯ Yes ◯ No
If Yes, who is this person?	☐ Spouse ☐ Partner ☐ Daughter/Son/Grandchild ☐ Neighbor ☐ Friend ☐ Someone hired for a fee ☐ Daughter-in-law/Son-in-law/Other Relative ☐ Other
If Other is selected, please enter the home caregiver who helps manage patient's medications at home	_____
In the past, has your caregiver helped you with any of the following things? [READ OPTIONS OUT LOUD]	☐ Read discharge instructions ☐ Explain to you how to take your medications ☐ Create a medication schedule for when to take what medications ☐ Fill pillboxes ☐ Make changes to medications as a result of hospitalization ☐ Remind you to take your medications ☐ Update your list of medications ☐ Help you with medical appointments and other needed tasks
Did you or your caregiver bring a list of your medications OR medication bottles to the hospital when you were admitted?	◯ Yes ◯ No
IS CAREGIVER PRESENT AND CONSENTED TO BE INTERVIEWED?	◯ Yes ◯ No

THE FOLLOWING QUESTIONS ONLY ASKED TO A CAREGIVER, IF AVAILABLE [GIVE CAREGIVER SHOW CARD FOR REFERENCE]

On a scale of 1 to 5, 1=Strongly Disagree, 2=Disagree, 3=Neither Agree nor Disagree, 4=Agree, 5=Strongly Agree, what is your level of agreement with the following statements?

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree

I maintain an updated list of [PATIENT'S NAME]'s medications	◯	◯	◯	◯	◯
For every medication [PATIENT'S NAME] takes, I know when, how much, and how it is to be taken	◯	◯	◯	◯	◯
I have a trusted pharmacist or pharmacy in my community that I can contact if I have medication-related questions	◯	◯	◯	◯	◯
I have or will check with [PATIENT'S NAME] doctor to make sure what medication [HE/SHE] should be taking	◯	◯	◯	◯	◯
I know what things to watch for that would mean [PATIENT'S NAME]'s condition is getting worse and how to respond	◯	◯	◯	◯	◯

COMPLETE THE NEXT SECTION BY ASKING THE PATIENT

In the past, have you always been able to pick up new medications prescribed at discharge? ◯ Yes ◯ No ◯ Not Applicable

If not applicable, choose that applies:
◯ Discharge medications received at hospital
◯ Mail order for new discharge medications

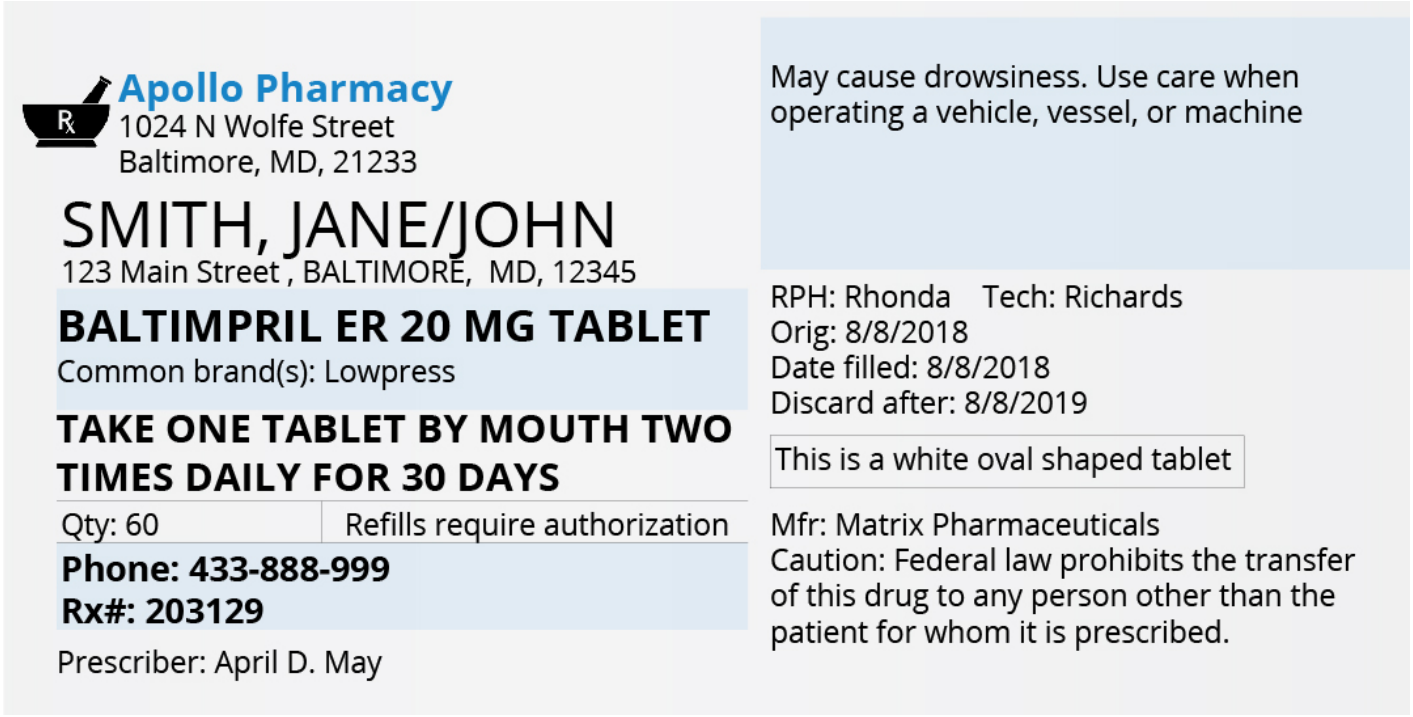
Have you skipped filling your prescriptions due to problems with insurance or paying for medications [such as high co-pays, gaps in coverage, insurance not covering brand name medications]? ◯ Yes ◯ No

On a scale of 1 to 5, 1=Strongly Disagree, 2=Disagree, 3=Neither Agree nor Disagree, 4=Agree, 5=Strongly Agree, what is your level of agreement with the following statements? [GIVE PATIENT SHOW CARD FOR REFERENCE]

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
I can follow directions when my doctor changes my medications	◯	◯	◯	◯	◯
I can manage my medications without help	◯	◯	◯	◯	◯
I can list my medications, inlcuding the doses and schedule	◯	◯	◯	◯	◯

I can take my medications when there is a change in my usual day	○	○	○	○	○

FOR INFORMATION ONLY:
THE BELOW PRESCRIPTION LABEL APPEARS ON BOTTLE GIVEN TO PATIENTS



Assume that you have been prescribed this medication by your doctor and you just filled the prescription at your local pharmacy. [HAND OVER THE PRESCRIPTION BOTTLE TO PATIENT]. Next, I will ask you some questions based on the prescription bottle in your hand. Now take a moment to examine the bottle before I begin my questions. [PAUSE AND GIVE PATIENT ABOUT A MINUTE OR TWO].

	Complete	Incomplete
Can you please read the drug name on the medication bottle?	○	○
Based on your understanding of the label on the bottle, can you please tell me how you will take this medication?	○	○
Can you please open the bottle?	○	○

Did patient complete all tasks above?

- ○ All tasks completed
- ○ Tasks partially completed
- ○ No task completed

If no task completed or only partially completed, please describe?

_____

INTERVIEWER NOTES

Please type additional things mentioned by patient or caregiver

_____