Time 3: Home Visit Interview, Medication Review and Structured Observation

Record ID	_____
Date of Interview (Time 3)	_____ (mm/dd/yyyy)
WHO IS THE RESPONDENT?	◯ Patient ◯ Primary Caregiver
Since you came home after your recent hospital discharge, did you go to the emergency department or hospital?	◯ Yes ◯ No
If Yes, was it for the same problem for which you were previously hospitalized?	◯ Yes ◯ No
Since you came home after your recent hospital discharge, were your medications changed by a doctor or a pharmacist?	◯ Yes ◯ No
Since you came home after your recent hospital discharge, has anyone from the hospital or home care agency helped you?	◯ Yes ◯ No
If Yes, can you tell me who helped you and what type of help you received?	_____
When being discharged from the hospital, did you receive an electronic or printed discharge instruction material?	◯ Yes ◯ No
Since you came home after your recent hospital discharge, did you or someone else at home review the written discharge instruction materials?	◯ Yes ◯ No
If Yes, can you tell me who reviewed the discharge instruction material?	_____
Since you came home after your recent hospital discharge, did you or someone else at home review the discharge medication list?	◯ Yes ◯ No
If Yes, can you tell me who reviewed the discharge medication list?	_____
Was it clear to you when the next dose of your medication was DUE after coming home from the hospital?	◯ Yes ◯ No

What errors, issues, or concerns did you have about the discharge medication list from the hospital?

_____

Did the hospital doctors make any changes to your medications?

◯ Yes ◯ No

What were the medication changes made in the hospital (such as new, stopped, changed medication doses, how often to take, etc)?

_____

Why were the changes made? (e.g., benefit coverage changes, different indications, addressing side effects, etc)?

_____

Did the hospital doctors prescribe new medications?

◯ Yes ◯ No

What would happen if you DO NOT take the new medication(s)?

_____

PHARMACIST REVIEW OF PATIENT RESPONSE

Pharmacist review of patient response: [for the question "What would happen if you DO NOT take the new medication(s)"]

◯ Specific and appropriate
◯ Not specific but appropriate
◯ Not appropriate

CONTINUE DATA COLLECTION BELOW:

Have you experienced UNEXPECTED side effects to the new medications?

◯ Yes ◯ No

When is the follow-up appointment with your primary care doctor or provider?

_____
(Type date (mm/dd/yyyy))

Are there prescriptions you have had trouble filling?

◯ Yes ◯ No

If Yes, can you tell me which prescriptions/medications you have had trouble filling?

_____

If Yes, what was the reason you had difficulty filling the prescription?

_____

COMPLETE THE FOLLOWING SECTION BY ASKING THE PATIENT

Were you overwhelmed in the first few days after coming home with the new medication regimen?	◯ Yes ◯ No
Did you spend a lot of time dealing with insurance approval for your medications?	◯ Yes ◯ No
If Yes, who is this person? [CHECK BOTH IF PATIENT AND CAREGIVER INVOLVED]	☐ Patient ☐ Caregiver
Are you worried about the cost of your medications?	◯ Yes ◯ No

TRANSITIONAL CARE MEASURES (TCM)

WHO IS RESPONDING?	◯ Patient ◯ Primary caregiver

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
The hospital staff took my preferences and those of my family or caregiver into account in deciding what my healthcare needs would be when I left the hospital	◯	◯	◯	◯	◯
When I left the hospital, I had a good understanding of the things I was responsible for in managing my health	◯	◯	◯	◯	◯
When I left the hospital, I clearly understood the purpose of taking each of my medications	◯	◯	◯	◯	◯

MEDICATION RELATED CONCERNS

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
My medication is helping improve my condition	◯	◯	◯	◯	◯
My medication does not seem to help that much	◯	◯	◯	◯	◯
Sometimes I think I take too many medications	◯	◯	◯	◯	◯
Sometimes I think I may not be taking the right medication for my condition	◯	◯	◯	◯	◯
Sometimes my medication has effects I do not like	◯	◯	◯	◯	◯
Sometimes I feel worse after I take my medication	◯	◯	◯	◯	◯
I worry about drug interactions between the medications I take	◯	◯	◯	◯	◯
My medication interferes with my routine daily activities	◯	◯	◯	◯	◯
I have trouble taking my medication the way I am supposed to	◯	◯	◯	◯	◯

Where do you keep your medications?

	Living room	Bedroom	Bathroom	Car	Pocket/Purse	Other
Medication storage location	☐	☐	☐	☐	☐	☐

Please type the storage location(s) if Other is answered for the question "Where do you keep your medications?" _____

Where do you store your medications?

	Cabinets	Drawers	Pill boxes	Table tops	Baskets	Shopping bags	Zip lock bags	Fridge
Storage Methods	☐	☐	☐	☐	☐	☐	☐	☐

What types of medications do you have?

	Pills/Tabs	Capsules	Liquid	Inhalers	Eye/Ear drops	Injection	Skin patches	Topicals (cream, ointment, lotion)	Other
Medication types	☐	☐	☐	☐	☐	☐	☐	☐	☐

Do you keep a written list of medications? ◯ Yes ◯ No

Please type any observation about medication list
(E.g., handwritten, computer printed list, etc)

_____

If Yes, who prepared this list?

	Myself	Caregiver	Pharmacy	Home nurse	Hospital	PCP	Other
List prepared by: [CHOOSE ALL THAT APPLY]	☐	☐	☐	☐	☐	☐	☐

Do you use medication schedule helpers? ◯ Yes ◯ No

Types of medication schedule helpers:

	Note pads	Medications schedule grids	Fridge/calendar reminders	Mobile apps	Automated dispensers	Other
If Yes, what type of schedule helpers do you use? [CHOOSE ALL THAT APPLY]	☐	☐	☐	☐	☐	☐

Do you use pill boxes? ◯ Yes ◯ No

If Yes, do you use them for all pills or only for some pills? ◯ Used for all pills ◯ Used only for some pills

If Yes, how many pill boxes?

_____

Sizes of pill boxes used

_____
(Note pillbox sizes: E.g., small, medium, large; number of days, frequency of administration)

Do you use blister packs? ◯ Yes ◯ No

Where do you obtain your medications?

	Community pharmacy	Mail-order pharmacy	Hospitals	Outpatient pharmacies	Sharing other people's medications	Community health centers	Doctor's office	Other
Where do you obtain your medications [CHOOSE ALL THAT APPLY]	☐	☐	☐	☐	☐	☐	☐	☐

Who is doing what for medications? [CHECK FOR EACH TASK]

	Patient	Primary Caregiver	Other
Reviewing prescriptions/discharge paper work	☐	☐	☐
Getting medications	☐	☐	☐
Filling pill boxes	☐	☐	☐
Understand instructions	☐	☐	☐
Getting rid of expired medications	☐	☐	☐
Making sure medications do not run out	☐	☐	☐
Requesting refills when medications run out	☐	☐	☐
Communicate/share medication information between family members	☐	☐	☐

Please describe the patient's living condition

_____

(E.g, House is clean and tidy, messy and unkempt, multiple obstacles in hallway, highly cluttered environment, etc)

Interviewer field notes from home visit

_____

(Type any note you think is relevant . E.g, patient's experience during the hospital stay, discharge, etc.)