**Online-only**

**SUPPLEMENTARY FILE: PATIENT INTERVIEW GUIDE**

**Introduction**

Thank you for agreeing to participate in the interview. We are interviewing you to better understand what patients think about the way we provide care when patients are returning home, and their experience within the first 30-days of discharge. There are no right or wrong answers to any of our questions, we are interested in your own experiences.

Participation in this study is voluntary and your decision to participate, or not participate, will not affect the care your [mother/ father/spouse/friend, etc.] \*\*receives.

The interview should take between thirty minutes to one hour depending on how much information you would like to share. With your permission, I would like to audio record the interview because I don’t want to miss any of your comments. All responses will be kept confidential. This means that you will only be identified with a participant ID in the interview and recordings. You may decline to answer any question or stop the interview at any time and for any reason.

Are there any questions about what I have just explained?

May I turn on the digital recorder?

**\*\*** personalize and use throughout interview. Be as conversational as possible, say “your mom” or “your dad” if that is the term participant uses to describe their relative.

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*Please note that this guide only represents the main themes to be discussed with the participants and as such does not include the various prompts that may also be used (examples given for each question). Non-leading and general prompts will also be used, such as* ***“Can you please tell me a little bit more about that?”*** *and* ***“What does that look like for you”****. If the same caregiver has agreed to participate in the interview a second or third time, interviews should be adjusted to ask if there are any changes or additions for them to add on each topic.*

**1. Establishing Rapport and Understanding of their Transition Home**

What stands out for you regarding your transition home after being admitted to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (*hospital/rehabilitation*)?

What stands out for you regarding your discharge instructions (or the instructions you received prior to your leaving the hospital)?

Did you have difficulties understanding the discharge instructions that were given to you?

If yes, how?

Did you feel ready to leave the hospital/rehabilitation setting? Why or why not? (or how were you prepared for your discharge prior to leaving the hospital/rehabilitation setting?)

How has your [insert relation to patient] health been since you returned home?

**2. Patient Involvement at discharge**

How were you engaged in discussions about your discharge? [or how did you participate in discussions about going home?]

Were there any verbal or written instructions you received that you found useful for your transition?

Any which you found difficult to understand or follow once you were home?

**3. Service provision in community post hospitalization**

Did you receive additional help or services when you returned home?

If YES, how were these coordinated for you? How were you involved in coordinating the services? Did the services meet your needs? If no, why not?

If NO, what type of services are you missing? How are you managing without these services in place?

**4. Challenges and struggle in the posthospitalization period**

What have been some of the challenges that you’ve experienced since returning home?

How are you managing to cope with these challenges that you face?

What is your support system like? (Who is there to help you?)

Was there anything the health-care team who cared for you did which helped you with the transition and these challenges?

How does this transition differ from previous transitions that you may have experienced in the health care system?

**4b. Role of disability**

How has your physical disability or sensory disability impacted your transition home from hospital?

How could the health care team have helped you in regard to your physical or sensory disability *(ask individually)* in transitioning home?

**5. Role of enables and barriers to quality care transition**

From your perspective, what went really well with your discharge [from hospital or rehab]?

What do you think could have been done better?

What could be changed to make going home easier for patients like yourself?

**Conclusion**

Is there anything else that you would like to comment on or share on your [insert relation to patient]’s transition home or his/her discharge instructions?

*Thank you very much for your time and the information you shared today.*