

**IP SW, KBC IP CM, KBC TOC CM Interview Guide  
November 2012**

Characteristics of the HCO:	<input type="checkbox"/> Hospital	<input type="checkbox"/> Clinic	<input type="checkbox"/> HH Agency	<input type="checkbox"/> Skilled Nursing Facility
Type of HCO staff:	<input type="checkbox"/> Physician	<input type="checkbox"/> Mid-level provider	<input type="checkbox"/> Nurse	
	<input type="checkbox"/> Social worker	<input type="checkbox"/> Home health provider	<input type="checkbox"/> CM (indicate type): _____	

Day of interview: \_\_\_\_\_

Gender of interviewee:  Male  Female

Time of interview: Beginning: \_\_\_\_\_ End: \_\_\_\_\_

Total duration of interview: \_\_\_\_\_

Interviewers (circle initials):      PC      PH      BA      ASH      RSC      SK

**Please note: these questions are open-ended to encourage the respondent to discuss topics related to the study. In such discussions, additional questions and prompts may be used to encourage the respondent to fully explain his or her answer. These questions and prompts include “Can you tell me a bit more?” “I’m not sure I quite understand about [repeat respondent’s words],” “You said [repeat respondent’s words], could I ask you a bit more about that?” or “Could you explain more about what you meant in saying [repeat respondent’s words].”**

**Introduction:**

In collaboration with Geisinger Health System, our research team at the University of Wisconsin received a grant from the Office of the National Coordinator for Health IT to evaluate the implementation of the Keystone Beacon Project.

You were invited to participate in this interview because you work in a healthcare organization participating in or related to the Keystone Beacon Project. The objective of this interview is to better understand **care coordination** from your perspective as a \_\_\_\_\_ (role).

Participation in this study is voluntary. You may change your mind at any time and discontinue participating in this study. [Hand out another copy of the information sheet to the interviewee, if s/he would like to see one.]

There is minimal risk associated with this interview. Your contact information will be kept by the research team to allow us to contact you again, but it will never be linked to your interview responses. Only researchers associated with this project will have access to the data gathered.

Do you have any questions about the study? Are you willing to proceed with the interview?

Is it OK to audiotape the interview?

## **Care Coordination**

The purpose of this interview is to better understand the coordination activities associated with chronically ill patients you care for. We are going to ask you about patients that are seen in clinic, patients that have been hospitalized and discharged home and patients that have been hospitalized and discharged to a skilled nursing facility. We like to know your specific role in the process of managing these patients. We will ask you questions about what can go well in the process of managing these patients (e.g. you got the information you needed in a timely manner, and everything was done for the patient in a timely and efficient manner). We also want to know what does not go well for you and for patient care when the process is poorly coordinated.

Do you have any questions before we begin?

## **Patient admitted to the hospital and discharged home (with home health)**

- Consider a Beacon patient with CHF and COPD who experienced pulmonary exacerbations, while in the hospital had changes to his/her medication regimen and was discharged home with home health services.
  - What is your role caring for this patient in this process (hospitalization and patient discharge home)?
  - Give us examples where the coordination for this patient was very good; where this process (hospitalization and patient discharge home) went well. It was well coordinated. The patient received everything he/she needed. And the process also went well from your viewpoint. Tell us about these examples. We're interested in understanding what went well in terms of **coordination**.
  - Give us examples where the coordination for this patient was poor; where this process (hospitalization and patient discharge home) did not go well. It was poorly coordinated. The patient did not receive everything he/she needed. And the process also did not go well from your viewpoint. Tell us about these examples. We're interested in understanding what did not go well in terms of **coordination**.

### **Follow up on anything that has a potential for interdependency**

#### Interdependencies

- *Prerequisite*: one activity needs to occur in order for the next activity to happen
- *Shared resources*: an activity requires two (or more) people to share
  - patient information
  - knowledge/insights about patient
- *Simultaneous*: two (or more) activities need to happen at the same time

## **Patient admitted to the hospital and to skilled nursing facility**

- Consider a Beacon patient with CHF, COPD and diabetes, who on discharge requires continued nursing care and was therefore discharged to a SNF.
  - What is your role caring for this patient in this process (hospitalization and patient discharge to SNF)?
  - Give us examples where the coordination for this patient was very good; where this process (hospitalization and patient discharge to SNF) went well. It was well coordinated. The patient received everything he/she needed. And the process also went well from your viewpoint. Tell us about these examples. We're interested in understanding what went well in terms of **coordination**.
  - Give us examples where the coordination for this patient was poor; where this process (hospitalization and patient discharge to SNF) did not go well. It was poorly coordinated. The patient did not receive everything he/she needed. And the process also did not go well from your viewpoint. Tell us about these examples. We're interested in understanding what did not go well in terms of **coordination**.

### **Follow up on anything that has a potential for interdependency**

#### Interdependencies

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Wrap up questions:

From your view point, are there any other challenges in coordinating care of HF and COPD patients?

Do you have any questions for us?

**Thank you for your participation.**

## References for interviewers

Definition of coordination: the act of managing interdependencies between activities performed to achieve a goal. (Malone, 1990)

Definition of care coordination team: the team of different people involved at various times in the patient's care to facilitate the appropriate delivery of health care services. (McDonald, et al. 2007. *Care Coordination*, in *Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies*. Technical Review 9)

When utilizing this document please cite:

1. Kianfar, S., Carayon, P., Hundt, A.S., Hoonakker, P., Alyousef, B., Tomcavage, J., Salek, D., Petrucci, J., Hassol, A., Walker, J. (2013). Care providers' perception of care coordination team members. Poster presented at the Human Factors and Ergonomics Society (HFES) Symposium on Health Care, Baltimore, MD.