HIT Project, AHRQ Task Order #3
QUALITATIVE COMPONENT

SITE VISIT QUESTIONS

BACKGROUND

First, let us THANK YOU for agreeing to participate in our research project. We are (Ann McAlearney, others) and we are (a faculty researchers from The Ohio State University, other). As you may know, we are studying the use of health information technologies in community health center laboratory processes. You have been identified as someone who would provide invaluable information about this topic. We have scheduled the next hour (half-hour) to discuss this involvement and topic with you.

Before we begin the discussion, let me make sure that you understand that:

a. Your participation is completely voluntary. If you do choose to stay and talk with us, you may decide to leave at any time during this interview.

b. We consider this discussion to be confidential. Your participation is confidential in the sense that your name will not be used in any reports or articles.

c. Do you have any questions about this interview process?

INTRODUCTION

In this interview, we will ask you several open-ended questions about your experience using health information technologies and primary care screening tests provided through your clinic. Do you have any questions before we begin?

Overview of Interview Topics

1. Leadership
2. Processes and Roles
3. IT Tools and Training
4. Communication of Results
5. Barriers and Facilitators in Process
6. Chronic Disease Management Forms
7. Cervical Cancer Screening
8. HIV Follow-Up
9. Recommendations and Lessons Learned

INTERVIEW GUIDE

SECTION 1: LEADERSHIP

- Why did your health center decide to implement an electronic health record (EHR) to change information technology (and laboratory) practice? (HIT tools to reduce errors, reduce loss to follow-up, improve efficiency?)

- How important was the laboratory component of this system?

- Who was involved in decision-making about these changes?

- What was the vision and/or involvement of senior administrative leadership?

- What was the involvement level of clinical leadership?

- How was the implementation team connected to health center leadership?

- How were members of operational leadership from the health center (e.g., administrators, clinical leaders, finance, other leadership teams) involved?

- How did participation in the Network affect any of these decisions? Can you provide examples?

If interview is short and role of key informant is purely from a leadership perspective, continue with questions in rest of Section 1, then end interview. If key informant has additional roles and could provide more information, continue with rest of interview guide.

(From Section 5: Barriers and Facilitators)

- What are any barriers to the using the laboratory (EHRS) system? (Were there barriers introduced with the EHRS? Do any of these barriers remain?)

- What barriers are there specific to work flow?

- What problems (with using the lab system or with workflow) have you personally experienced or witnessed?

- Were there things that occurred prior to implementation that needed to be addressed to facilitate implementation?

- What could have been done differently to improve what happened with these changes?

- How has implementation of the EHRS affected workflow?

- What suggestions do you have for improvements in the use of the EHRS?

- What suggestions do you have for improvements in work flow around laboratory processes?

- Do you have ideas about how work roles could be changed to improve the process?

- What were the most important things that you think went well with implementation? (went right with this introduction of HIT in the lab)

- Do you have other ideas about how the process could be facilitated (helped)?

(From Section 9: Recommendations and Lessons Learned)

- Knowing what you know now about these IT tools, if you were going to introduce and implement these IT tools again here, what would you recommend for that process?

- Are there specific recommendations you might have with respect to needed infrastructure, associated costs of implementation, noted barriers to implementation, etc. that we should consider?

- What suggestions do you have for other clinics or health systems that plan to implement these tools?

SECTION 2: PROCESSES AND ROLES

Processes

- What processes are in place for ordering lab tests and reviewing results?

- If follow up steps are necessary after reviewing results, who is responsible for these actions?

- Is this process complete or are other steps or processes involved? (is anything routinely missed?)

- Do you have any stories of how you have devised a solution of your own to address a problem you had with the current process?

- How are you alerted if a redundant order is placed?

Roles

- What are the roles of the physician and nurse in these processes?

- What are other staff roles in these processes?

SECTION 3: IT TOOLS AND TRAINING

IT Tools

- What types of health IT tools are used in these processes?
- Are there specific decision support features that are included within the system?
- How would the clinician be alerted if no results are received for a given order?
- Have you had any trouble using the IT tools you have? (any stories?)
- Do you have any stories of how you have devised a solution to address a problem with the IT tools?

IT Training

- How do you receive training to use these tools?
- Do you receive re-training in any area? (how frequently?)
- When you have problems using these tools, where do you go/to whom do you go for help?
- Have you provided help and/or training to others? (any examples?)
- Do you have suggestions for improving this training?

SECTION 4: COMMUNICATION OF RESULTS

- How are lab orders communicated to reference labs?
- How are results received from the reference lab?
- How is a patient notified about the results of their laboratory test?
- Are normal results communicated differently from abnormal results?
- How are lab results from other settings of care communicated to the patient's clinician?
- Is this communication complete or are other links in the communication chain? (is anything routinely missed?)

SECTION 5: BARRIERS AND FACILITATORS IN PROCESS

- What are any barriers to the using the laboratory (EHRS and Care 360) system? (Were there barriers introduced with the EHRS? Do any of these barriers remain?)

- What barriers are there specific to work flow?

- What problems (with using the lab system or with workflow) have you personally experienced or witnessed?

- Were there things that occurred prior to implementation that needed to be addressed to facilitate implementation?

- How has implementation of the EHRS affected workflow?

- What suggestions do you have for improvements in the use of the EHRS?

- What suggestions do you have for improvements in work flow around laboratory processes?

- Do you have ideas about how work roles could be changed to improve the process?

- What were the most important things that you think went well with implementation? (went right with this introduction of HIT in the lab)

- Do you have other ideas about how the process could be facilitated (helped)?

SECTION 6: CHRONIC DISEASE MANAGEMENT FORMS (following clinical practice guidelines)

- How widely used is the chronic disease management form for HIV?

- Which areas of the form are most used and most beneficial?

- What do you see as the most important benefit of using this tool? Have you shared this perspective with others? (any stories?)

- How has the chronic disease form changed what you do? (Can you provide examples?)

- Would you consider yourself a "champion" of health IT or chronic disease management?

- What reasons do clinicians typically give for failing to utilize this form?

- Do nurses have different reasons?

- What are the biggest barriers to using these forms?
- Do you have any suggestions about how these barriers can be overcome?

SECTION 7: CERVICAL CANCER SCREENING

- How are clinicians alerted that a woman is due for cervical cancer screening?
- How is the patient notified that she is overdue for a Pap smear?
- How is IT involved in the notification process?
- What staff are involved?
- How is the clinician alerted about an abnormal Pap smear?
- How is the patient notified about an abnormal Pap smear? Who is responsible for this notification?
- What are the barriers to this notification process?
- What do you do to work around these barriers? (what do staff do?)
- Do you have suggestions for improvements in this process?

SECTION 8: HIV FOLLOW-UP

- How are clinicians alerted that an individual patient is appropriate for HIV monitoring?
- How is the clinician alerted about an abnormal HIV monitoring lab result?
- How is IT involved in the notification process?
- What staff are involved?
- What do you think of the notification process? (i.e., alerts, clinician dashboards, etc.)
- What happens if you do not receive a lab result in a timely manner (e.g., lab results are missing)?

- How is the patient notified about an abnormal HIV monitoring lab result? Who is responsible for this notification?

- What are the barriers to this notification process? What do you do to work around these barriers?

- Do you have suggestions for improvements in this process?

- How has the chronic disease form changed what you do with HIV positive patients being monitored? (Can you provide examples?)

- Has the lab system or the chronic disease form affected the lab ordering process? (Is there less reduncancy in ordering labs?)

SECTION 9: RECOMMENDATIONS AND LESSONS LEARNED

- Knowing what you know now about these IT tools, if you were going to introduce and implement these IT tools again here, what would you recommend for that process?

- Are there specific recommendations you might have with respect to needed infrastructure, associated costs of implementation, noted barriers to implementation, etc. that we should consider?

- What suggestions do you have for other clinics or health systems that plan to implement these tools?

INTERVIEW CLOSURE AND FOLLOW-UP

THANK YOU!! so much for your time and participation. Your comments were extremely helpful.