CASE STUDY PROTOCOL

Agency ID_____ Date_____ Time Start_____

Patient ID_____ Time End_____

Interviewer_____

☐ **I. REVIEW CONSENT FORM**

☐ **II. OPENING EXPLANATION AND EXPRESSING CULTURAL IGNORANCE**

I want to thank you again for meeting with me today. As I mentioned before, I am interested in understanding your work as a home health care nurse. We are trying to understand what is involved in taking care of frail elderly patients at home. We are especially interested in those that receive Medicare benefits, since that is where the government is spending quite a lot of money. Unfortunately, I am not a nurse and a lot of policy makers are not nurses. Of my colleagues at the Research Center, some are nurses and some are not. And, when we are just reading nursing and home health care journals, it does not necessarily give us a clear picture of what actually happens during a home care visit. So, we want to truly understand what is involved in providing home care and we want to help inform policy makers who make decisions about legislation that affects so many elderly people in our country.

In order to do this, we want to focus on a specific patient and really focus on all of the details of care that were provided to that patient. In that way, we can provide a rich, narrative description of care for one patient to our funder. So, we are going to focus today, on this specific patient. I have briefly read a summary of her chart but I still do not completely understand all of the activities that were performed both inside the home and outside the home.

III. CARE PLANNING

To begin, I'd like to ask you about the services that were provided for this patient by yourself and others and the process that you went through in deciding which services were needed and who should provide them.

☐ 1a. First, can you describe what services were provided to the patient at SOC and how often they were provided? These services should include ALL services provided including skilled and unskilled services, other disciplines, community services, and your role in the patient's care both in and out of the home.

☐ 1b. While you were talking, I jotted down some notes. Could you review them to be sure I got all of the services you described and how often they were provided?

☐ 2. Was the family involved in providing care for the patient? If yes, how so?

☐ 3. Did the number and type of services that were provided change during the course of this patients home health episode? If so, how?

☐ 4. Now I'd like to discuss how you made the decisions regarding the type and number of services that you provided for this patient. What were the most important factors that you considered when deciding what skilled services you would provide? [Possible probes: patient goals, safety, medical compliance, lack of support system, agency pathway, and so forth. Be sure everything mentioned in #1 is discussed.]

☐ 5. For what reasons were the other disciplines in the home?

☐ 6. Who made the decision regarding what disciplines would be involved in the patient's care?

☐ 7. Was there anyone else involved in the decision making process regarding the number and type of services? If so, who were they and how were they involved?

☐ 8. Was the patient and/or family involved in the decision making regarding the number and type of services that the patient would receive? If so, how?

☐ 9. Were there services you would have liked to use that weren't available? IF YES: Why weren't the services available and for what reason did you want to use them if they had been available?

☐ 10. How was the care plan documented?

IV. CARE COORDINATION

Now I would like to discuss how you communicated with the various care providers involved in this patient's care.

☐ 11. You mentioned that X, Y, and Z disciplines/agencies/persons were involved in the patient's care. At the start of care, how often did you communicate with these various care providers regarding the patient's care and what did you talk about? Let's start with one at a time and cover each discipline/care provider involved in this case. (BE SURE TO COVER PHYSICIAN, FAMILY, OTHER DISCIPLINES, ALTERNATIVE SERVICES, OTHER NURSES IN SAME AGENCY, and HOME HEALTH AIDE/CNA.)

☐ 12. Did the frequency or content of your communication with these care providers change during the treatment episode? If so, how?

V. VISIT CONTENT

☐ 13. We've talked a lot about the services provided for this patient, but now I want to get a picture of what you did in the patient's home. Tell me about a typical visit at this patient's home around the start of care. Try to think of a specific visit with this patient.

☐ 14. Did the types of activities that you performed during the visit change over the course of the home health care episode? If so, how?

VI. DISCHARGE PLANNING

☐ 15. Why was this patient discharged from home health care?

☐ 16. What did you do to plan for the patient's discharge?

☐ 17. At what point in the home health episode did you begin planning for the patient's discharge?

☐ 18. Who else was involved in the discharge planning process and how were they involved? Anyone else?

VII. GENERAL QUESTIONS

☐ 19. Looking back on the patient case, what did you spend the most time doing when you were at the patient's home? (Probe for teaching, observation, assessment, skilled services, management and evaluation, etc.).

☐ 20. When you were working on this case outside of the patient's home, what did you spend the most time doing?

☐ 21. Is there any aspect of care that you spent time on for this patient that we have not discussed? If so, please explain.

☐ 22. In your opinion, what had the greatest impact on the length of this patient's episode of care? (Probe for single, most important aspect.)

☐ 23. One of the issues our funder is interested in is how new federal policies and regulations have impacted the provision of home health care. Have there been any changes in the way care is provided in your agency that might be related to these new federal policies and regulations?