Care Transitions Focus Group Questions

The following “Question Groups” are a guide for the Focus Group Leader to assure that all areas are covered and to keep the discussion on track. Every question does not need to be asked. Other questions may be added during the discussions depending on what the participants bring up during the conversation.

Focus Group Questions for Hospital Clinical Teams

Will first get some idea of who they are:

- Doctors, Nurses, NPs, Discharge Planners?
- How long they’ve been in their current position?

Questions:

- What issues do you feel are the most important to ensure that the patients are receiving ongoing care?
- Do you feel that you have input in the discharge plan for the patients?
- Do you receive information from the community physician?
- Do you think that all team members understand the wishes of the patient and/or family?
- What barriers do you think hinder good transitions?
- What do you think would most help the patients in the transition process?

Focus Group Questions for Hospital Discharge Planners

Will first get some idea of who they are:

- How long have you been a Discharge Planner?
- Are you a Nurse or Social Worker?
- Do you work on a special unit (i.e. RE, ICU, CCU)?

Questions:

- How is a case referred to you?
- When is a case referred to you?
• What are the barriers to getting Patient referrals early in your system?
• Do you see the patient on the day of referral?
• Do you do a complete psychosocial assessment?
• When do you contact the family prior to discharge?
• Do you feel that you are able to provide support to both the patient and the family, and if not what is the barrier to being able to give this support?
• Do you make the discharge plan with both patient and family input?
• Is there enough time to make complete discharge plans prior to discharge?
• How involved is the physician in developing the discharge plan?
• Do you review the patient’s financial status?
• If the patient does not have a community physician do you help the patient/family find one and is it difficult to find a physician for the patient?
• How do you make referrals to the community agencies? (i.e. Electronic, Phone, fax)
• Do you feel there are enough services in the community and if not what services are lacking?
• Do you hear back from community agencies once referral has been made?
• What barriers are there in making community referrals?
• What would you like to see changed in the discharge planning process to improve transitions to the community?

Focus Group Questions for Skilled Community Agencies

Will first get some idea of who they are:

• Who is representing the Agency and their role in the agency?
• What services their agency provides for the community?
• How long they have work for the agency?
• How long they have worked with clients in the community?

Questions:

• How do you receive your referrals from the hospitals?
• How do you receive your referrals from Nursing Homes?
• How do you receive your referrals from people and physicians in the community?
• How long, on average, does it take for a patient to be seen once the referral has been received?
• Do you get all the information from the hospital that you need prior to seeing the patient in the community?
• What type of information is missing from the hospital referral that hampers your first visit to the patient?
• When a patient does not have a community physician, is it difficult to find on to follow the patient?
• Do the patient and/or family always know that your agency will be visiting them?
• If a patient’s insurance does not cover the visits that are assessed to be necessary, what is your process to discharge, continue service, or refer out?
• How to you keep the patient’s physician informed of the patient’s progress?
• What barriers to you see in dealing with the patient’s physician in providing care?
• What is you discharge process?
• If a patient is admitted to the hospital do you contact the Discharge Planning office in the hospital?
• If a patient is admitted into a nursing home from home do you contact the nursing home to give them clinical information?
• Does the community physician receive a summary when a patient is discharge from a skilled service?
• What barriers do you see in transitioning patients in your community?
• What do you think drives referrals from the Hospital to your agency?”

Focus Questions for Non Skilled Agencies in the Community

Will first get some idea of who they are:

• Who is representing the Agency and what is their role in the agency?
• What services does the agency provide in the community?
• How long have they work for the agency?
• How long have they worked with clients in the community?

Questions:

• How do you receive your referrals?
• Do you receive more referrals from the community or from hospitals?
• When receiving referrals from hospitals, skilled agencies, or nursing homes, do you receive all the information that you need?
• What is the information most often missing when you receive a referral?
• Do the client and/or family always know that a referral has been made to your agency?
• Does the client/family always know what their financial responsibility is prior to receiving the service?
• How do you discharge or end the service with the client?
• How do you make referrals to other services in the community?
• When you know that your client has been admitted into the hospital, do you contact the Discharge Planning office to inform them that your client was active with a service?
• What do you see as a barrier in receiving or giving a referral to a health care provider?

Focus Group Questions for Nursing Homes

Will first get some idea of who they are:

• How large is your facility?
• What is the position that you hold at the facility?
• How long has the facility been in the community?
• How long have you worked in long-term care?

Questions:

• How do you receive your referrals from the hospitals?
• How do you receive referrals from the community? HH, Family, PCP?
• Do you receive all the information you need to make a good decision on acceptance with the referral material or do you need to follow up with more questions?
• How long does a patient wait once a referral has been made to be admitted, if medically ready?
• Do you see the patient prior to admission?
• Do you see the family prior to admission?
• Do you contact the community physician prior to admission if the patient is coming from the hospital?
• On the day of admission how accurate is the medical transfer information?
• Do you call the hospital nursing unit or discharging planning department if, on admission, medical information is missing?
• Do you have the medications available on day of admission for the new resident?
• What is your process for getting last minute medications?
• Does the nursing home physician or community physician see the new resident on day of admission? If not, what is the average wait time for a resident to see a physician?
• When a resident is transferred to the hospital, what is the process of transferring medical information? Is that process different on weekends or nights?
• Is the family notified when the patient is going to the hospital? Either planned or emergency?
• Does the facility call the nursing ED to report?
• Does the facility call the hospital once a resident has been admitted and give report to the nursing unit?
• When a resident is being discharged home what is the process to involve both the resident and the family and who is in charge of making the discharge plan?
• When a resident is being discharged home what referrals are made to the community?
• How does the nursing home make referrals to the community?
• When a resident is discharged home, how does the nursing home give medical information to the community physician?
• Does the nursing home follow up with the resident and/or family once home?

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**Focus Questions for Patients/Families and Caregivers**

**Will first get some idea of who they are:**

- Are you a patient or family member?

**For Patients:**

- Are you currently receiving services?
- When were you hospitalized? In Nursing Home etc.
- Do you live alone?

**For Families and Caregivers:**

- What is your relationship to the patient?
- Does the Patient live with you?

**Questions for Patients:**

- If you were hospitalized, were you informed why you were there?
- Was your family informed why you were in the hospital?
- Did a hospital staff member come and talk to you about your discharge home (or to a skilled nursing facility, rehab facility, long-term care facility, etc.)? And if so, do you remember the first time you saw this staff member?
- When did this occur during your hospital stay?
- Did you understand what was happening with your care while in the hospital?
- After discharge, did anyone contact you to ask you how thing were going at home?
- Did the staff tell you why any medication may have been changed or added?
- Did any staff member go over the effects of your medication?
- Did you see your community physician in the hospital? If not, did anyone ask you who your community doctor was?
- When you were getting close to discharge, did a staff member discuss what you may need at home and/or were you able to discuss with a staff member your concerns about returning home?
- If you have a family member involved in your care or decisions about your health (i.e. POA, HCPOA), do you think they understood what care you may need when you were discharged home?
- If you needed services when you returned home, did you have a choice in what services you wanted?
- Did any staff member discuss the cost of services and what would be covered by your insurance?
- Did you understand the need for a particular service and what that service would entail once you were at home?
- Did you feel you were a part of the planning process for you to return home?
- Did you feel you received enough information about what you would need once home?
- Did you feel that you could ask any questions you had about your discharge plan?
- On the day you were discharged did a staff member go over your medications, diet, and services that you would receive at home?
- Before you left the hospital did you have an appointment with your community doctor or specialist?
- On the day you were discharged from the Hospital could you or your caregiver get your new medications for you that day? Did you have any problems getting your medications?
- What problems do you feel you had when you were discharged?
- What could have helped to make your discharge a better experience?
- If services were arranged for you when you returned home, did they arrive when you expected them?
• Did you have any financial barriers to receiving the care you needed once home?
• Did you have paper work from the hospital that you could look at to remind you about your medications, services, and when to see your doctor? And was the paper work easy to read and understand?
• Did you have a phone number to call the hospital discharge planner if you had questions? Did you have your doctor’s number?
• What could the hospital do to make your discharge home better?
• If you have a home health agency coming to your home, did you have their phone number and did you feel comfortable calling them if you needed to?
• Did you have all the medical equipment you needed?
• How long after you got out of the hospital did you see your doctor? Did you have any problems getting an appointment and did you have any problems with transportation?
• If you did receive services at home, did the in home staff review your medications with you?”
• Do you use any community support services, in addition to any Medical Services that may have been put in the home after discharge?

Questions for Families and Care Givers:
• When your family member was admitted to either the ED or Hospital did the hospital staff inform you of the medical reasons for admission?
• Were you able to ask questions?
• When were you contacted by the Discharge Planner?
• Were you included in the planning process?
• Did you understand the discharge instructions?
• Did you understand your family’s member’s medical condition?
• Did you know if there was a follow up medical appointment?
• Did you know if an agency was coming to the home, what they were coming for, and when they were coming?
• Did you have contact information to call if you needed help or did not understand all of the instructions when your family member returned home?
• What were the major issues that you had in the transition to the home setting?
• What would have made the transition better for you and your family member?
Focus Group for Community Physicians

Questions:

- What do you think are the major issues for your patients transitioning to and from the hospital for continued care?
- What major issues do you face when your patients are discharged from either a hospital or nursing home?
- Are you notified when one of your patients is admitted into the hospital?
- How and when do you receive medical information regarding your patient’s hospital stay?
- Do you feel you have a full picture of what happened to your patient while they were in the hospital?
- What, on average, is the time frame that you are able to see a patient after hospital discharge?
- What do you feel are the barriers in this community to good care transitions for your patients?
- What would you like to see changed in the transitions process?