Appendix 1: Qualitative and quantitative questions

Quantitative Questions:
What is your background?
How long have you worked in this position as a CAC/ PSM?
How long have you been at this facility?
Does the Site Have Modified Software that impacts alert management?
Can you provide a list of enabled, mandatory alerts?
How long do alerts stay in the alert window?
How often do you get calls from providers about missed/lost alerts
How much time is spent on CPRS training?
 Do you have specific training focused on view alerts?
If yes, how much time is spent on view alerts training?
Do you utilize Super Users or Physician Champions for alert related issues?
When alerts are unacknowledged for a certain time what action is taken?
Are alerts set to go to a team rather than a specific provider?
Does your facility have a case manager who is notified of abnormal tests?
Who is responsible for determining the definition of critical levels, mandatory alerts, enabled and disabled alerts?
Do you generate any reports to monitor the changes made to the software? Are different aspects of alert rule programming, implementation and impact tracked at your facility?
Do you have an EHR committee for oversight which is responsible for View Alert related issues?
In the last year have you had any safety related issues involving view alerts or missed test results?
What has your facility done to address patient notification of test results (VA 2009- 019)?

Qualitative Questions:

1. Do providers come to you with questions or concerns about view alerts? What questions and concerns (FAQ) do providers raise about View Alerts?
2. When there is safety concerns/ problems related to view alerts. How do you handle them - What process do you have in place?
3. When alerts are unacknowledged for a certain time what action is taken?
4. When there are alerts for patients that are not assigned to a PCP, who receives those alerts – how do you handle them?
5. How are alerts handled when tests are ordered by residents/trainees?
6. How does the surrogate process work?
7. Please describe any surrogate associated safety concerns related to view alerts at your facility?
8. Is acknowledgement and follow-up of alerts monitored at your facility? If so, how? What monitoring practices do you have in place for follow-up of critical/abnormal diagnostic test results?
9. What mechanisms do you have to prevent test results "falling through the cracks"?
10. Explain how you work with CACs or other IT personnel to resolve "EHR related" safety issues?

11. Have you observed any safety concerns related to critical test result follow-up at your facility? Maybe you can start with something that happens often. Can you describe, - what was the issue?

12. What actions have been taken to address safety issues (above mentioned) involving view alerts or missed test results?

13. Can you describe, what effect directive VHA 2009-019 has had on local practices?