ANNALS OF FAMILY MEDICINE

Online Supplementary Material

Russell G, Thille P, Hogg W, Lemelin J. Beyond fighting fires and chasing tails? Chronic care plans in Ontario, Canada. *Ann Fam Med.* 2008;6(2):146-153.

http://www.annfammed.org/cgi/content/full/6/2/146/DC1

Supplemental Appendix. Physician Interview Guide

Care-Planning Experiences

- Ask for a story about a patient who took part in the care-planning process.
- If you were telling a colleague about this approach to chronic illness management, what would you say (probe: approach to care vs. care plan specifically)?
    1. How would you describe the role that you were asked to take?
    2. Is that a reasonable expectation?
- In light of population aging, physicians are treating more patients with multiple chronic illnesses. How do you deal these more complex patients in your practice? Why do you use this approach?
- How comfortable were you with the written care plan initially? Now?
- How comfortable were you with scheduling follow-up visits initially? Now?
- What about the care-planning process was easy? Anticipated or surprising?
- What about the care-planning process was difficult? Anticipated or surprising?
- What did you anticipate would happen after you'd completed the care plan with patients? Any surprises?
- What sort of impact, if any, did the care-planning part of the study have on your practice (probe: positive and negative; organizational; staff development; knowledge; attitudes)?
- Now that the study is done, will you consider ongoing use the care plan?
    1. If yes, how?
    2. If no, why not?

Facilitation

- What types of support did the facilitator provide (examples: setting goals for your personal practice, giving feedback on completed care plans, etc)?
    1. Which of these were most helpful?
    2. Which of these were least helpful?
- How sufficient was the support you received in integrating the CICM into your clinical care?
- What would you recommend we change if we were to try this again?
- What would you recommend we keep the same?
- Do you see potential for further use of this facilitation process in your practice and with others?
    1. If yes, what would make the process work optimally? What supports would you need for success?
    2. If no, why not?

Chronic Illness Care

- Do you see potential for further use of this chronic illness care model in your practice?
- If yes, what supports would you need to integrate the model successfully?
- If no, why not?

Impacts

- How much time did participating in this study take you? Other costs to practice?

Other Players

- How do you think patients or other involved staff felt about the process?
- This approach emphasizes patient involvement in care. How do you perceive patients engaged with this idea? What value is there in this process?

Other Comments?

Demographic Details

- Training (location; undergraduate; postgraduate; family practice)
- Specific training postgraduate: with the elderly, with chronic illness, with health counseling or communication skills?
- CME in past 2 years?
- Current practice situation (partners; FHN, others, ie, nursing staff)
- Practice organization (IT, recall, register)
- Other studies involved in during ICFPC (ie, ~2 years)

Member Checking

We would like to send a single-page summary for review and correction – is that OK? What is the best method?

CICM = chronic illness care management; CME = continuing medical education; FHN = Family Health Network; ICFPC = I Care for Primary Care; IT = information technology.