**Appendix 4: Hospital Focus Group Discussion Guide**

1. Let’s talk about some of the ways organizations collect data for the New York State registry. Let’s start with the overall process…I’d like each of you to walk us through the various steps your organization takes (e.g. chart abstraction to form) [repeat this process for each participant].

[The following questions below should be asked if not discussed by participants]

* 1. Any other processes used that you know other organizations use? [Probe for examples on specific fields/variables]
  2. When does data collection take place (i.e., during or after hospitalization)?
  3. Who is responsible for data collection (e.g., nurse, physician, multiple people)?
  4. What data sources does your organization use?
     1. Paper medical records?
     2. Electronic health record?
     3. Other health information systems (e.g. OR/anesthesia system, lab system, other departmental systems)?
     4. Any others (e.g. administrative systems, ADT (admission/discharge/transfer, billing systems)?
     5. Probe on different systems, if and how they’re integrated, what systems allow automated extraction of data (e.g. reports). For example, a patient who’s coming in for a CABG surgery: how many systems would patient information be recorded in during the process of care (from arrival through discharge)?] Please refer to the “Variables by level of feasibility” list that was sent to you via email for the next part of our discussion.

1. First, based on our discussions with other organizations, it seems there are some variables that would be relatively easy to collect from clinical information systems without manually reviewing and abstracting the information. As you quickly review the list of data elements that we’ve categorized as “very easy” to collect electronically, do you agree these are relatively easy to capture via information systems without any manual review? [Have Rute probe on any specific items for that column.] [Continue this questioning/process through each column; allowing for the participants to review the list and provide input as to whether some do or do not fit; if they don’t fit probe on reasons why and what column they would fit.]
2. For information available from structured data sources in the “very easy” and “easy columns] Would you trust the data to be accurate, if it was automatically extracted from clinical information systems, **without** manual intervention/review? If not, why not? [Ask them to provide specific examples].
3. [For variables that are pointed out by participants as more difficult than the column they were placed] Let’s talk about this variable/data element in more detail…
   1. [If not already discussed] Is the data required to meet this variable’s definition available (captured in one or more structured fields) and extractable (can produce reports/queries on the data) from structured data sources? Probe for reasons when data is not obviously sourced without abstraction (e.g. data is not captured in a structured field, cannot produce data reports from system where data is captured, cannot access data in certain systems, variable requires use of multiple data sources and inferencing)
   2. In your opinion, what would have need to happen in order for the data required to meet the variable to be sourced from health information systems **without** manual review/abstraction (i.e., having the data available and being extractable)? To clarify, not setting up additional data capture processes specifically for the purpose of submitting data to the NY state registry, but as part of patient care? [Probe on process: kinds of data, parts of data that may be partially feasible (even if overall isn’t feasible)]
   3. [If not discussed] For variables/data elements that are difficult, talk about which ones may be somewhat easier than others to source from health information systems? Where’s the low hanging fruit?
      1. What would need to happen so they could be sourced from health information systems?
      2. Which ones are the most difficult?
4. The next topic for discussion is around standard vocabularies or terminologies that data may be coded in to complete the New York State cardiac registry report. Can you please share any standard vocabularies that your organizations are currently using. For example, organizations in Stage 2 of Meaningful Use may be using SNOMED-CT codes to capture problems in the “Problem List”. [Probe on ICD-10-CM, RxNorm, LOINC and SNOMED-CT]