Appendix B Post-Clinical Scenario Interview Guide

Demographics
Assigned Subject ID
Gender (male or female)
Training level (current PGY level)
Experience with computers:
1. In general, not just in terms of electronic medical records systems, how would you rate yourself as a computer user? Novice, Average, Expert
2. What training or experience with computers have you had? (check all that apply)
   Formal course(s) in computer science or related field
   Formal training in medical informatics
   Workshops or conferences on computers or specific software applications
   Self-guided learning about computers
   None

General Experience
1. Overall, how was your experience with the EDIS?
   a. What did you like? What did you dislike? What could be improved?
   b. How did you feel about... (anything noticeable during use)
   c. Can you tell me about your decision to ...(probe on why)
2. Was there a part of the clinical encounter you just documented that was particularly difficult to document? What made it frustrating? (if no, can you think of an example where something has been frustrating to document?)
3. We noticed that you completed the electronic documentation primarily (during the H&P, after the H&P), and (at the patient bedside/distance from the patient).
   a. Did you feel comfortable (or uncomfortable) documenting in real-time during the encounter? Why or why not?
   b. In this particular scenario what are your reasons for documenting where you did?

Information Requirements & Decision Support
1. You made decisions during this clinical scenario. For example, at what point did you decide to order a head CT (or not order one)? How did you come to that decision? If they talk about decision rules ... We noticed that you did (not) document use of decision rules (tell me about that).
2. Do you typically seek out additional patient data from other sources during your encounter and documentation?
   a. Where do you pull data form?
   b. At what point in your encounter and/or documentation of encounter do you most often do this?
3. Did the system help you retrieve clinical information at the right time to make clinical decisions in this case? If so, how? If not, what was missing at what point in time?
   a. HPI section?
   b. Problem lists?
   c. Medications?
   d. Results?
4. Do you typically refer to additional resources during documentation? (e.g., guidelines, clinical references, other electronic systems, internet)
a. At what point during the encounter do you seek them out?
b. Would additional resources be valuable to you while you’re actively documenting?

5. Overall, how did you feel the session went today? How similar did you feel the process was to your real activities in the ER?

User Interface

1. We noticed that you used the HPI section (based on observation during scenario). Can you tell me about that?

2. We noticed that you used (or did not use) the retrieve buttons for the problem lists? Can you tell me about this?
   a. Do you typically review past medical history?
   b. Do you look in other places for the patient’s problem lists or PMH?
   c. Do you have a different method for retrieving patients past history?

3. We noticed that you used (or did not use) the retrieve buttons for medications? Can you tell me about this?
   a. Do you typically enter medications yourself and if so, how much detail (name, does, route, and frequency)? Why?
   b. Does another person enter medications?

4. In this case, the patient had an abnormal test result. We noticed that you did (or did not) do… (based on observation during scenario of whether clinician used retrieve button, reviewed results button or other behavior). Can you tell me about this?
   a. How do you typically document test results?

5. You were interrupted during your documentation (remind them what the interruption was and when it occurred). Did this affect your documentation process somehow? If so, how? Can you tell me about that?