

ACC Care Coordination Dyad Interviews

Final Report

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Accountable Care Collaborative Dyad Interviews

This report outlines findings of “dyad” interviews conducted in June of 2016 with Accountable Care Collaborative (ACC) Care Coordinators and the members with whom they work. This project is being conducted in parallel with a larger effort to complement the current ACC evaluation by adding the members’ perspectives on the program. Dyad interviews were tailored to discover common themes specifically around successful **care coordination** within the ACC. Care coordination, for this report, is defined broadly and is implemented in diverse ways across the state. In some cases, the Regional Care Collaborative Organization (RCCO) is responsible for care coordination, while in others it is delegated to specific practices. Beyond these two distinctions, it is important to note that there isn’t a standardized set of activities associated with coordination. We observed some variation across the dyads in the specific activities undertaken by care coordinators on behalf of members.

Because the purpose of the interviews was to explore common elements in successful care coordination, we did not take a random sample of coordinators and members. Each pair was selected using a convenience and snowball sampling methodology. RCCOs were contacted to identify specific coordinators that would likely have a successful example of care coordination. Dyads were also selected to ensure representation across the state and variation across multiple member characteristics.

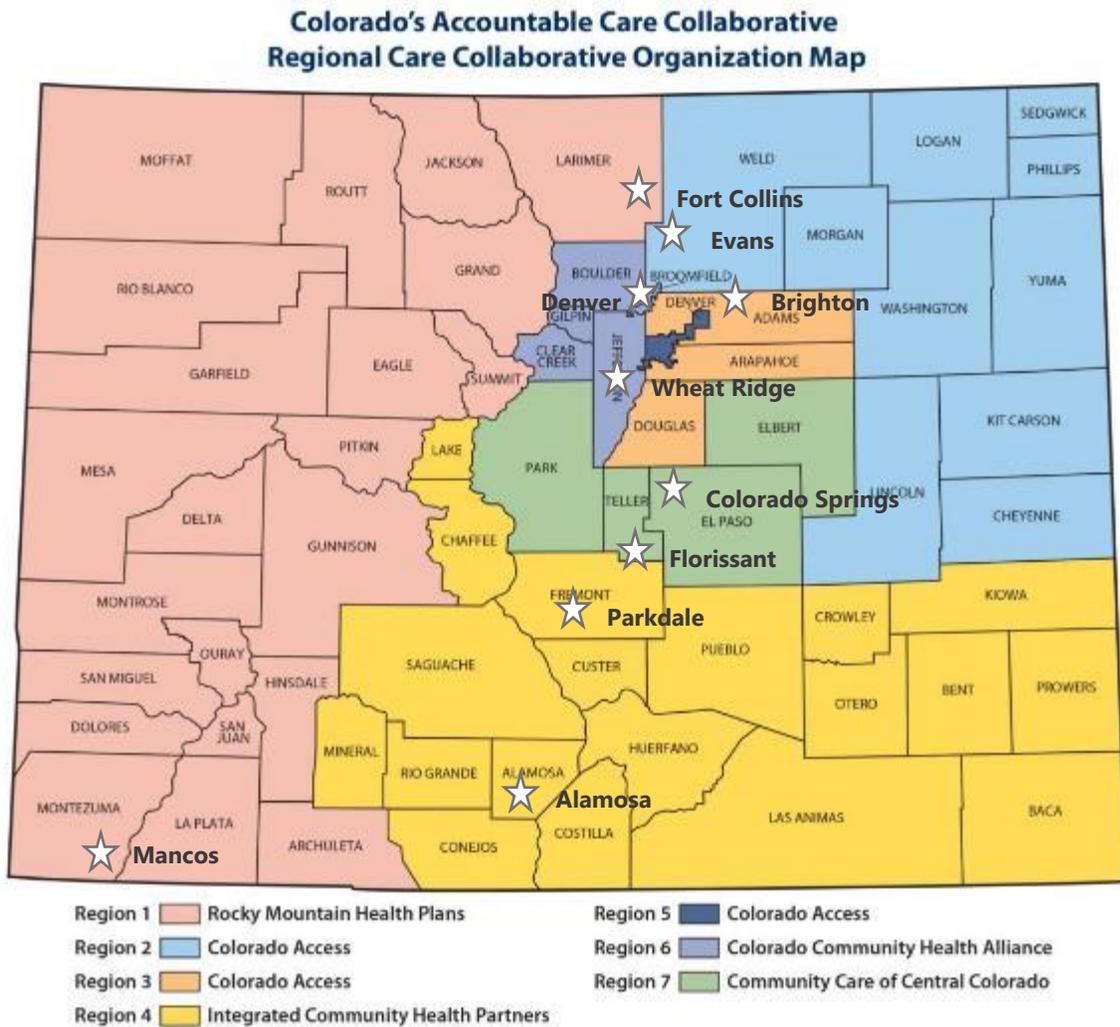
Interviews were conducted using an “appreciative inquiry” approach, meaning that questions focused specifically on successes and factors that contributed to success, rather than barriers or challenges encountered. For further information on the methodology for conducting interviews, please see Appendix A: Dyad Interview Protocol.

Interview Methodology and Respondents

All interviews were conducted between June 1 and June 17, 2016. The table on the following page shows the distribution of dyads across the state.

Member Characteristics	# Interviewees
Geographic Areas	
Urban	6
Rural	4
Care Coordination Models	
Care coordination provided by practice site?	3
Care coordination provided by RCCO?	7

The map below shows the location of each participating dyad.



As can be seen in the graphic above, most of the dyads interviewed lived in the Front Range area of the state. One pair was located in Southwestern Colorado. Attempts were made to locate potential dyads in the Northwestern corner and Eastern part of the state. However, time constraints did not allow pursuit of those additional potential interviewees.

The final sample did contain the desired variability across the targeted demographic and clinical characteristics of participating members. As shown in the table on the following page, the one targeted primary characteristic that was not included in the sample was a pregnant woman, although three parents with children (including a woman with a newborn) were interviewed.

Member Characteristics	# of Interviewees
Priority Characteristics	
Has a disability	6
Adult without dependent children	6
Parent	3
Pregnant Woman	0
Medicaid and Medicare	4
Spanish as a first language	1

Member Characteristics	# Interviewees
Secondary Characteristics	
Older adult	4
Has a chronic disease	8
Episodic need for care coordination	6
Intense need for care coordination	6
Ongoing need for care coordination	8
Medicaid Expansion enrollee	2
Very recent Medicaid enrollee	2

Member Characteristics	# Interviewees
Secondary Characteristics	
Previous, frequent exacerbations of illness	7
Previously often sought health care in emergency department	4

Key Findings

Several key themes emerged around components of successful care coordination. These themes are summarized from two perspectives. First we discuss the key roles and efforts of care coordinators in making the partnership successful. Second, we describe important roles and efforts on the part of members to ensure progress in obtaining health goals. While some of these themes involved specific steps and activities undertaken by the coordinator and the member, many of the respondents spoke at length about the importance of the relationship between coordinator and member in meeting goals and improving the members' health.

Key roles of the Care Coordinator in successful care coordination include:

1. Invest the time it takes to build trusting relationships.

“Probably [the most important thing to our success is] being able to build [a] trust[ing] relationship, because if they can trust you with their medical information first of all and then their medical care ...that makes it successful. They’re trusting you to make sure that you’re in communication with the docs and you’re in communication with the providers of whatever [the service] might be.”

--Care Coordinator

Coordinators and members both underscored the importance of building trust to establish a successful relationship. Coordinators noted that establishing trust could often take time and that members are not necessarily automatically inclined to trust them, since they are part of “the system.” One member mentioned that she initially thought her care coordinator was from child protective services and she was scared and concerned. In this situation, the care coordinator took the time to go to the member’s house, meet with several members of the family and talk about the specific kinds of support she could offer.

For most of the pairs, trust emerged when the coordinator was able to offer help, and then follow through with that help for the member. One coordinator discussed “small victories” that build up a feeling of trust over time. She stressed the importance of setting and achieving small goals that can help to demonstrate the kind of assistance a care coordinator can provide.

Across all of the dyads, one common thread was that a coordinator who really tries to listen to the member's perspective is also an important component of trust. Some providers can tend to "mandate" certain care, goals, or treatment (from the member's perspective), instead of allowing the member to communicate what's important to them. The coordinator in many cases builds trust by alleviating the member's frustration with providers that didn't seem to listen to or consider their perspectives.

Two members specifically mentioned that trust between themselves and the coordinator was facilitated by a trusted third party. In one case a member had a long-time primary care doctor who recommended and introduced her to the coordinator. She noted that she was *"surprised I even let her in my house [the first time she came over],"* and added that she likely would not have agreed to see her coordinator if the recommendation hadn't been supported by her late husband's trusted doctor. In another situation, the care coordinator was recommended and introduced by the member's pediatric provider. The care coordinator reported that it was easier/faster to establish trust because of the introduction.

One coordinator in a rural area remarked that it is very important for her, when making first contact with members, to explain that she is local, *"That I'm not calling from Denver, or anything like that. I'm from here."*

2. Frequently communicate with members and develop open honest communication channels.

In addition to more formal interactions (coordinating meetings, going to appointments, etc.), many coordinators alluded to a lot of informal communication between themselves and members. Coordinators frequently contacted members to remind them of upcoming appointments, to make sure they were following through with a referral or action item from a previous meeting, or to provide information about a new resource in the community.

Similarly, members expressed gratitude at having someone they could communicate with freely beyond the relationship they would typically have with a health care provider. Coordinators in these successful dyads were available for members when they had questions about their (or their child's) care, when they needed a specific resource, or when they were unsure about a next step to take in their care. "I just know I can call whenever I need anything," said one member.

3. Facilitate positive relationships between providers and members by attending appointments as needed and finding different providers if necessary.

Every dyad mentioned the importance of the relationship between the member and the provider. Most also discussed the key role played by the care coordinator in facilitating

Coordinator: *"For people like Tim who want to engage in [their] health care and take everything to heart and try to do what they need to do, need to have more personalization [from their provider]."*

Member: *"I think [changing my doctor] was for me like a fresh start and [everyone in the new provider's office] knew; they didn't judge me they were here to help and that's what really helped."*

these relationships. Strategies used by care coordinators ranged from speaking directly with clinicians on the member's behalf to clarify issues, to attending appointments with members, and, in some cases, facilitating a transition to a new provider. One example of this was a member who was doing poorly with his current provider (not following through with appointments, not taking medication, etc.). By speaking with the member and attending an appointment with the provider, the care coordinator observed a poor relationship between the two with a perceived lack of trust on the part of the member. She helped the member to find and switch to a provider who was able to quickly develop a more personal and trusting relationship with the member. This member believes changing providers has made a significant difference in his overall health. In this situation, the care coordinator worked for the RCCO and supported members in multiple practices with multiple providers. This may have been an advantage in this situation, over a care coordinator who works only in one clinic, making switching providers perhaps more complicated.

In another similar example of a poor relationship between a member and a provider the option to change providers was not available. Instead, the care coordinator became the liaison between the provider and the member. She improved communication by becoming the primary contact for the provider's office staff on behalf of the member and helped to slowly improve the relationship between the member and provider by attending all appointments with the member and being available to answer all the member's questions when the provider did not have the time to do so.

Some care coordinators mentioned the work they did to build relationships among themselves and the providers. Some providers seem to be more immediately open to working with care coordinators and to value the role they can play while others needed more time to build trust and get to know the care coordinator. This finding seemed to hold true for care coordinators in delegated practices as well as those working for the RCCO in multiple practices.

4. Follow up on everything offered or promised as quickly as possible.

Universally, coordinators stressed the importance of following through with tasks and assistance promised to their members in a timely manner. This was closely related to the need to build trust early on in the relationships. Most pairs described an initial relationship that was somewhat tentative. However, once coordinators could demonstrate the types of services available and members could see improvements (even if initially small) in their situations, then members became much more likely to ask for help when needed and to be more proactive in seeking out assistance for various needs.

Likewise, members consistently mentioned the importance of care coordinators following through on everything they promised. In some cases, members seemed surprised that care coordinators actually did what they said they were going to do.

5. Listen and learn about all aspects of members' lives and attend to needs beyond those that are directly related to medical issues (e. g., food assistance, transportation, house cleaning, children's activities).

The importance of listening was discussed in all interviews. From the perspective of the members, they felt valued, respected and understood because the care coordinators took the time to listen. From the perspective of the care coordinators, they mentioned the importance of taking the time to listen to members' questions and concerns as a benefit to providers who may not have the time they would like to spend with each member.

Care coordinators stressed listening as a key to identifying barriers to improving member health that are not directly related to medical care and that might otherwise go unnoticed. All of the members interviewed reported that their coordinator provided them with assistance for other personal needs that were impacting either their access to care or their overall health and quality of life. In each case, the member's health was being significantly impacted by other social determinants, including:

- Transportation
- Food and housing security
- Child care/parenting
- Social supports (friends and family)
- Acting as primary caregiver for a family member

For the members interviewed, having these needs addressed was an important step in their ability to take on greater responsibility for their own care and in becoming more active in improving their overall health. Examples of the range of non-medical needs care coordinators were able to address include:

- Replacing a rotted wheelchair ramp at a member's house
- Negotiating a lease with a private landlord and the local Housing Authority
- Food assistance
- Housekeeping assistance
- Assistance with after school activities for children
- Clothing for the member and her children

6. Explain and interpret information from clinicians and staff about the member's health and health care, and help the member navigate the system.

One of the most important things a care coordinator can do is to explain in less technical terms any medical information the member may have missed, misunderstood or forgotten. Several dyads shared examples of the care coordinator interpreting medical information after and between appointments. Care

"I'll go to make an appointment and I'll make a mess out of it. I forget what I'm going to say or I bugger it up so bad they don't know what in the world I'm talking about.

She picks up the phone, dials the dentist and, no problem!"

-- Member

coordinators discussed keeping detailed notes at each appointment and referring back to them when members had questions. Care coordinators and members both mentioned the benefit of having enough time to talk, ask and answer questions particularly when the medical providers did not have much time to spend with the members.

The members interviewed for this project often reported difficulty in communicating with their providers (or, more often, their providers communicating with them) regarding various aspects of their care, as described by one care coordinator below:

***Coordinator (to member):** When you decided not to go back [to your doctor] and you got really frustrated and you expressed your frustration to a lot of the people in the office [it seemed] you were frustrated because you didn't understand what was going on, right? **(To interviewer:)** I think it was a breakdown in [the member] not understanding and [the doctors and nurses] thinking that he should have understood that it was just the next follow-up thing to do and that kind of -- just got lost in translation somewhere. And no one was really calling from that office to relay that to [the member]. And that's where I stepped in.*

We've only been to one appointment. We have the next one scheduled for next month. But it was mostly [a conversation] between me and the front desk working through me, was basically what we ended up deciding. They give me the information and I'll actually talk to [the member] and go through all the pieces of why another scan is needed or what's coming up, why they're scheduled on this day, what's best for him and kind of be the in-between between that office and him..

And [the doctor] and I just talked during the appointment about how that was a good setup. That worked for them because they didn't know really quite how to communicate to the best of their ability with [the member].

In addition to interpreting and explaining medical information, the care coordinators play a critical role in helping members navigate the system. In particular, interviewees shared several examples of times when the member was unsuccessful getting timely answers or making appointments. In these cases the care coordinator, either through pre-existing contacts in the provider's office or through persistence, was able to make more progress more quickly than the member could on their own.

Key roles of the member in successful care coordination include:

1. Trust the care coordinator.

While the care coordinator took on much responsibility for initial trust building in the relationship, many members discussed the importance, from their perspective, of being open and willing to initially engage in the process.

“Well, I trusted her to do everything for me. So that was a big deal because especially since [my husband] died, he was my anchor and life pretty much. And he always made sure I was up for appointments... made sure I was ready on time. And then when he died, I was just lost. So if I didn't have [my care coordinator], I probably wouldn't have made a lot of those appointments. I just wouldn't have. Even if I called up and made the appointment, there was no guarantee that I'd get to be there.”

--Member

Some members described initial feelings of distrust of their coordinators, mostly stemming from concern about what was unknown. However, all members reported that, now, the trust in their relationship facilitates more engagement on their part. The time it took to build a trusting relationship seemed to vary. For those members who were initially more skeptical it may take several visits and a few early successes or fulfilled promises on the part of the care coordinator.

Having a trusted ally is key to members reporting that they were more likely to follow through on tasks, to make and attend appointments, follow care/medication instructions, and otherwise participate in their own care. Many members credited their relationship with the care coordinator for behavior changes including fewer missed appointments and increased compliance with medication regimes.

2. Ask questions, communicate needs and challenges.

Coordinators reported that for members to be successful, it is important that they ask for help when they need it and they communicate about their needs. Being a pro-active “team” member is a vital role for the member. Being able to ask for help and to outline specific needs was highlighted as particularly important from the perspective of the care coordinators. Often, members were better able to formulate those questions after the coordinator was able to demonstrate the assistance available. Positive outcomes seemed much more likely in scenarios where the coordinator approached the member with an idea of a particular need they may be able to meet rather than simply asking, “What can I do for you?”

“[The member] asked questions and she followed through ...so many people don't ask [for what they need] and sometimes ... they don't follow through, but she did. So she's the author of [her] success. It's her willingness to ask and follow through that's so important.”

--Care Coordinator

However, members seemed to have better experiences when they were cognizant of their own needs and goals, and were able to communicate these needs and goals to their coordinator.

This seems to be somewhat of an intrinsic characteristic of the member, although coordinators often provide members with assistance in framing and thinking about these goals. Most coordinators stressed that members have to want to get better and be willing to work at it.

3. Be honest and keep an open mind.

When asked what advice they have for other ACC members, members in the dyad interviews said they would encourage other members to be honest and open-minded. They talked about their own realizations that the more open and honest they were, the better able care coordinators were to help them with the issues that really mattered. Members also talked about being open-minded and “giving care coordination a try.” As mentioned above, most members interviewed were initially skeptical but all found the support they received from their care coordinators to be helpful in many ways. Many members made comments about not knowing what their health conditions would be today without the support of their care coordinators.

“[You need to] be honest, just be open, I went there with an open mind, be honest you know take your sense of humor with you, don’t walk in there all scared and serious and thinking that somebody is going to be telling you what to do ... because you’re part of it. [You’ve got] to take the time to try and work with somebody to help you get better.”

--Member

4. Prioritize your health/your child’s health and be proactive.

For many members, one of the most valuable services provided by the coordinator included an ability to remind the member of the importance of taking care of their own health, pointing out

“Probably she keeps me pointed [in the right direction]. She asks me how am I doing or we go here and do this, go to this person or call this person and so it gives me a better roadmap to finding things and doing things. Because that’s not an easy thing, I mean you’re in this big expanse of all these people and you just kind of -- if you don’t pay attention, you get lost in the shuffle.”

-- Member

that their ability to care for others is compromised when they themselves are not healthy. Particularly in cases where the member was also acting as a primary caregiver (for children or for an elderly parent), it was important that the coordinator keep focus on the member’s health and well being.

One mother of a child with multiple health issues talked about feeling completely overwhelmed and “ready to give up.” She credited her care coordinator with helping her prioritize her child’s health and to take everything one step at a time.

5. Set small goals and follow up as much as you can; take on more as you are able.

The role of setting small goals and following up is really a shared role for the coordinators and members. Dyads discussed two ways that goal setting can be helpful for members working to improve their health. In one scenario, members may identify barriers to getting and staying healthy but may not see a path to overcome the barriers.

Coordinators can play a crucial role in helping members to set and realize a series

of small goals that can quickly add up and overcome a seemingly impassible barrier. In other cases, members may expect too much of themselves too fast and become frustrated when they don't see the outcomes they want right away. In this situation, care coordinators can help the member set small goals and to be more realistic and patient with themselves. As members build small successes they build confidence and are better able to take on more responsibility for their health and health care.

“In all the years that I’ve done case management, I don’t think that I’ve ever had somebody who truly doesn’t have any goals. Sometimes if you say ‘what’s your goal,’ they might say that they don’t have any. But when you talk to them and get to know them and their situation, something always comes up. That dentist appointment they’ve been putting off for a year or getting a shower bar or -- there’s always something.”

–Care Coordinator

Coordinator: *“So usually, that’s what we do: he tells me what he wants. I’ll give him the tools. I walk through each step that he has to take one at a time. And we don’t throw too much at one time on someone, because you got to give them a little bit, so they can be successful. If you give too much of it at one time, they’re not going to be successful and we want him to be successful, so it’s those little steps, baby steps to get [to] the ultimate goal.”*

Patient: *“She helps me manage goals. Because I was always one . . . like I want to be from here to there and then I would get frustrated with that, but she -- with her, it’s like little steps. So I went a lot further over time, doing that, having a care coordinator.”*

Summary

The purpose of these 10 dyad interviews was to explore common themes in successful care coordination and to inform the next phase of interviews with a larger number of ACC members. Eleven themes were identified and can be categorized as those related more to the role of care coordinator and those related more to the role of the member in creating a successful experience.

“If it weren’t for [my care coordinator] I don’t know where I would be. You know, [she’s] really great!”

-- Member

These themes are:

Role of the Care Coordinator

1. Invest the time it takes to build trusting relationships.
2. Frequently communicate with members and develop open honest communication channels.
3. Facilitate positive relationships between providers and members by attending appointments as needed and finding different providers if necessary.
4. Follow up on everything offered or promised as quickly as possible.
5. Listen and learn about all aspects of members' lives and attend to needs beyond those that are directly related to medical issues (e. g. , food assistance, transportation, house cleaning, children's activities).
6. Explain and interpret information from clinicians and staff about the member's health and health care, and help the member navigate the system.

“And she’s like an ace in the hole. I love her to death. She has helped me in so many ways that it isn’t even funny.”

-- Member

Role of the Member

1. Trust the care coordinator.
2. Ask questions, communicate needs and challenges.
3. Be honest and keep an open mind.
4. Prioritize your health/your child's health and be proactive.
5. Set small goals and follow up as much as you can; take on more as you are able.

Based on the findings from the 10 dyad interviews it seems important for the ACC program to continue to allow care coordinators the time needed to build effective, trusting relationships with each member. The time required to do so appears to vary significantly and seems essential to long term success. Some dyads reported a high level of trust by the end of the first contact while others reported a period of weeks along with a few small successes before an effective level of trust was established. In the current health care environment, members recognize that their providers have limited time to spend with them. Care coordinators offer an important and valuable response to this problem by providing members with the time needed to listen and answer (or find answers to their) questions.

In addition, the care coordinators' ability to communicate effectively with both members and medical professionals, and their knowledge of community resources and the health care system appear to be required for success. Structured and regular supervision for care coordinators and frequent opportunities to meet with fellow care coordinators can help reinforce and expand these skills.

In the coming months a much larger number of members will be interviewed and these themes will be further explored in an effort to provide feedback on ACC program strengths and possible areas of improvement.

“And sometimes I’ll be trying to do something and I get myself confused. And I don’t know which way to turn, what to do and I just have to stop and go sit down.

“But [my care coordinator], she’s been with me to my appointment for my cancer, which meant a lot to me. And she just [does so much] -- it goes on and on and it might not be much to some people. But it’s a whole bunch to me, you know.”

-- Member

Appendix A: ACC Dyad Interview Protocol

Sampling

TriWest Group (TriWest) proposes a convenience/snowball sampling strategy to identify 10 pairs of Member/Care Manager dyads for interviews. The following is a list of proposed steps for sampling:

1. Contact the School of Public Health and request a list of 20 practices that may have particularly interesting or innovative models for care coordination.
2. Contact each of the RCCOs and request from each a list of two to three (2-3) practices where they feel care coordination is particularly strong.
3. TriWest will begin to reach out to practices to recruit possible coordinator/member dyads for interviews. As we contact practices, we will stratify our sampling to include:
 - Three practices from each of five RCCOs (including one each from Colorado Access' three RCCO regions);
 - If possible, one practice from each RCCO in which care coordination is primarily provided within the practice and one practice for each RCCO in which care coordination is primarily provided by the RCCO care coordinator;
 - If possible, five practices in rural or frontier communities;
 - If possible, five pediatric practices;
 - If possible, three small, three medium, and three large size practices.
 - Target broad geographic representation across the identified practices (including Metro, Front Range, Eastern Plains, Western Slope, Southwestern Colorado).
4. Work with selected practices (or RCCOs in cases where most care coordination happens at the RCCO level) to request identification and assistance in scheduling an interview with a care coordinator/member dyad in which:
 - The dyad offers an example of effective care coordination (but not necessarily with members who are likely to succeed in any setting and not necessarily those with “successful” health outcomes);
 - Both the care coordinator and the member are likely to agree to an interview; and
 - The member meets one of the required characteristics and one of the optional characteristics:
 - **Required:**
 - Having a disability (need at least two overall),
 - Medicaid Medicare program enrollee (at least one overall),

- Spanish as a first language (one to two overall),
 - Parents/pregnant women (three to four overall),
 - Adults without dependent children (at least two overall).
- **Optional:**
- Having a chronic disease,
 - Older adult,
 - Episodic need for care coordination,
 - Intense need for care coordination,
 - On-going need for care coordination,
 - Early enrollee in Medicaid,
 - Medicaid expansion enrollee,
 - Very recent Medicaid enrollee,
 - Previously sought health care in an emergency department,
 - Previous frequent exacerbations of illness.
5. Once the first five dyads are identified, contact one or two RCCOs to request identification and assistance in scheduling an interview with two more dyads (one rural and one urban or suburban) who meet criteria or combinations of criteria not adequately represented by the first five dyads.
6. Once the first seven dyads are identified, review the combinations of characteristics that are adequately represented and combinations that are missing and important. Request dyads who offer an example of successful care coordination and represent missing and important characteristics or combinations of characteristics. RCCO's will be contacted one at a time seeking missing combinations of characteristics until three more dyads (for a total of ten) have been identified and scheduled.

Interview Protocol

Scheduling

Following the sampling protocol described above, TriWest staff will schedule and conduct ten (10) dyad interviews. Interviews will be scheduled for sixty (60) minutes and conducted at a location recommended by the care coordinator. TriWest will offer \$25 grocery store gift cards to members as an incentive for their participation.

Conducting and Documenting

To establish reliability of the interview process, TriWest staff will conduct the first two to four interviews in pairs. Interviewers will then meet to refine question wording, timing, and

potential follow up/probative questions and agree on consistent interview administration. Subsequent interviews will be conducted by one staff member.

Each respondent (both caregiver and member) will be provided with a consent form outlining their expected participation, as well as a list of potential risks and benefits for participating in the interview. If consent is granted by the member and care coordinator (and documented in the consent form), interviews will be recorded. If recording is not an option, interviews will be documented with written notes.

In order to protect member and coordinator confidentiality, no other observers will be permitted during the interview process. Full, de-identified interview transcriptions will be provided upon project completion.

Collection of Demographic Information

Members will be asked to complete a brief questionnaire, focused primarily on demographics, at the conclusion of the interview. This questionnaire will include questions about programs in which the member is currently enrolled. Demographic questions will be limited to avoid inadvertent identification of the member.

Key Concepts to Explore in Dyad Interviews

1. What are the key components of effective care coordination?
2. What do members see as helpful in understanding of their health, their family's health, and health promotion?
3. What factors do members consider when making decisions that support improved health outcomes?
4. What factors do members consider when making decisions to seek care at their health home instead of an emergency department (when not in need of emergency care)?

Semi-Structured Interview Questions

Black text = question for member

Red text = question for care coordinator (CC)

Green text = question for both

1. What are the most important things that [the care coordinator] does for you? (*Prompt if needed – what does the care coordinator do to help you to manage your health care; to improve your health/your child's health? Other prompts: what does the care coordinator do to help you to schedule and get to appointments, talk with your doctors, answer questions about treatments or medications?*)
 - If the goal is to improve your health, what has [the care coordinator] done that has been

- helpful in improving your health?
- **CC: What are some of the ways you feel you make the most difference or are most helpful?**
 - What are some things [the CC] could do that would be helpful and may not have been tried before?
 - **CC: What are some new ideas you have for ways you can support improved health?**
2. Describe how you see your role in working with [the CC] to help you get and stay healthy?
- In what ways do you feel you play a part in getting and staying healthy?
 - We think of a healthcare team as everyone who is working with you to help you get and stay healthy. Your team might include your doctor and his/her nurse or assistant, your care coordinator [CC], maybe some specialists or counselors. Who is on your healthcare team?
 - How would you describe your role on your healthcare team?
 - **CC: How would you describe the member/patient role on the healthcare team?**
 - In what ways does [the CC] support you being involved in your health care?
 - **CC: What are some of the most effective strategies you use to encourage members/patients to be actively involved on their health care team? In other words, what works?**
 - What are some new ways [the CC] could help you continue to be actively involved or become actively involved in your health care?
 - **CC: What new ideas do you have to encourage active involvement?**
3. What does [the CC] do that helps you understand your/your child's health condition?
- In what ways do other members of your healthcare team help you understand your/your child's health condition(s)?
 - **CC: What are the most effective ways to ensure members/patients understand their health condition(s)?**
 - **CC: In what ways do you see other members of the healthcare team contributing effectively to a member/patient's understanding of their health conditions(s)?**
 - What are some new ways [the CC] can help you understand your/your child's health condition(s)?
 - **CC: What new ideas do you have to encourage active involvement?**
4. When you make decisions about your health (for example: when and where to get care, how closely you follow medical advice, when and whether to follow up on referrals for additional services, etc.), what impacts your decisions the most?
- How do you decide when and where to get medical care? *(Prompt if needed: How do you decide when to seek care at an emergency department?)*

- What does [the CC] do that impacts the decisions you make about your health and health care?
 - CC: In what ways do you support decisions that have a positive impact on your member/patient's health?
 - What are some new ways [the CC] can help you continue to make decisions that are positive for your health or help you make more decisions that are positive?
 - CC: What new ideas do you have to support decisions that have a positive impact on member/patient health?
5. Please share an example of a time when the two of you feel like you really worked well together as a team to achieve something important to you.
- What was the most important factor in your success?
 - CC: If you were going to give advice to other care coordinators (perhaps those just starting out in the role), what would that advice be?
6. CC: What do you most enjoy about your work?
7. What is the one thing you appreciate most about [the CC]?
8. If you could go back and change some things you two have done together, what would it/they be?