Qualitative Guides

Consent and Information Sheet

Good day! My name is ____. I am working with KOFIH to assess Provider and Purchaser Readiness for the Implementation of a Case-Based Payment (CBP) System in Ethiopia. Given your experience and involvement in the health system, your insights and reflections are incredibly valuable to this study. This qualitative component aims to gather rich, detailed narratives to better understand the effective implementation of a CBP System in Ethiopia.

Voluntary Participation: Your participation in this interview is entirely voluntary. You may choose not to answer specific questions, and you can stop the interview at any time without consequence. Your decision whether or not to participate will not impact your professional standing or any services you receive.

Confidentiality: All responses will remain strictly confidential. Your identity will not be disclosed in any reports or publications resulting from this study. The data will be aggregated to ensure individual anonymity, although general identification of the facility may be possible.

Procedure and Duration: The interview will last approximately 60 minutes and may be audio-recorded or notes taken for accuracy. You will be asked questions related to how CBP could be implemented in Ethiopia.

Potential Benefits and Risks: Although participation has no direct benefits, your insights could significantly contribute to the improvement of the health system in Ethiopia. No significant risks are anticipated.

Consent Confirmation: Do you have any questions or concerns about this study, your participation, or how the information will be used?

Do I have your permission to proceed with this interview?

- Participant's verbal agreement: __ Yes __ No
- Interviewer's signature: _____ Date: _____

Region: _____District: _____Town_____

Participant code	**Age**	**Sex**	**Residence**	**Role in the institution**	**Position in the institution**	**Educational status**
P1						
P2						
P3						
P4						
P5						
P6						
P7						
P8						

Data collection team information

Name of facilitator: _____
Name of note taker: _____
Discussion language: _____
Code of audio recorder: _____
Name of audio file: _____
Date of data collection: _____
Start time _____ End time _____
Place of interview: _____

Facilitator Guidelines

- Recommended group size: 3-8 participants
- Duration: 45-90 minutes
- Co-facilitator needed for note-taking and observing group dynamics
- Ensure private, comfortable space
- Arrange seating in a circle
- Prepare flipchart/materials for participatory activities
- Obtain informed consent before beginning the focus group

Introduction (5 minutes)

- Welcome and introductions
- Purpose of discussion
- Ground rules:
    - Everyone's views are important
    - No right or wrong answers
    - Respect others' opinions
    - One person speaks at a time
    - Confidentiality
    - Permission to leave if uncomfortable
    - No pressure to speak about personal experiences

FOCUS GROUP DISCUSSION (FGD) GUIDE

Target Groups:

- **Healthcare Providers:** Clinicians, nurses, medical record officers, finance staff, hospital administrators.
- **Purchasing Institution Staff:** EHIA/CBHI claims processors, contract managers, data analysts.

A. FGD GUIDE FOR HEALTHCARE PROVIDERS

Introduction:

As healthcare providers, your firsthand experience with patient documentation, medical coding, and claims processing is critical to understanding the readiness for implementing a Case-Based Payment (CBP) system. The following questions aim to explore your current practices, challenges, and the potential adjustments needed for a smooth transition to CBP.

I. Patient Documentation Practices

1. Describe your facility's patient documentation workflow from admission to discharge.
    - *Probe:* Who documents what at each stage? (Specify roles: nurses, clinicians, clerks)
    - *Probe:* Where do critical data gaps (comorbidities/complications) typically occur?
    - *Probe:* How do you handle documentation for complex cases like HIV/TB co-infections?
2. What tools support your documentation system?
    - *Probe:* What % of records use paper vs. digital? Which departments rely most on paper?
    - *Probe:* How do you transfer data between hybrid (paper-digital) systems?

3. Looking ahead to the implementation of Case-Based Payment (CBP), what do you anticipate will be the three biggest documentation-related challenges for ensuring accurate tracking and reporting of community capacities and outcomes?

Probe (Systemic Barriers): How might factors like staff capacity, existing infrastructure, financial constraints, or the current HMIS design help or hinder our ability to document the specific data needed for CBP?

Probe (Data Integrity & Gaps): What currently happens when there are inconsistencies in data (e.g., between different reports or sources)? How would such gaps impact the reliability of the data we'll use to measure community-level progress under CBP?

Probe (Usability & Policy): Is our current documentation system designed to capture the qualitative stories of community change as well as quantitative data? Is there clear policy guidance on what must be documented for community programs, and how could that be improved for CBP?

II. Medical Coding Infrastructure

4. Walk us through how a diagnosis becomes a coded claim.

- *Probe:* What clinical terms most confuse coders? (e.g., "severe sepsis" vs. "septic shock")
- *Probe:* How often do coders consult clinicians? What delays this process?

5. How do you ensure coding accuracy?
    - *Probe:* What system flags MCC/CC (major comorbidities) for payment accuracy?
    - *Probe:* Are coders trained to capture complications affecting CBP case complexity?
6. What coding errors impact revenue most?
    - *Probe:* Give an example where under-coding caused payment loss.
    - *Probe:* What % of cases require re-coding due to errors?

III. Claims Management

7. Describe your claim submission process. (Hint: taking Community Based Health Insurance (CBHI) or Social Health Insurance (SHI)…as example)

- *Probe:* What causes the longest delay? (e.g., coding backlog, missing signatures)
- *Probe:* How do you verify supporting documents like lab results?

8. How do claim rejections affect operations?
    - *Probe:* What % of rejections stem from documentation-coding mismatches?
    - *Probe:* How much revenue is lost monthly to preventable errors?

IV. Human Resource Capacity

9. As we look ahead to implementing Case-Based payment (CBP), what do you see as the most critical human resource gaps or training needs, we will need to address to ensure its success?

- **Probe (Skills):** Beyond clinical skills, what new competencies might be needed? (e.g., data collection and analysis for community profiling, participatory planning techniques, resource mapping, monitoring and evaluation for community-level outcomes).

- **Probe (Roles & Certification):** Which staff roles will be most impacted first? Do we have the right number of staff with the right certifications (e.g., in data management, project design, or specific technical areas) to support a CBP model?
- **Probe (Mindset):** What kind of shifts in attitude or approach (e.g., from service delivery to facilitation) will be required for staff to effectively support community-led initiatives?

10. What new roles would CBP require?
    - *Probe:* Estimate full time equivalents (FTE)s needed for:
      » Clinical documentation improvement (CDI) specialists
      » CBP data auditors

V. IT System Preparedness

11. what is the current status of EMR?

Probe: What data elements are captured by EMR?

12. Can your EMR support CBP?

- *Probe:* Does it auto-flag incomplete records pre-discharge?
- *Probe:* Can it generate bundled payment reports?

13. What IT upgrades are most urgent?
    - *Probe:* How would you integrate paper-based departments (e.g., rural OPD) into digital CBP?
    - *Probe:* What interoperability is needed for purchaser data exchange?

VI. Service Reorganization & Care Delivery

13. Considering the shift to a CBP model, how do you imagine the entire patient journey or care pathway might need to be redesigned to improve efficiency and outcomes?

- **Probe (Process & Volume):** Under a system that rewards outcomes and capacity-building, which types of services or procedures (e.g., preventative care, same-day surgeries, chronic disease management) might become more prioritized? Which might be redesigned or reduced?
- Probe (Equity & Case-Mix): A core goal of CBP is equitable care. What mechanisms or protocols would need to be in place to ensure that facilities remain motivated to treat all patients, including those with complex conditions, and not just those that are most financially advantageous under the new model?

- Probe (Team Roles): How might the roles of doctors, nurses, community health workers, and social workers need to change to work as a team focused on a patient's long-term capacity and health outcomes?

14. In a CBP model that incentivizes outcomes and healthy communities, how would we define and safeguard "quality of care" to ensure it improves for all patient groups?

- **Probe (Clinical Standards):** Beyond financial incentives, what clinical governance protocols (e.g., new checklists, review committees, readmission audits) would be essential to prevent unintended consequences like premature discharge and ensure clinical decisions are always patient-centered?
- **Probe (Protecting Vulnerable Populations):** How can the CBP payment structure and care protocols be designed to actively protect and provide for the needs of patients with chronic, complex, or costly conditions?
- **Probe (Beyond the Clinic Walls):** Since CBP focuses on community capacity, what new "quality" metrics should we consider (e.g., patient education, community support group linkages, successful home management) that go beyond traditional clinical metrics?

VII. Transition Roadmap

15. What low-cost improvements boost readiness in 3 months?

- *Probe:* Would standardize/utilize checklists or clinician-coder huddles help?

16. What pilot units are best for CBP testing?
    - *Probe:* Why choose maternity/diabetes over trauma?
17. What policy support is critical?
    - *Probe:* Should Ethiopia adopt national CBP coding guidelines?

B. FGD GUIDE FOR PURCHASING INSTITUTION STAFF

Introduction:

As staff involved in claims processing and payment systems, your perspective is invaluable in assessing the readiness of purchasing institutions to adopt a Case-Based Payment (CBP) system. The following questions will explore your current processes, challenges, and the adaptations required for CBP implementation.

1. Current claims processing & payment systems

1. Describe your end-to-end claims verification and payment process.
    - *Probe:* What manual checks exist for coding/documentation accuracy?
    - *Probe:* How do you reconcile discrepancies between claims and clinical notes?
    - *Probe:* What % of claims are auto-adjudicated vs. manually reviewed?
2. How do you detect fraud/errors today?
    - *Probe:* What tools flag suspicious patterns (e.g., duplicate claims)?
    - *Probe:* What analytics dashboards are used? Are they real-time?
3. What is your average reimbursement timeline?
    - *Probe:* Where do delays cluster? (e.g., pre-payment audits, provider queries)
    - *Probe:* How do delays impact provider trust/cash flow?
4. How do you monitor provider performance?
    - *Probe:* What metrics are tracked? (e.g., denial rates, readmissions, patient complaints)
    - *Probe:* How are "poor performers" sanctioned? (e.g., penalties, mandatory training)

2. Capacity for CBP management

5. What skills are missing for CBP pricing and monitoring?

- *Probe:* Do you have actuarial staff to set bundle prices? If not, how would you outsource?
- *Probe:* What training is needed for data analysts to track CBP outcomes?

6. Can existing IT systems handle CBP?
    - *Probe:* Can your software:
        » Process bundled payments?
        » Track quality metrics per case?
        » Integrate with provider EMRs?
    - *Probe:* What legacy systems would block CBP (e.g., outdated claim engines)?

7. How should CBP coexist with fee-for-service (FFS)?
    - *Probe:* Would a hybrid model (CBP for surgeries + FFS for outpatient) work?
    - *Probe:* How would you phase out FFS without disrupting providers?

3. Risk management & equity safeguards

8. How would you prevent CBP "gaming" (e.g., upcoding, case selection)?
    - *Probe:* Describe your audit strategy: Random checks? Targeted high-risk providers?
    - *Probe:* Would you use AI to detect outlier billing patterns?
9. A key principle of CBP is equity. How should we design the CBP system to actively identify and protect vulnerable patient groups to ensure they have equitable access to high-quality care and services?
    - **Probe (Financial Risk Protection & Equity Adjustments):** Building on lessons from schemes like CBHI, what specific financial mechanisms should be built into the pricing structure? For example, should there be risk-adjusted payments or higher bundled rates for facilities serving populations with greater complexity or socioeconomic barriers (e.g., rural, impoverished, or highly elderly populations) to ensure it is financially viable for them to provide care?
    - **Probe (Accountability & Redress):** What robust, accessible, and transparent mechanisms would we need to create for patients and communities to report concerns, such as perceived denial of care or discrimination? How can communities be involved in overseeing this process?
    - **Probe (Beyond Finance - Proactive Outreach):** Beyond financial protections, what non-financial strategies are essential? (e.g., community health worker outreach, targeted health education, transportation support, and culturally/linguistically appropriate services).
10. How can we proactively design the CBP model to actively narrow, rather than inadvertently widen, the existing gaps in care quality and access between urban and rural areas?
    - **Probe (Risk Adjustment & Fair Incentives):** What specific adjustments to the payment or incentive structure (e.g., risk-adjusted payments, higher bundled rates for remote areas, different performance targets) could be made to account for the different challenges and patient populations that rural facilities face, ensuring it is financially sustainable for them to participate and provide high-quality care?
    - **Probe (Community-Centric Metrics):** How can we ensure that the "quality" and "outcome" measures in CBP are meaningful and fair for rural contexts? For example, how could we integrate community-collected data on health status or access into performance scoring, rather than relying solely on clinical data that might be harder for rural clinics to generate?

- **Probe (Investment & Support):** Beyond financial adjustments, what investments in infrastructure, technology (e.g., telehealth), and specialized support (e.g., rotating specialist visits, enhanced training for generalists) are essential to build the capacity of rural facilities to succeed under a CBP model?

4. Coordination & transition planning

11. What policy changes are essential for CBP?

- *Probe:* Should Ethiopia create a *CBP regulatory body*? What powers would it need?
- *Probe:* How align CBP with MoH's *Essential Health Services Package*?

12. What phased rollout would you recommend?
    - *Probe:* Pilot sequencing: Start with regional hospitals? Prioritize high-volume procedures?
    - *Probe:* What 12-month milestones would ensure sustainable scale-up?

13. How will you coordinate with providers during transition?
    - *Probe:* Joint trainings? Shared dashboards? Co-design of bundle definitions?
    - *Probe:* How resolve pricing disputes transparently?

KEY INFORMANT INTERVIEW (KII) GUIDE

Background Characteristics

Details	KII for Hospital CEOs, medical directors, health financing experts
Region	
Name of institution	
Profession	
Sex	
Age	
Position	
Years of total professional experience	
Years of experience in the institution	
Organizational post (Post holder/not holder)	

Data collection team information

Name of interviewer: _____

Name of note taker: _____

Interview language: _____

Code of audio recorder: _____

Name of audio file: _____

Date of data collection: _____

Start time _____ End time _____

Place of interview: _____

A. KIIs FOR HEALTHCARE LEADERS

Introduction:

Thank you for your time. As a senior leader, your perspective is critical for shaping a successful transition to a Capacity-Based Payment (CBP) model. This shift isn't just about changing how we get paid; it's about fundamentally redesigning care for better outcomes and sustainability. Our conversation will focus on strategic readiness, system-wide challenges, and the opportunities you see for this transformation.

1. Strategic Readiness & System Barriers

1. From a strategic vantage point, what do you see as the most significant system-wide barriers to implementing CBP at your facility?

- **Probe (Quantification & Impact):** To make this concrete, could you estimate the resource gap? (e.g., "We would need approximately [X] additional full-time coders or [Y] clinicians with dedicated documentation time to meet CBP requirements.")
- **Probe (Data Integrity):** Based on internal audits, what is your estimate of the current gap in clinical documentation that fails to capture complications or comorbidities crucial for accurate CBP billing?
- **Probe (Innovative Solutions):** Instead of large investments, what are some low-cost, high-impact process changes we could implement in the next 6 months to overcome 50% of these challenges? (e.g., new auditing procedures, quick-win training modules, template redesign).

2. Digital Infrastructure & Transformation

2. Thinking beyond basic functionality, what strategic investments in digital infrastructure are non-negotiable to not just support, but thrive under, CBP?

- **Probe (System Capability):** To what extent can your current EMR/EHR system support CBP? Specifically, can it auto-generate proposed bundles or groups based on clinical documentation, and if not, what functionality is missing?
- **Probe (Process Vulnerability):** Under a mandate for rapid, accurate coding, which of our current manual workflows are most vulnerable to failure? What would be the operational consequence of a breakdown in these areas?

3. Leadership Assessment & Vision

3. Overall, how would you assess your organization's readiness to harness CBP as a tool for improving care, not just a new reimbursement mechanism?

- **Probe (Evidence-Based Scoring):** If you were to rate your facility's readiness on a scale of 1-10, what specific evidence informs your score? Please consider:
    - **Coding Accuracy:** Our current coding accuracy rate is approximately [ ]%; for CBP, we would need to target [ ]%.
    - **Financial Health:** Our current claim denial rate sits at [ ]%; under CBP, this would need to be below [ ]% to be sustainable.
    - **Human Capital:** Roughly []% of our relevant staff have received advanced, applied training in ICD-10/11 and the principles of CBP.

- **Probe (Strategic Vision):** What is your biggest strategic concern about this transition, and what is the single greatest opportunity you see for our health system if we get it right?

II. Strategic Financial & Operational Implications

4. From a financial perspective, how might CBP fundamentally reshape service line profitability, and what is your strategy to ensure the entire care continuum remains financially sustainable?

- **Probe (Scenario Planning):** In a CBP model, which service lines (e.g., high-volume surgery, chronic disease management, pediatrics) might see significant gains or losses? How would you define and fund essential but potentially less profitable "loss leader" services that are critical to community health?
- **Probe (Strategic Reallocation):** What mechanisms would you put in place to proactively reallocate resources to protect vulnerable service lines and ensure integrated, patient-centered care is not compromised?

5. Operationally, CBP demands a more integrated approach to care delivery and documentation. What transformational changes to your organizational structure and workflows do you anticipate?

- **Probe (Team Structure):** To improve accuracy and efficiency, would you consider models like embedding certified coders within clinical units or creating integrated patient care teams? What would be the reporting structure for such a role?
- **Probe (Clinician Well-being):** A common concern is increased documentation burden leading to clinician burnout. What specific strategies, technologies, or support systems would you implement to make documentation more efficient and protect clinician-patient interaction time?

6. How will you align the incentives of CBP with the academic and research missions of your institution to ensure they are mutually reinforcing rather than in conflict?

- **Probe (Education & Training):** How would you adjust the CBP model or secure adjustments to ensure that the longer patient stays often required for training residents do not result in financial penalties?
- **Probe (Research Funding):** Research costs are typically excluded from bundled payments. What is your strategy for explicitly budgeting and subsidizing the costs of clinical research to ensure it remains a viable and funded activity?

III. Leadership, Alignment, and Risk Mitigation

7. CBP can create tension between clinical priorities and financial imperatives. As a leader, how will you foster alignment and create effective conflict resolution pathways between clinicians and administrators?

- **Probe (Conflict Resolution):** How would you mediate a situation where a clinician believes a coding or billing directive conflicts with their medical judgment for a specific patient? What process would you use?
- **Probe (Liaison Role):** Imagine creating a "Clinical Documentation Integrity Lead" role. What would be the core responsibilities, necessary credentials, and ideal reporting line (e.g., to Medical Affairs, Finance, or jointly) to ensure credibility with both sides?

8. Based on your assessment, what single greatest risk to a successful CBP transition keeps you awake at night, and what is your mitigation plan?

- **Probe (Prioritization):** Is your primary concern **financial volatility** (revenue shortfalls), **cultural resistance** (staff burnout/opposition), or **unintended clinical consequences** (care rationing, avoidance of complex cases)?
- **Probe (Financial Contingency):** To manage the inherent volatility of a new payment model, what size of a financial contingency reserve (e.g., a percentage of operating revenue) would you recommend to buffer the organization through at least the first 6-12 months of implementation?

IV. Transition Roadmap & Policy Advocacy

10. What does a prudent, phased implementation roadmap look like for your organization? What criteria would you use to sequence the rollout?

- **Probe (Pilot Selection):** Would you pilot CBP with specific conditions (e.g., elective surgeries like joint replacements, maternity care) or specific patient populations? What are the advantages of your chosen approach?
- **Probe (Realistic Timeline):** Is a timeline of a 6-month pilot, followed by a 12-month scaling phase, and full adoption within 3 years realistic? What are the key milestones that would define success at each stage?

11. For CBP to succeed, certain policy enablers are essential. What are the non-negotiable forms of support you need from the Ministry of Health or other regulators?

- **Probe (Standardization & Equity):** Is the standardization of coding guidelines and a mechanism for regional price adjustments (e.g., for rural vs. urban costs) critical? Why?
- **Probe (Safeguards):** If you were to draft one clause for a national "CBP Transition Safeguards" policy to protect patients and providers, what would it be? (e.g., "A mandatory independent review process for potential cases of care denial" or "A risk-adjusted outlier fund for exceptionally complex cases").

Background Characteristics KII: FOR POLICY MAKERS

Details	KII for MoH officials, EHIA/CBHI directors, RHB heads.
Region	
Name of institution	
Profession	
Sex	
Age	
Position	
Years of total professional experience	
Years of experience in the institution	
Organizational post (Post holder/not holder)	

Data collection team information

Name of interviewer: _____

Name of note taker: _____

Interview language: _____

Code of audio recorder: _____

Name of audio file: _____

Date of data collection: _____

Start time _____ End time _____

Place of interview: _____

Introduction:

Thank you for your time. Your expertise is indispensable in shaping a strategic and sustainable framework for implementing Case-Based Payment (CBP) in Ethiopia. This transition represents more than a financial change; it is a systemic shift towards a more efficient, equitable, and quality-focused health system. Our discussion will focus on high-level policy design, international lessons, and the strategic enablers needed for success.

1. Policy and Legal Framework Assessment

1. How do we strategically align Ethiopia's current health financing policies with the CBP model to ensure a coherent and legally sound transition?

- **Probe:** Which specific existing proclamations or regulations would require amendment to explicitly authorize and govern bundled payments? What is the most efficient pathway to create this legal enabling environment?
- **Probe:** How can we design the CBP framework to ensure national standards for quality and equity, while accommodating the operational mandates of regional health bureaus? What coordination mechanism is needed to manage pricing and cross-regional patient flows?

II. International Lessons & Strategic Adaptation

2. Looking at global precedents, what are the most critical design principles from other countries' experiences with similar payment models that we should adopt or avoid?
    - **Probe:** Beyond the payment model itself, what were the key governance, data, and accountability preconditions for success in countries like Ghana or Thailand? (e.g., strong data systems, independent auditing, stakeholder buy-in). How can we build those foundations here?
    - **Probe:** What specific policy safeguards (e.g., risk-adjusted payments, equity funds, protected health services) are non-negotiable to ensure CBP actively reduces rather than widens existing urban-rural and socioeconomic disparities?

3. Equity is a cornerstone of our health system. What foundational safeguards must be irreversibly baked into the very architecture of the CBP system to protect and actively support vulnerable and rural populations?
    - **Probe (Proactive Equity Levers):** Rather than reacting to disparities, what proactive **financial levers** can we design in from day one? (e.g., risk-adjusted payments that automatically account for patient complexity, geographic equity factors in bundle pricing, explicit subsidies for essential but underfunded services).
    - **Probe (Systemic Stability):** Transitioning payment models creates financial uncertainty for providers. What **transitional stabilization mechanisms** (e.g., phased implementation, blended payment models, a volatility risk fund) are non-negotiable to ensure patient care is not disrupted and essential facilities, especially in rural areas, remain solvent during the shift to CBP?

III. Pilot Design & Sequencing for System Learning

4. What pilot strategy would maximize learning and manage risk to build confidence for a national scale-up?
    - **Probe (Site Selection Rationale):** What are the strategic trade-offs between piloting in tertiary hospitals (complexity), regional hubs (balance), or primary health centers (prevention)? Which sequence offers the best pathway for sustainable system-wide learning?
    - **Probe (Phased Implementation):** What is a realistic yet ambitious set of milestones and a timeline for a national rollout that allows for iterative learning and adjustment?
5. How can we leverage Ethiopia's experience in digitalization to build a secure, interoperable data backbone that supports CBP?
    - **Probe (Interoperability):** What is the strategic approach to integrating hospital EMRs with insurance systems? Should we mandate a standardized API framework for data exchange?
    - **Probe (Resilience & Equity):** What 'offline-first' protocols or low-tech solutions must be designed into the system from the start to ensure facilities in low-connectivity regions can participate fully and are not left behind?

IV. Monitoring, Evaluation & Sustainability

6. How do we move from tracking costs to measuring value? What five core indicators would define a successful and sustainable CBP system?
    - **Probe (The Balance of Metrics):** If you had to prioritize one ultimate measure each for quality, equity, and efficiency, what would they be and why?
    - **Probe (Fiscal Sustainability):** How should a 'CBP Transition Stabilization Fund' be structured and financed to manage initial volatility and protect public health finances? How do we model the long-term return on investment to make the case for upfront costs?
7. CBP is an investment intended to generate long-term fiscal sustainability. How do we structure the transition to protect public health finances during the initial implementation period and ensure the model is financially resilient for the future?
    - **Probe (Financing the Transition):** A "CBP Transition Stabilization Fund" is critical to manage volatility. What is the most sustainable mix of financing sources for this fund?

(e.g., reallocated internal budgets, a dedicated health tax, or catalytic donor funding that phases out over time).

- **Probe (Modeling Sustainability):** The business case for CBP hinges on its ability to generate efficiencies. How do we proactively model the Return on Investment (ROI) to demonstrate that the long-term gains from a healthier population and a more efficient hospital system will outweigh the significant upfront costs of digitalization and system change?