Summary of Revisions Made to Site Visit Interview Protocols' Existing Content in Response to Public Comments Received Regarding CMS's Planned Information Collection for the Evaluation of the Multi-payer Advanced Primary Care Practice Demonstration
(Document Identifier: CMS-10436)

Protocol	Question #	Original Wording	Revised Wording	Reason for Revision
State Officials	15ai	[Optional] Do any of these new services focus on improving care coordination? If so, how?	Do any of these new services focus on improving access? If so, how?	Removed "optional" status due to increased importance of the question, and further revised to probe if the new services focus on improving access instead of care coordination. A probe question about care coordination was added (15aii) (see table below).
State Officials	21a	[Optional] How, if at all, do you feel these changes impact patient access to and coordination of care?	How, if at all, do you feel these changes impact patient access? We are particularly interested in the impact on Medicare, Medicaid, and special populations.	Removed "optional" status due to increased importance of the question, and further revised to probe only about patient access. A new probe question about care coordination was added (21b) (see table below).
State Officials	27a	What about in terms of measuring performance (in terms of quality, utilization, and cost)?	What about in terms of improving and measuring performance (in terms of quality, utilization, and cost)?	Revised to ask about improving performance in addition to measuring it.
State Officials	28	What state and/or federal health IT-focused projects or programs does [state] participate in? (e.g., EHR payment incentive programs through Medicare and Medicaid, Health Information Exchange grants to the state)	What state and/or federal health IT-focused projects or programs does [state] participate in? (e.g., EHR payment incentive programs through Medicaid, regional health extension centers, Health Information Exchange grants to the state)	Removed language asking about incentive programs through Medicare (now the question only asks about incentive programs through Medicaid), and added language asking about regional extension centers.

Protocol	Question #	Original Wording	Revised Wording	Reason for Revision
State Officials	35aiii	Patient participation or behavior? (e.g., patients engaging more in decisions and managing their care)	Patient and family caregiver participation or behavior? (e.g., patients engaging more in decisions and managing their care, use of patient and family advisory boards for practice quality improvement efforts)	Revised to ask about family caregiver participation or behavior in addition to patient participation or behavior.
State Officials	36aiii	Patient participation or behavior? (e.g., patients engaging more in decisions and managing their care)	Patient and family caregiver participation or behavior? (e.g., patients engaging more in decisions and managing their care, use of patient and family advisory boards for practice quality improvement efforts)	Revised to ask about family caregiver participation or behavior in addition to patient participation or behavior.
State Officials	37e	For patients?	For patients and family caregivers?	Revised to ask about major barriers to achieving the goals of this initiative for family caregivers in addition to barriers for patients.
Payers	21	What activities has your [plan / organization undertaken to support participating practices or the [state-specific name of PCMH initiative] in general? For example, have you provided more timely or user-friendly data? Disease management support? Support for learning collaboratives? Practice coaches or consultants?	What activities has your [plan / organization] undertaken to support participating practices or the [state-specific name of PCMH initiative] in general? For example, have you solicited member input on the medical home model or provided information to members on their medical home? Have you provided more timely or user-friendly data? Care coordination or disease management support? Support for learning collaboratives? Practice coaches or consultants?	Revised to probe about the extent to which payers have solicited input from or provided information to their members about the patient-centered medical home.

Protocol	Question #	Original Wording	Revised Wording	Reason for Revision
Payers	21b	Have you reached out to or undertaken any activities with consumers and [beneficiaries / plan members] served by participating practices? In so, please briefly describe. If not, why not?	Have you reached out to or undertaken any activities with consumers and [beneficiaries / plan members] served by participating practices? In so, please describe. If not, why not?	Revised so that the respondent is asked to provide a longer response, not a brief one.
Payers	23	Since the state initiative began, how successful has the [state-specific name of PCMH initiative] been in getting practices to change the way they deliver care?	Since the state initiative began, how successful has the [state-specific name of PCMH initiative] been in getting practices to change the way they deliver care, particularly improving access, care coordination and transitions, and making linkages with community health resources?	Revised to ask specifically about the state's degree of success in improving access, care coordination and transitions, and linkages to community health resources.
Payers	27aiii	Patient participation or behavior? (e.g., patients engaging more in decisions and managing their care)	Patient and family participation or behavior? (e.g., patients engaging more in decisions and managing their care)	Revised to ask specifically about the initiative's impact on family participation or behavior in addition to patient participation or behavior.
Payers	30	[Before Visit] [Optional] Have you conducted, or do you plan on conducting, a patient experience survey among your [members / beneficiaries]?	[Before Visit] [Optional] Have you conducted, or do you plan on conducting, a patient experience survey among your [members / beneficiaries]? We are particularly interested in any survey that may more specifically assess aspects of the medical home, such as C-G CAHPS or the newly developed PCMH CAHPS.	Revised to specifically ask about surveys that assess the medical home approach.

Protocol	Question #	Original Wording	Revised Wording	Reason for Revision
Community Health [Teams/ Networks]	6	Prior to [2011/2012]—when Medicare [and Medicaid (if joined at the same time0] joined [name of state]'s [state-specific name of PCMH initiative]—what were the most significant problems that practices involved in this initiative faced in serving Medicare [and Medicaid (if joined at the same time)] beneficiaries?	Prior to [2011/2012]—when Medicare [and Medicaid (if joined at the same time0] joined [name of state]'s [state-specific name of PCMH initiative]—what were the most significant problems that practices involved in this initiative faced in serving Medicare [and Medicaid (if joined at the same time)] beneficiaries and their families or caregivers?	Revised to ask about the problems that practices faced in serving Medicare (and potentially Medicaid depending on the specifics of the state initiative) beneficiaries' families or caregivers, in addition to the beneficiaries themselves.
Community Health [Teams/ Networks]	7	[Optional] What were the most important features of [name of state]'s [state-specific name of PCMH initiative] implemented prior to [2011/2012]?	What were the most important features of [name of state]'s [state-specific name of PCMH initiative] implemented prior to [2011/2012]?	Removed "optional" status due to increased importance of the question.
Community Health [Teams/ Networks]	7b	[Optional] Now that Medicare [and Medicaid (joined at the same time)] has joined the effort, what features of [name of state]'s [state-specific name of PCMH initiative] are most important?	Now that Medicare [and Medicaid (joined at the same time)] has joined the effort, what features of [name of state]'s [state-specific name of PCMH initiative] are most important?	Removed "optional" status due to increased importance of the question.
Community Health [Teams/ Networks]	12	[Optional] [Before Visit] How were community health [Teams/ networks] paid prior to [2011/2012]—before Medicare [and Medicaid (if joined at the same time)] joined the demonstration? What major changes have been made since Medicare [and Medicaid (if joined at the same time)] joined, if any?	[Optional] [Before Visit] How were community health [Teams/ networks] paid prior to [2011/2012]—before Medicare [and Medicaid (if joined at the same time)] joined the demonstration? What major changes have been made since Medicare [and Medicaid (if joined at the same time)] joined, if any?	Removed "optional" status due to increased importance of the question.

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Community Health [Teams/ Networks]	15	[Before Visit] What types of health information technology capabilities does [name of organization] use to carry out its functions? For example, do you use web portals maintained by payers or referral tracking databases developed by the community health [team / network]?	[Before Visit] What types of health information technology capabilities does [name of organization] use to carry out its functions? For example, do you use web portals maintained by payers or participating practices or referral tracking databases developed by the community health [team / network]?	Revised to probe specifically about webportals maintained by practice participating in the initiative.
Community Health [Teams/ Networks]	21ai	Assign a staff member within your community health [team / network] to a patient?	Assign a staff member within your community health [team / network] to a patient and/or their family or caregiver?	Revised to probe specifically about whether community health Teams/ networks assign a staff member to a patient's family or caregiver in addition to asking about whether a network / team assigns a staff member to the patient.
Community Health [Teams/ Networks]	21aii	Follow up with patients after they are discharged from a hospital? ER?	Follow up with patients and/or their family or caregiver after they are discharged from a hospital? ER?	Revised to probe specifically about whether community health Teams/ networks follow up with a patient's family or caregiver in addition to the patient.
Community Health [Teams/ Networks]	21aiv	Coordinate care with specialists?	Coordinate care with specialists (e.g., physical and mental health)?	Revised to probe specifically about whether community health Teams/ networks coordinate care with physician and mental health specialists.
Community Health [Teams/ Networks]	21avii	Work with patients to address challenges they may face caring for themselves?	Work with patients and families or caregivers to address challenges they may face caring for themselves?	Revised to probe specifically about whether community health Teams/ networks work with families or caregivers in addition to patients.

Protocol	Question #	Original Wording	Revised Wording	Reason for Revision
Community Health [Teams/ Networks]	25	What are patients' reactions when you contact them?	What are patients' reactions when you contact them? What do they see as the potential benefits of working with a community health network/team? What do they see as the potential drawbacks, if any?	Revised to ask about patients' perception of the benefits and drawbacks of working with a community health team or network.
Community Health [Teams/ Networks]	28a	[Optional] Which quality data did your community health [team / network] or your assigned practices begin collecting and sharing once Medicare [and Medicaid (if joined at the same time)] joined the [state-specific name of PCMH initiative]? Were any quality and safety measures added or dropped?	Which quality data did your community health [team / network] or your assigned practices begin collecting and sharing once Medicare [and Medicaid (if joined at the same time)] joined the [state-specific name of PCMH initiative]? Were any quality and safety measures added or dropped?	Removed "optional" status due to increased importance of the question.
Community Health [Teams/ Networks]	28aii	[Optional] Are there any chronic conditions your community health [team / network] or your assigned practices collect or share data on?	Are there any chronic conditions your community health [team / network] or your assigned practices collect or share data on?	Removed "optional" status due to increased importance of the question.
Community Health [Teams/ Networks]	30a	What quality and safety measures are reported back to you?	What other measures (e.g., utilization) are reported back to you?	Revised to reflect that the interview protocol asks about quality and safety measures in an earlier question.
Professional Association	9a	What do the care coordinators do? What kind of services do they provide to the practices and/or the practice's patients?	What do the care coordinators do? What kind of services do they provide to the practices and/or the practice's patients and families?	Revised to probe about patients' families instead of only patients.

Protocol	Question #	Original Wording	Revised Wording	Reason for Revision
Local Chapters of Physician and Clinical Professional Associations	9b	How do care coordinators coordinate with specialists, hospitals, mental health and nursing facilities, and community services?	How do care coordinators work with specialists, hospitals, mental health and nursing home facilities, and community services?	Revised to eliminate redundant language and also revised to ask specifically about nursing home facilities in addition to the other types of providers already listed in the question.
Local Chapters of Physician and Clinical Professional Associations	10b	[If needed:] What do you think patients see as the main strengths and weaknesses of the model?	[If needed:] What do you think patients and families see as the main strengths and weaknesses of the model?	Revised to probe specifically about patients' families in addition to patients themselves.
Local Chapters of Physician and Clinical Professional Associations	22aiii	Patient participation or behavior? (e.g., patients engaging more in decisions and managing their care)	Patient and family or caregiver participation or behavior? (e.g., patients engaging more in decisions and managing their care)	Revised to probe specifically about patients' families or caregivers in addition to patients themselves.
Office of Aging Staff and Other Patient Advocates	2ai	Patients having access to care when they need it? Could you give me an example of that?	Patients and families or caregivers having access to care when they need it? Could you give me an example of that?	Revised to probe specifically about patients' families or caregivers in addition to patients themselves.
Office of Aging Staff and Other Patient Advocates	2aii	Effective communication between these patients and practice staff (including doctors and other staff)? Could you give me an example of that?	Effective communication between patients, families or caregivers, and practice staff (including doctors and other staff)? Could you give me an example of that?	Revised to probe specifically about patients' families or caregivers in addition to patients themselves.
Office of Aging Staff and Other Patient Advocates	2aiv	Patients being better able to self-manage their health and medical conditions?	Patients and families or caregivers being better able to self-manage their health and medical conditions?	Revised to probe specifically about patients' families or caregivers in addition to patients themselves.

Protocol	Question #	Original Wording	Revised Wording	Reason for Revision
Office of Aging Staff and Other Patient Advocates	8aii	Coordination of care?	Coordination of care or care transitions?	Revised to ask about evidence of improvements in care transitions in addition to coordination of care.
Office of Aging Staff and Other Patient Advocates	9a	Do you anticipate better access to care? If so, please explain how.	Do you anticipate better access to care? If so, please explain how. For example, through expanded office hours, additional practice staff, on-line access to the practice and electronic health information?	Revised to probe about specific ways that a practice can improve access.
Office of Aging Staff and Other Patient Advocates	9b	Do you anticipate more effective participation in health care decisions? If so, please explain how.	Do you anticipate more effective patient and family or caregiver participation in health care decisions? If so, please explain how. For example, through more active role in care management plans, greater use of shared decision-making tools, explicit conversation about whether other family or caregivers should be involved in care and how?	Revised to probe specifically about patients and family or caregiver participation and to provide specific examples of ways that practices can encourage more patient and family or caregiver participation in health care decisions.
Office of Aging Staff and Other Patient Advocates	9c	Do you anticipate increased engagement in health behaviors (e.g., healthy diet and exercise)? If so, please explain how.	Do you anticipate increased engagement in healthy behaviors (e.g., healthy diet and exercise)? If so, please explain how. For example, through motivational interviewing or brief counseling by providers, educational materials made available in appropriate languages and literacy levels, linkages to local health and wellness classes provided by local community groups?	Revised to include examples of ways of engaging patients in healthy behaviors.

Protocol	Question #	Original Wording	Revised Wording	Reason for Revision
Office of Aging Staff and Other Patient Advocates	9d	Do you anticipate increased adherence to preventive services? For example, cancer screening, smoking cessation, influenza vaccination, or pneumonia vaccination.	Do you anticipate increased adherence to preventive services? For example, cancer screening, smoking cessation, influenza vaccination, or pneumonia vaccination. For example, through motivational interviewing or brief counseling by providers, educational materials made available in appropriate languages and literacy levels, linkages to local community resources?	Revised to include additional examples of ways that practices can improve adherence to preventive services.
Office of Aging Staff and Other Patient Advocates	9e	Do you anticipate better management of their chronic health conditions (e.g., diabetes)? If so, please explain how.	Do you anticipate better management of their chronic health conditions (e.g., diabetes)? If so, please explain how. For example, through motivational interviewing or brief counseling by providers, educational materials made available in appropriate languages and literacy levels, better self-management skills, linkages to local community health networks/teams or resources?	Revised to include examples of ways in which practices can improve management of chronic conditions.
Office of Aging Staff and Other Patient Advocates	9f	Do you anticipate better coordination of care, such as between primary care and specialists or physicians and hospitals? If so, please explain how.	Do you anticipate better coordination of care, such as between primary care and specialists or physicians and hospitals? If so, please explain how. For example, though new care coordinators in practices or health plans and community health networks/teams working with practices.	Revised to include examples of ways that practices can improve care coordination.
Office of Aging Staff and Other Patient Advocates	10a	For beneficiaries/patients?	For beneficiaries/patients, including special or vulnerable populations?	Revised to probe specifically about major barriers for special or vulnerable populations

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Medical Home Practices (Physicians, Office Managers and Other Staff)	8b	[If needed:] What do you think patients see as the main strengths and weaknesses of the model?	[If needed:] What do you think patients and families or caregivers see as the main strengths and weaknesses of the model?	Revised to probe specifically about patients' families or caregivers in addition to patients themselves.
Medical Home Practices (Physicians, Office Managers and Other Staff)	9e	What major changes did your [office / clinic / hospital] make to become recognized as a medical home or to be eligible for the [state initiative] when it first began in [year that the state initiative began] (e.g., focusing on new conditions, using new care processes, adopting new health IT tools, interacting differently with patients)	What major changes did your [office / clinic / hospital] make to become recognized as a medical home or to be eligible for the [state initiative] when it first began in [year that the state initiative began] (e.g., focusing on new conditions, improving access through additional evening and weekend hours or same-day appointments, using new care processes to improve care coordination and transitions, adopting new health IT tools, interacting differently with patients and families or caregivers)	Revised to probe specifically about changes practices made to improve access through additional hours and same-day appointments; care coordination and transitions; and interaction with patients' families or caregivers in addition to patients themselves.
Medical Home Practices (Physicians, Office Managers and Other Staff)	13	How have your interactions with patients changed—before, during, and after a visit--since you became a medical home?	How have your interactions with patients and families or caregivers changed since you became a medical home—before, during, and after a visit?	Revised to probe specifically about patients' families or caregivers in addition to patients themselves.
Medical Home Practices (Physicians, Office Managers and Other Staff)	13f	Are there any major differences for Medicare or Medicaid patients or special populations (e.g., dual eligibles, patients with chronic conditions)?	Are there any major differences in the extent to which Medicare or Medicaid patients or special populations (e.g., dual eligibles, patients with chronic conditions) are willing and able to engage in these patient and family or caregiver engagement activities? If so, please describe these major differences.	Revised to probe about differences in the level of engagement in these activities among Medicare or Medicaid patients or special populations.

Protocol	Question #	Original Wording	Revised Wording	Reason for Revision
Medical Home Practices (Physicians, Office Managers and Other Staff)	14f	Why not?	Why not? Who coordinates care for your patients?	Revised to probe about who coordinates care for patients.
Medical Home Practices (Physicians, Office Managers and Other Staff)	15	[Before Visit] Does your practice work with a community health [team / network]?	[Before Visit] Does your practice work with a community health [team / network] and/or develop linkages with other local community health resources?	Revised to ask if practices develop linkages with other local community health resources.
Medical Home Practices (Physicians, Office Managers and Other Staff)	15a	What do they do? What kind of services do they provide to your [office / clinic / hospital] and/or your patients?	What do these community health [team/network] do and/or how do you make linkages with other local community health resources? What kind of services do they provide to your [office / clinic / hospital] and/or your patients?	Revised to ask what community health teams or networks do and how practices make linkages to community resources.
Medical Home Practices (Physicians, Office Managers and Other Staff)	15b	What specific types of patients does your community health [team / network] focus on? (e.g., Medicare or Medicaid patients, special populations of patients. Special populations can include: Medicare and Medicaid dual eligibles; children; racial and ethnic subgroups; people living in rural or inner-city areas; and persons with chronic illnesses, mental illnesses, and disabilities.) How do they decide which patients to focus on?	What specific types of patients does your community health [team / network] and/or other local community resource(s) focus on? (e.g., Medicare or Medicaid patients, special populations of patients. Special populations can include: Medicare and Medicaid dual eligibles; children; racial and ethnic subgroups; people living in rural or inner-city areas; and persons with chronic illnesses, mental illnesses, and disabilities.) How do they decide which patients to focus on?	Revised to ask about other local community resources.

Protocol	Question #	Original Wording	Revised Wording	Reason for Revision
Medical Home Practices (Physicians, Office Managers and Other Staff)	15c	How do you communicate with your community health team / network]?	How do you communicate with your community health team / network] and/or other local community resource(s)?	Revised to ask about other local community resources.
Medical Home Practices (Physicians, Office Managers and Other Staff)	15d	What have been the benefits of working with a community health [team / network]?	What have been the benefits of working with a community health [team / network] and/or other local community resource(s)?	Revised to ask about other local community resources.
Medical Home Practices (Physicians, Office Managers and Other Staff)	15e	What have been some drawbacks of using a community health [team / network]?	What have been some drawbacks of using a community health [team / network] and/or working with other local community health resources?	Revised to ask about other local community resources.
Medical Home Practices (Physicians, Office Managers and Other Staff)	19	Does your [office / clinic / hospital] typically exchange medical records with other providers and health care facilities?	Does your [office / clinic / hospital] typically exchange medical records with other providers (e.g., physical and mental health specialists, diagnostic testing or laboratory) and health care facilities, such as hospitals or nursing homes?	Revised to probe about physical and mental health specialists, diagnostic testing or laboratory.

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Medical Home Practices (Physicians, Office Managers and Other Staff)	20	Does your [office / clinic / hospital] typically receive medical records from other providers and health care facilities?	Does your [office / clinic / hospital] typically receive medical records from other providers (e.g., physical and mental health specialists) and health care facilities (e.g., hospitals, mental health facilities, diagnostic testing facilities, laboratories)?	Revised to probe about physical and mental health specialists, diagnostic testing or laboratory.
Medical Home Practices (Physicians, Office Managers and Other Staff)	24a	Are you participating in the Medicare or Medicaid EHR payment incentive program?	Are you participating in the Medicare or Medicaid EHR payment incentive program? If so, from your perspective, how well aligned are stage 1 meaningful use criteria and the clinical quality and other reporting requirements for [state-specific name of PCMH initiative]? To what extent are the measures for both initiatives similar or different?	Revised to ask about the extent to which stage 1 meaningful use criteria and the initiative's reporting requirements are aligned.
Medical Home Practices (Physicians, Office Managers and Other Staff)	28bi	Are these quality results broke out by payer type (e.g., Medicare, Medicaid, commercial payers?)	Are these quality results broke out by payer type (e.g., Medicare, Medicaid, commercial payers) or demographic (e.g., race/ethnicity), language, gender or disability categories?	Revised to ask if quality results are broken down by patient demographics.
Medical Home Practices (Physicians, Office Managers and Other Staff)	31aiii	Patient participating or behavior? (e.g., patients engaging more in decisions and managing their care)	Patient and family or caregiver participating or behavior? (e.g., patients engaging more in decisions and managing their care)	Revised to probe specifically about patients' families or caregivers in addition to patients themselves.

Summary of New Questions Added to Existing Site Visit Interview Protocols in Response to Public Comments Received Regarding CMS's Planned Information Collection for the Evaluation of the Multi-payer Advanced Primary Care Practice Demonstration
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Protocol	Question #	New Question Added	Reason for Addition
State Officials	3	Briefly describe the major goals of the [state-specific name of the PCMH initiative]?	Added so that the interviewer can probe about stakeholder involvement, including consumers or patients, in setting goals and monitoring implementation.
State Officials	3a	How were key stakeholders, including consumers or patients, involved in setting the goals for [state-specific name of the PCMH initiative]?	Added to probe about stakeholder involvement, including patients and consumers, in setting the initiative's goals.
State Officials	3b	How are key stakeholders, including consumers or patients currently involved in monitoring the implementation of [state-specific name of the PCMH initiative] and providing input on any aspects that need to be more fully articulated or refined?	Added to probe about stakeholder monitoring of the initiative's implementation and their degree of input, if any, on implementation issues.
State Officials	15aii	Do any of these new services focus on improving care coordination or care transition, including transitions from hospital to home? If so, how?	Added to probe specifically about new care coordination and transition services.
State Officials	20	Please describe briefly the kinds of technical assistance or supports the [state-specific name of the PCMH initiative] is providing to support the development of greater medical home capacity as reflected in medical home assessment or recognition tool level or score? For example, learning collaboratives, practice coaching or consultation, care coordinators, etc.	Added to ask specifically about the technical assistance that the initiative provides to practices trying to develop greater medical home capacity.
State Officials	20a	What are the strengths of the technical assistance and practice supports put in place by [state-specific name of PCMH initiative?	Added to probe about the strengths of the initiative's medical home technical assistance to practices.

Protocol	Question #	New Question Added	Reason for Addition
State Officials	20b	What are the challenges or areas for improvement needed with respect to technical assistance or practice supports put in place by [state-specific name of PCMH initiative]?	Added to probe about the weaknesses of the initiative's medical home technical assistance to practices.
State Officials	21b	How, if at all, do you feel these changes impact care coordination or care transitions, including from transitions from hospital to home? We are particularly interested in the impact on Medicare, Medicaid, and special populations.	Added to ask in a separate probe question about care coordination (previously this was included in 21a) and care transitions (which was not asked about in 21a).
State Officials	21c	How, if at all, do you feel these changes impact patient and family engagement? For example, identifying and involving key family members involved in care, self-management skills, and development of care plans or shared decision making?	Added to probe specifically about the impact of practice changes on patient and family engagement.
State Officials	30	To what extent are EHR requirements and related clinical quality measures used by the [state-specific name of PCMH initiative] aligned with Medicare and Medicaid Meaningful Use (MU) measures? For example, have stage 1 MU requirements to collect demographic information, provide on-line access to patients, or report particular clinical quality measures been incorporated into the medical home assessment or recognition criteria?	Added to ask about the degree of alignment between the initiative's EHR requirements and Medicare and Medicaid's Meaningful Use measures.
State Officials	31c	How aligned are the states' clinical quality measure and other reporting requirements with those required for other CMS programs?	Added to probe about the degree of alignment between state clinical quality measures and others required by other CMS programs.
State Officials	37d	For community health teams or networks?	Added to probe about major barriers to achieving the goals of the initiative for community health teams or networks.

Protocol	Question #	New Question Added	Reason for Addition
Payers	22	What activities has your [plan / organization] undertaken to support community health networks / teams or other community resources or linkages between primary care practices and these networks / teams or other community resources? For example, do you work directly with state and local social service agencies such as housing departments, office of aging or transportation services for the disabled?	Added to ask whether and to what extent the payer engages in any activities that would create links between primary care practices and community resources or community health Teams/ networks.
Payers	22a	How do encourage and help support primary care practices' efforts to create linkages to and work with these community networks / teams or other community resources?	Added to probe about payer activities that support and encourage practices' own efforts to create linkages with the community or community health Teams/ networks.
Payers	24	What state and/or federal health IT-focused projects or programs does [payer] participate in? (e.g., Health Information Exchange grants to the state, Beacon communities)	Added to ask about payer activities related to state and/or federal health information technology projects.
Payers	25	What has [payer] done to support [medical home / health care home] practices in health IT implementation or upgrade? For example, does the [payer] have any financial incentive for practices to implement or upgrade their electronic health record (EHR) and/or electronically exchange data with the plan and other providers?	Added to ask about payer activities in support of practices in health information technology implementation or upgrade.
Payers	26	To what extent are EHR requirements and quality measures used by [state-specific name of PCMH initiative] aligned with the Medicare and Medicaid Meaningful Use (MU) measures? For example, have stage 1 MU requirements to collect demographic information, provide on-line access to patients, or report particular clinical quality measures been incorporated into the medical home assessment or recognition criteria?	Added to ask about the alignment between 1) the initiative's EHR requirements and quality measures and 2) the Medicare and Medicaid Meaningful Use measures.

Protocol	Question #	New Question Added	Reason for Addition
Payers	28biii	How aligned is your plan and states' clinical quality measure and other reporting requirements aligned with those required for other CMS programs?	Added to ask about the extent of alignment among the payer's quality reporting, state quality reporting, and requirements for other CMS programs.
Community Health [Teams/ Networks]	27a	Do you or participating practices ask adult patients who, if anyone, they want involved in their care and what role they would play? If so, is that information recorded in their electronic or paper medical record?	Added to find out if community health Teams/ networks record in patient medical records who, if anyone, patients want involved in their care.
Community Health [Teams/ Networks]	29b	Are these quality and safety measures stratified by payer and/or other patient characteristics, such as demographics (e.g., race/ethnicity), language, gender, or disability?	Added to find out if the quality and safety measures reported back to community health Teams/ networks are stratified by a range of patient characteristics.
Community Health [Teams/ Networks]	30b	Are these other measures (e.g., utilization) stratified by payer and/or other patient characteristics, such as demographics (e.g., race/ethnicity), language, gender, or disability?	Added to find out if the other measures reported back to community health Teams/ networks (such as utilization) are stratified by a range of patient characteristics.
Local Chapters of Physician and Clinical Professional Associations	6	We understand your state uses [name of state's medical home assessment or recognition tool]. Why was that tool selected or developed?	Added to ask about the state's reasons for selecting its medical home assessment or recognition tool.
Local Chapters of Physician and Clinical Professional Associations	6a	How well do you feel it assesses a practice's medical home capabilities?	Added to determine the respondent's opinion on how well the tool assesses medical home capabilities.
Local Chapters of Physician and Clinical Professional Associations	6b	How is this medical home assessment or recognition information used? For example, does the state and/or your organization use it to guide learning collaborative activities? To determine practice payment levels?	Added to find out how the medical home assessment or recognition information is used in the initiative.

Protocol	Question #	New Question Added	Reason for Addition
Local Chapters of Physician and Clinical Professional Associations	8a	Access, such as same-day appointments or extended evening or weekend hours?	Added to probe specifically about improvements in access.
Local Chapters of Physician and Clinical Professional Associations	8b	Care coordination and care transitions with other practices, hospitals, and other nearby health providers such as mental health facilities or nursing homes?	Added to probe specifically about improvements in care coordination and care transitions.
Local Chapters of Physician and Clinical Professional Associations	8c	Linkages with community health [Teams/ networks] and resources?	Added to probe specifically about improvements in linkages with community health [Teams/ networks] and resources
Local Chapters of Physician and Clinical Professional Associations	8d	Patient and family caregiver engagement at the individual and practice level? For example, more involvement in care plans, shared decision-making, patient and family caregiver input on quality improvement efforts by the practice?	Added to probe specifically about improvements in patient and family caregiver engagement.
Local Chapters of Physician and Clinical Professional Associations	16	To what extent are EHR requirements and quality measures used by [state-specific name of PCMH initiative] aligned with the Medicare and Medicaid Meaningful Use (MU) measures? For example, have stage 1 MU requirements to collect demographic information, provide on-line access to patients, or report particular clinical quality measures been incorporated into the medical home assessment or recognition criteria?	Added to ask about the extent of alignment between the initiative's EHR requirements and quality measures in Medicare and Medicaid's Meaningful Use measures.

Protocol	Question #	New Question Added	Reason for Addition
Local Chapters of Physician and Clinical Professional Associations	19aiv	How aligned are the state's clinical quality measures and other reporting requirements aligned with those required for other CMS programs?	Added to ask about the extent of alignment between the initiative's EHR requirements and quality measures and other CMS programs.
Local Chapters of Physician and Clinical Professional Associations	19bii	Are these quality results broken down by patient demographics (race/ethnicity), gender, language, or disability status?	Added to find if quality measurements results are broken down by a range of patient characteristics.
Office of Aging Staff and Other Patient Advocates	2aiii	How do practices, community health [teams/networks], and plans communicate with patients? Families or caregivers? Patients who do not speak or cannot read English?	Added to probe specifically about practice, payer, and community health team / network communication with patients and their families or caregivers.
Office of Aging Staff and Other Patient Advocates	3a	Were you involved in planning of the demonstration, including goal setting?	Added to inquire about the respondent's role in the planning stages of the demonstration.
Office of Aging Staff and Other Patient Advocates	3b	To what extent are you involved in implementing or monitoring the implementation of the [state-specific name of PCMH initiative], formally and informally, if at all?	Added to probe about extent of the respondent's role in the planning stages of the demonstration.
Office of Aging Staff and Other Patient Advocates	3c	To what extent are you asked and given opportunities to provide input into how to refine the [state-specific name of PCMH initiative], formally and informally, if at all?	Added to probe about the respondent's opportunities to provide input on the initiative.
Office of Aging Staff and Other Patient Advocates	8c	To what extent do the impacts observed differ depending on demographics (e.g., race/ethnicity), language, gender, or disability status?	Added to find out if the initiatives impacts differ based on patient demographics.

Protocol	Question #	New Question Added	Reason for Addition
Office of Aging Staff and Other Patient Advocates	10c	For community health networks/teams and/or other local community health resources linked to participating practices?	Added to probe about major barriers for community health teams/networks and/or other local community resources linked to practices.
Practices	13b	What efforts has the practice undertaken to improve patient self-management skills and/or engage in care planning and shared decision-making?	Added to probe about patient self-management, care planning, and shared decision-making.
Practices	13c	How do you communicate with patients who do not speak or cannot read English? Does the practice screen for language or literacy problems? Does the practice arrange for translators or other services or information products	Added to probe about the ways that practices communicate with patients who do not speak English.
Practices	13d	Do you ask adult patients who, if anyone, they want involved in their care and what role they would play? If so, is that information recorded in the electronic or paper medical record?	Added to probe about whether practices include in the patient's medical record the people the patient wants involved in their care.
Practices	13e	To what extent do you involve patients and families or caregivers in practice quality improvement or redesign efforts?	Added to probe about the extent to which practices involve patients and families or caregivers in quality improvement efforts.
Practices	21	Do patients and families or caregivers have on-line access to the practice and their medical record information? If so, through what mechanisms (e.g., web-portal, personal health record) and what kind of services (e.g., e-visits) or information can they access?	Added to ask about patient and family or caregiver access to medical record information online.

Summary of Questions Removed From Existing Site Visit Interview Protocols in Response to Public Comments Received Regarding CMS's Planned Information Collection for the Evaluation of the Multi-payer Advanced Primary Care Practice Demonstration
(Document Identifier: CMS-10436)

Protocol	Question #	Deleted Question	Reason for Deletion
Community Health [Teams/ Networks]	N/A	Work with patients to address challenges they may face caring for themselves?	Deleted because the question was duplicative.

Summary of Questions from New Site Visit Interview Protocols (Added After the 60-day Comment Period)

Protocol	Question #	New Question Added	Reason for Addition
Community-based Care Networks	1	How long have you been with your network?	Added to obtain information about the respondent's background and responsibilities.
Community-based Care Networks	2-2b	Please tell me about your roles and responsibilities with the network. How long have you served in this role at the network? Were you previously with a similar kind of organization?	Added to obtain information about the respondent's background and responsibilities.
Community-based Care Networks	3	Please tell me about the staff composition of your network, including health care professionals, care managers, and administrative staff.	Added to obtain information about the organization's composition.
Community-based Care Networks	4	How many practices are part of your network? How many of these participate in the multipayer medical home demonstration?	Added to obtain information about the organization's composition.
Community-based Care Networks	5	How does your network communicate with practices?	Added to obtain information about of the organization's functions.
Community-based Care Networks	6	We understand that NC networks connect patients and community-based resources, provider care coordination for care transitions, support beneficiary self-care, and facilitate practice improvement and transformation. Is this an accurate capture of what your network does in support of the practices? What additional services do you provide? Which of these services are the most important for NC medical home demonstration? Why?	Added to obtain information about the organization's functions.
Community-based Care Networks	7	How do you track what care is delivered by what provider to which patient?	Added to obtain information about the organization's functions.
Community-based Care Networks	8	Prior to 2011—when Medicare joined NC's medical home demonstration—what were the most significant problems that practices faced in serving Medicare beneficiaries?	Added to obtain information about the problems facing Medicare beneficiaries.
Community-based Care Networks	9	What were the most important medical home features in the NC initiative prior to 2011?	Added to provide background information on the state's initiative.

Protocol	Question #	New Question Added	Reason for Addition
Community-based Care Networks	10	Now that Medicare has joined the effort, what new features were added to your medical home efforts?	Added to provide background information on the state's initiative.
Community-based Care Networks	11	What changes did you have to make to accommodate Medicare's participation?	Added to get a better sense of the organization's functions.
Community-based Care Networks	12-12b	How is the implementation of the NC demonstration with Medicare's involvement going so far? What has gone well? What hasn't gone well?	Added to obtain background information on the state's initiative.
Community-based Care Networks	13	What do you think are the strengths and weaknesses of the NC multi-payer medical home demonstration?	Added to obtain background information on the state's initiative.
Community-based Care Networks	14	What challenges do you anticipate in the future?	Added to obtain background information on the state's initiative.
Community-based Care Networks	15	What opportunities for improvement do you anticipate in the future?	Added to obtain background information on the state's initiative.
Community-based Care Networks	16	How were community care networks paid prior to 2011-before Medicare joined the demonstration? What changes did your network or practices have to make to accommodate Medicare's participation?	Added to obtain information about how the networks and practices are paid under the state's initiative.
Community-based Care Networks	17	What are the strengths of the current payment methodology for community health networks and practices? What are the weaknesses?	Added to obtain information about how the networks and practices are paid under the state's initiative.
Community-based Care Networks	18	Are the current payments sufficient to support collaboration and linkages between primary care practices, networks, and CCNC/NCCCN?	Added to obtain information about how the networks and practices are paid under the state's initiative..
Community-based Care Networks	19	Are the current payments sufficient to improve quality, utilization, and cost outcomes?	Added to obtain information about how the networks and practices are paid under the state's initiative.

Protocol	Question #	New Question Added	Reason for Addition
Community-based Care Networks	20-20a	We understand that as part of the multi-payer medical home initiative, practices are required to meet Blue Quality Physician Program standards, which require electronic prescribing and claims submission. What also understand that CCNC's informatics center provides a web-based portal for practices to monitor data at a state-, network-, practice- and patient-level. Finally, we have also learned that case managers use a case management system. Are there other types of health information technology that you use for North Carolina's multi-payer medical home initiative? We'd like to learn more about each of these systems.	Added to obtain information about health information technology use under the state's initiative.
Community-based Care Networks	21	What experiences does your network and practices have in meeting the Blue Quality Physician Program standards? What benefit does this system bring to the network and practices?	Added to obtain information about the Blue Quality Physician Program standards.
Community-based Care Networks	22	How does your network and practices use CCNC's web-based portal? What benefit does this portal bring to the network and practices? How often do you use it?	Added to obtain information about the CCNC's web-based portal.
Community-based Care Networks	23-23b	How do you use the Care Management Information System? What benefit does this system bring? How often do case managers use it and how?	Added to obtain information about the Care Management Information System.
Community-based Care Networks	24	Which of these systems allows you to track services provided to patients?	Added to gain a better understanding of networks' capacity to track services provided to patients.
Community-based Care Networks	25	To what extent can you readily exchange health information with primary care practices? Other practices/facilities (e.g., specialists, hospitals, long-term care facilities)?	Added to obtain information about health information technology use under the state's initiative.
Community-based Care Networks	26-26a	We understand that your network receives daily admission, discharge, and transfer lists for Medicare patients. How is it working? How far along are you in the process of receiving real time hospital admission and discharge information for these patients and those covered by BCBS or the State health Plan?	Added to gain a better understanding of the hospital admission, discharge, and transfer lists received by the networks.

Protocol	Question #	New Question Added	Reason for Addition
Community-based Care Networks	27	What challenges pertaining to health information technology do you face? How has your participation in the NC demonstration changed the amount or frequency with which you use health information technology?	Added to obtain information about health information technology use under the state's initiative.
Community-based Care Networks	28	What additional health IT features would help your community health network do a better job assisting/communicating with patients? Practices?	Added to obtain information about health information technology use under the state's initiative.
Community-based Care Networks	29-29b	What kinds of structural or organizational changes did your network make pre-2011—before Medicare became involved in the NC demonstration—in an effort to support the medical home model? What additional changes are you working on making now that Medicare is involved in the NC demonstration? What are the major challenges to implementing these additional changes?	Added to obtain information about the organizational changes that networks had to make.
Community-based Care Networks	30-30d	We understand that CCNC has hosted a series of webinars and developed a toolkit to help practices achieve NCQA recognition. We also know that the quality improvement coaches assist practices through the state's Area Health Education Centers. Can you tell use more about these activities? What is the role of quality improvement coaches? How did these tools and resources help networks and practices? How has the ASU PCMH practicum study helped practices to achieve NCQA PCMH recognition? Is this activity on-going?	Added to obtain information about networks' activities related to NCQA recognition.
Community-based Care Networks	31-31a	Now we'd like to discuss with you how beneficiaries access care and their experiences with this care. Please comment on patients overall, but also on whether there are any differences for Medicare or Medicaid beneficiaries or special populations of patients. Special populations can include: Medicare and Medicaid dual eligible; children; racial and ethnic subgroups; people living in rural or inner-city areas; and persons with chronic illnesses, mental illnesses, and disabilities. How do you identify people who need help or how do they get connected with your network? Please describe how you identify Medicare or Medicaid beneficiaries for case management, clinical pharmacy, or any additional services?	Added to obtain information about patients' access to care under the state's initiative.

Protocol	Question #	New Question Added	Reason for Addition
Community-based Care Networks	32-32f	How familiar are you with Medicare's beneficiary assignment process? Do you limit network services to those patients for whom a participating insurer pays a monthly fee and/or only those beneficiaries who have been assigned to the practice? Please describe briefly. How do you currently invite patients to participate? Please tell me about the activities of Patient Outreach Teams. What patient education tools do they provide to patients? How do they distribute those tools? How are patients transitioning between two practices participating in the demonstration identified and handled by the community health network? Please describe briefly. What about patients transitioning from participating practices to non-participating practices or vice versa? How are these patients identified and handled by community health network? How does your network coordinate patient care with primary care practices and other providers or facilities?	Added to gain a better understanding Medicare's beneficiary assignment process.
Community-based Care Networks	33-33k	How does the network or its practices: assign a staff member within your community health network to a patient? Follow up with patients after they are discharged from a hospital? ER? Identify patients for medication reconciliation? Coordinate care with specialists? Provide linkages to other services and facilities like long-term care, mental health, community services, or social services? Work with patients to address challenges they may face accessing care? Work with patients to address challenges they may face caring for themselves? Work with special populations such as the mentally ill to address any challenges they may face? Work with patients to address challenges they may face caring for themselves? Other? Are there any differences in how you or the practices coordinate care for Medicare or Medicaid beneficiaries, or other special populations?	Added to gain a better understanding of a range of networks activities under the state initiative.
Community-based Care Networks	34-34b	How do the practices that are in your network communicate with patients who do not speak or cannot read English? How do practices identify patients with different language or literacy needs? Who does the screening? What tools do they use? Do practices that are part of your network and this demonstration offer translation services?	Added to obtain information about how practices communicate with patients who cannot speak or read English.

Protocol	Question #	New Question Added	Reason for Addition
Community-based Care Networks	35-35a	What strategies do the practices that are part of your network and this demonstration use to engage patients in their care? To what extent are patients, their families, and/or their caregivers actually able to participate more effectively in decisions concerning their care as a result of the NC demonstration? Can you provide an example or do you have any early data on this?	Added to obtain information about patient engagement.
Community-based Care Networks	36-36b	How do the network or practice staff teach self-management to patients? How do patients use self-management notebooks? In your opinion, to what extent are patients actually better able to self-manage their health conditions or engage in healthy behaviors as a result of the NC demonstration? Can you provide an example or do you have any early data on this?	Added to obtain information about patient self-management.
Community-based Care Networks	37	Does your network or participating practices experience any challenges in reaching Medicare or Medicaid beneficiaries, in an effort to improve quality and safety? If so please describe briefly.	Added to obtain information about quality and safety under the state initiative.
Community-based Care Networks	38-38b	What quality and safety data does your network or participating practices collect? Were any quality and safety measures added or dropped since 2011, when Medicare joined the demonstration? Which preventive care services data do your network and participating practices collect or share? These might include cancer screening, smoking cessation, weight management, influenza vaccination, pneumonia vaccination. Please describe briefly. What quality and safety measures are reported back to your network? Are any of these measures new, since 2011?	Added to obtain information about quality and safety under the state's initiative.
Community-based Care Networks	39	How often does CCNC provide these reports?	Added to obtain information about quality and safety under the state's initiative.
Community-based Care Networks	40	How do you use the information provided in these reports?	Added to obtain information about quality and safety under the state's initiative.
Community-based Care Networks	41	What are the most useful features of the quality measure reports you receive?	Added to obtain information about quality and safety under the state's initiative.

Protocol	Question #	New Question Added	Reason for Addition
Community-based Care Networks	42-42f	Does your network or its assigned practices receive data summarizing other dimensions of your patients' care, such as their utilization of health care services? (for example, statistics on your patients' hospital or nursing home admissions or readmissions.) [If yes:] What quality and safety measures are reported back to you? Which of these are measures that you received feedback on prior to 2011—before Medicare joined the NC demonstration? Which of these measures (if any) did you begin to receive feedback on in 2011—when Medicare joined the NC demonstration? What entity provides you with these reports, and how often? How do you use the information provided in these reports? What are the most useful features of the quality measure reports you receive? How could these quality measure reports be made more useful to you? [If no:] If you were to receive a quality measure report, what quality measures would be the most useful to you? If you were to start receiving these types of data on your Medicare patients, how might you use it?	Added to obtain information about the reports that networks and/or practices receive under the state's initiative.
Community-based Care Networks	43-43b	What major areas will your network focus on in the next year? What changes will you make? What do you see as the facilities (or critical factors) of successful implementation of this demonstration? What did you see as the barriers or major challenges to implementing the changes that are part of this demonstration?	Added to obtain information about future activities under the state's initiative
Community-based Care Networks	44	What advice would you give to other networks if the NC demonstration were to be extended or expanded to include them?	Added to obtain information about advice that the respondent would give others.
Community-based Care Networks	45	What advice would you give to CMS (Medicaid and Medicare)? Given what you know now, what would you have done differently, both prior to and after Medicare's involvement in the NC medical home initiative?	Added to obtain information about advice that the respondent would give others.
Community-based Care Networks	46	Is there anything we have not discussed about the NC medical home demonstration or about the Medicare MAPCP Demonstration that you feel would be important for our National Evaluation Team to know?	Added to obtain any other information that was not discussed during the interview.

Protocol	Question #	New Question Added	Reason for Addition
NC Division of Aging and Adult Services (DAAS) & Care Managers	1 (Care Managers)	Are you employed by the [name of network]?	Added to obtain background information on the respondent.
NC Division of Aging and Adult Services (DAAS) & Care Managers	2 (Care Managers)	How long have you worked at [name of network]?	Added to obtain background information on the respondent.
NC Division of Aging and Adult Services (DAAS) & Care Managers	3-3b (Care Managers)	With how many practices or health centers do you work? For how many patients do you coordinate care per month? Which insurers do your patients represent?	Added to obtain background information on the respondent and his/her responsibilities.
NC Division of Aging and Adult Services (DAAS) & Care Managers	4-4b (Care Managers)	What kind of services do you provide to your practices and/or your patients? What specific types of patients do you focus on? (e.g., patients with comorbidities, Medicare and Medicaid dual eligible; children; racial and ethnic subgroups; people living in rural or inner-city areas; persons with Chronic illnesses, mental illnesses, and disabilities). How do you decide which patients to focus on?	Added to obtain background information on the respondent and his/her responsibilities.
NC Division of Aging and Adult Services (DAAS) & Care Managers	5-5a (Care Managers)	How do you communicate with physicians and other staff in your practice? What kind of information do you relay to providers for patients' care?	Added to obtain information about communication between networks and practices.
NC Division of Aging and Adult Services (DAAS) & Care Managers	6 (Care Managers)	What training do you receive? Who provides it?	Added to obtain background information on the respondent.

Protocol	Question #	New Question Added	Reason for Addition
NC Division of Aging and Adult Services (DAAS) & Care Managers	7 (Care Managers)	What kinds of health information technology do you use in case management?	Added to obtain information about health information technology use.
NC Division of Aging and Adult Services (DAAS) & Care Managers	8-8b (Care Managers)	How have EHRs and other health IT changed the way you manage specific cases? What particular features or capabilities have been especially helpful? What technical assistance for the health IT is available to you?	Added to obtain information about health information technology use.
NC Division of Aging and Adult Services (DAAS) & Care Managers	9-9b (Care Managers)	What are some problems with how care is currently delivered to rural, aging, or chronically ill patients in North Carolina? To what extent do you see problems with: Patients having access to care when they need it? Could you give me an example of that? Effective communication between these patients and practice staff (including doctors and other staff)? Could you give me an example of that? Does this include communication related to shared decision-making? Does this include communication related to self-management? Quality of care? Could you give me an example of that? Care coordination, specifically in instances where patients visit a specialist or are seen in a hospital-setting and require follow-up from their primary care provider? Patients being able to better self-manage their health and medical conditions? Do you see any major differences for Medicare beneficiaries, Medicaid beneficiaries, or other special populations?	Added to obtain information about problems in care delivery.
NC Division of Aging and Adult Services (DAAS) & Care Managers	10-10a (Care Managers)	For the problems that you've already identified in caring for rural, aging, and chronically ill patient populations, to what extent is Medicare's participation in the NC demonstration helping to address those issues? How does the NC demonstration improve care for these special populations? Could you give me an example of that?	Added to obtain information about problems in care delivery.

Protocol	Question #	New Question Added	Reason for Addition
NC Division of Aging and Adult Services (DAAS) & Care Managers	11 (Care Managers)	What do you think are the strengths and weaknesses of the medical home model of care?	Added to obtain background information on the medical home model.
NC Division of Aging and Adult Services (DAAS) & Care Managers	12 (Care Managers)	How do you coordinate with BCBS case managers?	Added to obtain information about the respondent's responsibilities.
NC Division of Aging and Adult Services (DAAS) & Care Managers	13-13a (Care Managers)	We understand that the NC Division of Aging and Adult Services provided training/education sessions regarding Medicare benefits and community resources. Did you attend that session? [If Yes:] What is helpful? In what ways?	Added to obtain information about the respondent's responsibilities.
NC Division of Aging and Adult Services (DAAS) & Care Managers	14-14j (Care Managers)	In the NC Demonstration practices, is there evidence of improvement in: access to care; coordination of care; increased adherence to preventive services; reduced acute care utilization, like ED visits, hospitalizations, readmissions; patient experience/satisfaction; self-management of health conditions; engagement in healthy behaviors; shared decision making between primary care providers and patients, their family members, and/or caregivers; health; other?	Added to obtain information about evidence of improvement.
NC Division of Aging and Adult Services (DAAS) & Care Managers	15 (Care Managers)	What recommendations do you have to improve the NC demonstration?	Added to obtain information about areas of the state's initiative that could be improved.
NC Division of Aging and Adult Services (DAAS) & Care Managers	16 (Care Managers)	What are your goals for improving the care delivered to patients in the next year? What are the facilitators of or barriers to their achievement?	Added to obtain information about future plans.

Protocol	Question #	New Question Added	Reason for Addition
NC Division of Aging and Adult Services (DAAS) & Care Managers	17 (Care Managers)	Is there anything else you would like to share about the NC demonstration that we did not cover today?	Added to obtain information about anything that might not have been covered in the interview.
NC Division of Aging and Adult Services (DAAS) & Care Managers	1-1b (DAAS)	Could you tell us a little about your role? How long have you worked at the DAAS? What has your role been in the NC multi-payer medical home demonstration?	Added to obtain background information on the respondent and his/her responsibilities.
NC Division of Aging and Adult Services (DAAS) & Care Managers	2-2b (DAAS)	What are some problems with how care is currently delivered to rural, aging, or chronically ill patients in North Carolina? To what extent do you see problems with: patients having access to care when they need it? Could you give me an example of that? Effective communication between these patients and practice staff (including doctors and other staff)? Could you give me an example of that? Does this include communication related to shared decision-making? Does this include communication related to self-management? Quality of care? Could you give me an example of that? Care coordination, specifically in instances where patients visit a specialist or are seen in a hospital-setting and require follow-up from their primary care provider? Patients being able to better self-manage their health and medical conditions? Do you see any major differences for Medicare beneficiaries, Medicaid beneficiaries, or other special populations?	Added to obtain information about problems in care delivery.
NC Division of Aging and Adult Services (DAAS) & Care Managers	3 (DAAS)	How has the NC Demonstration addressed some of these issues?	Added to obtain information about problems in care delivery and the state's initiative.

Protocol	Question #	New Question Added	Reason for Addition
NC Division of Aging and Adult Services (DAAS) & Care Managers	4 (DAAS)	Which of these issues remain unaddressed by the NC Demonstration?	Added to obtain information about problems in care delivery and the state's initiative.
NC Division of Aging and Adult Services (DAAS) & Care Managers	5-5j (DAAS)	In the NC Demonstration practices, is there evidence of improvement in: access to care; coordination of care; increased adherence to preventive services; reduced acute care utilization, like ED visits, hospitalizations, readmissions; patient experience/satisfaction; self-management of health conditions; engagement in healthy behaviors; shared decision making between primary care providers and patients, their family members, and/or caregivers; health; other?	Added to obtain information about evidence of improvement under the state's initiative.
NC Division of Aging and Adult Services (DAAS) & Care Managers	6 (DAAS)	How has health IT changed care management in practices that are participating in the demonstration?	Added to obtain information about health information technology use.
NC Division of Aging and Adult Services (DAAS) & Care Managers	7 (DAAS)	How could CMS or North Carolina change the demonstration to better serve the needs of the [list earlier identified special populations]? Why would that help?	Added to obtain information about special populations being served under the state's initiative.
NC Division of Aging and Adult Services (DAAS) & Care Managers	8 (DAAS)	If a colleague in another state was interested in advocating for a program like the NC demonstration, what advice would you give them?	Added to obtain information about areas of the state's initiative that could be improved.
NC Division of Aging and Adult Services (DAAS) & Care Managers	9-9a (DAAS)	What are your goals for improving the care delivered to aging and chronically ill patients in the context of this demonstration in the next year? What are the facilitators of or barriers to their achievement?	Added to obtain information about future plans.

Protocol	Question #	New Question Added	Reason for Addition
NC Division of Aging and Adult Services (DAAS) & Care Managers	10 (DAAS)	Is there anything else you would like to share about the NC demonstration that we did not cover today?	Added to obtain information about anything that might not have been covered in the interview.
Provider Organization / Organized Delivery System	1	How long have you been with [name of physician organization / organized delivery system]?	Added to obtain background information on the respondent and his/her responsibilities.
Provider Organization / Organized Delivery System	2	Please tell me about your roles and responsibilities with [name of physician organization / organized delivery system].	Added to obtain background information on the respondent and his/her responsibilities.
Provider Organization / Organized Delivery System	3-3d	Please tell me about our [physician organization / organized delivery system] overall. For example, how many physicians and practice sites or locations do you operate? How many hospitals do you own and operate? What is your approximate payer mix, particularly your percent Medicare and Medicaid? What is the mix of health care professionals and other team members or staff in your [name of physician organization / organized delivery system]? Where is your [physician organization / organized delivery system] located? Where do your staff physically work (e.g., on site at the practices)? Please describe the practices in this Chronic Care Initiative, including how they compare to other practices in your physician organization or organized delivery system that are not participating in the Chronic Care initiative. Please describe what other departments or individuals in the [name of physician organization / organized delivery system] provide support to the participating practice for medical home development and other activities related to the Chronic Care Initiative.	Added to obtain background information on the organization.
Provider Organization / Organized Delivery System	4	What is your [physician organization / organized delivery system]'s primary role with respect to medical home development and practice transformation?	Added to obtain information about the organization's medical home activities.

Protocol	Question #	New Question Added	Reason for Addition
Provider Organization / Organized Delivery System	5-5g	Which of the following activities does your [physician organization / organized delivery system engage in to support the practices: internal learning collaboratives? Practice coaching or facilitation? Leadership or staff training? EHR/HIT and disease registry support? Performance measurement and monitoring? Performance incentives? Other contracts with practices or other health care provider organizations?	Added to obtain information about the organization's support to practices.
Provider Organization / Organized Delivery System	6	How does your [physician organization / organized delivery system] interact with practices?	Added to obtain information about the organization's support to practices.
Provider Organization / Organized Delivery System	7-7a	If you were involved in Pennsylvania's Chronic Care Initiative implemented prior to January 2012, what features of the Chronic Care Initiative are most important for your organization and participating practices? What were the major strategies used prior to January 2012 to implement medical homes? How successfully were they implemented?	Added to obtain information about the organization's perspective on the state's initiative.
Provider Organization / Organized Delivery System	8-8b	Now that Medicare and Medicaid have joined the effort, what features of the Chronic Care Initiative are most important for your organization and participating practices? What changes were made to accommodate Medicare's participation, if any, or to accommodate the Medicare beneficiaries now being served by the Chronic Care Initiative? How does your own [physician organization / organized delivery system]'s activities fit with activities sponsored by the state, such as the learning collaborative, practice coaching, performance measurement and monitoring?	Added to obtain information about the organization's perspective on the state's initiative.
Provider Organization / Organized Delivery System	9-9b	How is the implementation of the Chronic Care Initiative with Medicare and Medicaid's involvement going so far? What has gone well? What has gone less well?	Added to obtain information about the organization's perspective on the state's initiative.
Provider Organization / Organized Delivery System	10	What do you think are the strengths and weaknesses of the Chronic Care Initiative?	Added to obtain information about the organization's perspective on the state's initiative.

Protocol	Question #	New Question Added	Reason for Addition
Provider Organization / Organized Delivery System	11	What new or persistent challenges do you anticipate in the future, if any?	Added to obtain information about the organization's perspective on the state's initiative.
Provider Organization / Organized Delivery System	12	What new opportunities for improvement do you anticipate in the future, if any?	Added to obtain information about the organization's perspective on the state's initiative.
Provider Organization / Organized Delivery System	13	Prior to Medicare joining the Chronic Care Initiative, participating practices received payments from Medicaid and private payers to engage in medical home-related activities. How do the participating practices use these medical home payments? For example, did they invest in disease registries or EHR infrastructure, hired additional staff, etc?	Added to obtain information about the state initiative's payment model.
Provider Organization / Organized Delivery System	14	We understand that as a participant in Pennsylvania's Chronic Care Initiative, your [office / clinic / hospital] receives two types of per member per month (PMPM] payments: the physician coordinated care oversight services PMPM and the coordinated care fees PMPM. We also understand that practices are eligible for shared savings payments. What are the strengths and weaknesses of the shared savings payment component with respect to supporting continued practice transformation and key outcomes?	Added to obtain information about the state initiative's payment model.
Provider Organization / Organized Delivery System	15-15b	Are participating practices engaging in additional activities now that they also are receiving medical home payments from Medicare? [If so:] what are those activities? [If not:] Why not?	Added to obtain information about the state initiative's payment model.
Provider Organization / Organized Delivery System	16-16b	Do you think that Medicare's medical home payments are adequate to allow your [physician organization / organized delivery system] and the practices you support to continue to invest in medical home development and sustain effective medical home activities? What kinds of infrastructure or care processes do the Medicare medical home payments support? What kinds of activities are the medical home payments not sufficient to support but that could be beneficial?	Added to obtain information about the state initiative's payment model.

Protocol	Question #	New Question Added	Reason for Addition
Provider Organization / Organized Delivery System	17	What are the strengths and weaknesses of the current payment methodology (since Medicare joined the Chronic Care Initiative) for [physician organizations / organized delivery systems]? For the participating practices?	Added to obtain information about the state initiative's payment model.
Provider Organization / Organized Delivery System	18-18a	How are employed physicians generally paid in [name of physician organization / organized delivery system]? Is it primarily productivity based or is there some portion tied to performance metrics or other factors? Has the [physician organization / organized delivery system]'s payment model been altered for employed physicians since this Chronic Care Initiative began? If so, how. Please briefly describe.	Added to obtain information about the state initiative's payment model.
Provider Organization / Organized Delivery System	19-19d	What types of health information technology capabilities does [name of physician organization / organized delivery system] use to carry out its functions? For example, do you use web portals maintained by payers, electronic disease registries, or electronic health records? Can you track services provided to patients in each participating practice and other owned or affiliated practices? If so, how do you do this? To what extent can you readily exchange health information with participating practices? Other practices or facilities (e.g., specialists, hospitals, long-term care facilities)? What are the major benefits of the health information technology that you use? What are the primary challenges you face, either because of any health information technology capabilities you are lacking or with the health IT that you have?	Added to obtain information about health information technology use.
Provider Organization / Organized Delivery System	20	What additional health IT features would help your [physician organization / organized delivery system] do a better job assisting participating practices? Providing care coordination to patients?	Added to obtain information about health information technology use.
Provider Organization / Organized Delivery System	21	Has your [physician organization / organized delivery system] registered for Medicare and/or Medicaid meaningful use (MU)? If so, which program and have you attested to adopt, implement, and upgrade (AIU) or stage 1 MU?	Added to obtain information about health information technology use.

Protocol	Question #	New Question Added	Reason for Addition
Provider Organization / Organized Delivery System	22-22e	We understand that before Medicare joined, practice performance was measured and monitored on a relatively small set focused on diabetes and pediatric asthma. These were collected by practices and reported to Pennsylvania Academy of Family Physicians (PAFP) and the Improving Performance in Practice (IPIP) initiative. Now that Medicare has joined, the set of measures has been expanded to preventive services for children and adults, as well as care for patients with diabetes, asthma (age 5-40), hypertension, and ischemic vascular disease. These measures are reported to PAFP and then the state. What is your organization's view of the measure set? What are the strengths and weaknesses of these measures? How does the [name of physician organization / organized delivery system] assist in these quality measurement efforts? What type of results do they focus on in these quality measurement efforts? Are these quality results broken out by payer type (e.g., Medicare, Medicaid, commercial payers?) What does your [physician organization / organized delivery system] usually do with these quality results? How about the participating practices? What specific changes, if any, have participating practices made based on these results? Have participating practices taken any special actions targeted at Medicare, Medicaid, or other special patient populations? Are there any special issues or challenges to reaching Medicare or Medicaid beneficiaries or special populations? Please describe briefly. We understand that under the shared savings component, practices are eligible for shared savings payments that will take into consideration practice performance on key quality and cost metrics. What are the strengths and weaknesses of using these measures to determine the distribution of shared savings?	Added to obtain information about quality measurement under the state's initiative.

Protocol	Question #	New Question Added	Reason for Addition
Provider Organization / Organized Delivery System	23-23c	Practices participating in the Chronic Care Initiative have been receiving beneficiary utilization files from CMS/RTI that show some quality measures, and hospital and ER utilization information (dates, principal diagnosis, hospital name) for their Medicare patients. Are you familiar with these files? If so, what do practices do with these data? What aspects of those files do you believe have been most useful in helping participating practices change the way they deliver care? What features are not as helpful, or need improvement? What specific changes, if any, have participating practices made based on these data?	Added to obtain information about utilization reports received by practices participating in the state's initiative.
Provider Organization / Organized Delivery System	24-24d	Do you monitor practices' utilization and cost information? [If yes:] what do you monitor? What do you do with the data you collect? Do you provide feedback to practices? Do you help them develop strategies to improve on any performance measures where they appear to have quality gaps?	Added to obtain information about the organization's activities related to utilization and cost monitoring.
Provider Organization / Organized Delivery System	25-25b	Does [name of physician organization / organized delivery system] hire care managers to provide care coordination? [If yes:] Please describe the services they provide. Where do they work? [If no:] Why not?	Added to obtain information about the organization's care management activities.
Provider Organization / Organized Delivery System	26-26bii	Now we'd like to discuss with you how beneficiaries access care coordination or management services and their experiences with it. Please comment on patients overall, but also on whether there are any differences for Medicare or Medicaid beneficiaries or special populations of patients. Special populations can include: Medicare and Medicaid dual eligible; children; racial and ethnic subgroups; people living in rural or inner-city areas; and persons with chronic illnesses, mental illnesses, and disabilities. How do you identify people who need care coordination and management help or how do they get connected with these staff in the participating practices or [name of your organization]? Are there any differences in how your practices or organization identify or are assigned Medicare or Medicaid beneficiaries, or other special populations? [If yes:] Please describe. [If no:] Why not?	Added to obtain information about the organization's care management activities.

Protocol	Question #	New Question Added	Reason for Addition
Provider Organization / Organized Delivery System	28-28b	What major areas will your [physician organization / organized delivery system] be focusing on in the next year, or what changes will you be making? What do you see as the facilitators (or critical factors) of successful implementation? What do you see as the barriers or major challenges to implementing these changes?	Added to obtain information about the organization's future plans.
Provider Organization / Organized Delivery System	29-29a	What advice would you give to other states or [physician organizations / organized delivery systems] if the Chronic Care Initiative were to be extended or expanded to include them? What advice would you give to CMS (Medicaid and Medicare)? Any particular advice on the role of [physician organization / organized delivery systems] in medical home implementation?	Added to obtain information about areas of the state's initiative that could be improved.
Provider Organization / Organized Delivery System	30	Give what you know now, what would you have done differently, both prior to and after Medicare and Medicaid's involvement in the Chronic Care Initiative?	Added to obtain information about areas of the state's initiative that could be improved.
Provider Organization / Organized Delivery System	31	Is there anything we have not discussed about the Chronic Care Initiative or about the MAPCP Demonstration that you feel would be important for our National Evaluation Team to know?	Added to obtain information about anything that might not have been covered in the interview.
Provider Organizations	1	How long have you been with [name of physician organization]?	Added to obtain information about the respondent's background and responsibilities.
Provider Organizations	2	Please tell me about your roles and responsibilities with [name of physician organization].	Added to obtain information about the respondent's background and responsibilities.
Provider Organizations	3	Please describe the mix of health care professionals and other team members or staff in your [name of physician organization].	Added to obtain background information on the organization.

Protocol	Question #	New Question Added	Reason for Addition
Provider Organizations	4-4d	What are your physician organization's primary activities? What are your major activities with practices? How does your physician organization interact with practices? What types of infrastructure and support does your physician organization provide to practices to support medical home development and medical home activities? What role do you have in distributing incentives to MiPCT? For other incentive programs?	Added to obtain information about the organizations activities related to practices.
Provider Organizations	5-5a	Where is your physician organization located? Where do your staff physically work (e.g., on site at the practices)? How about your care coordinators?	Added to obtain background information on the organization.
Provider Organizations	6-6a	What features of the Michigan Primary Care Transformation Project do you think are the most important? What do you think are the strengths and weaknesses of the Michigan Primary Care Transformation Project?	Added to obtain information about the respondent's perspective on the state's initiative.
Provider Organizations	7-7b	Were you involved in the BCBSM PCMH PGIP prior to January 2012? [If yes:] What were its most important features? What were the major strategies used to implement medical homes during that time period before January 2012? How successfully were those strategies implemented?	Added to obtain information about the respondent's (and organization's) role in the state's initiative.
Provider Organizations	8	What changes, if any, were made to the BCBSM PCMH PGIP or Michigan Primary Care Transformation Project to accommodate Medicare joining?	Added to obtain information about the organization's role in the state's initiative.
Provider Organizations	9-9b	How is the implementation of the Michigan Primary Care Transformation Project with Medicare and Medicaid's involvement going so far? What has gone well? What hasn't gone so well?	Added to obtain information about the respondent's perspective on the state's initiative.
Provider Organizations	10	What new or persistent challenges do you anticipate in the future, if any?	Added to obtain information about the respondent's perspective on the state's initiative.
Provider Organizations	11	What new opportunities for improvement do you anticipate in the future, if any?	Added to obtain information about the respondent's perspective on the state's initiative.

Protocol	Question #	New Question Added	Reason for Addition
Provider Organizations	12	How were physician organizations paying for the support they provided to practices prior to January 2012—before Medicare and Medicaid joined MiPCT? What major changes, if any, have been made since Medicare and Medicaid joined? How are they paid now?	Added to obtain information about the payment model under the state's initiative.
Provider Organizations	13	We understand that each payer contributes to an incentive pool that distributed to the POs based on their performance and improvement. How are those payments distributed to practices? How do you think these payments will be used?	Added to obtain information about the payment model under the state's initiative.
Provider Organizations	14	Prior to Medicare and Medicaid joining the Michigan Primary Care Transformation Project, participating practices received payments from Blue Cross Blue Shield of Michigan to engage in medical home-related activities. Do you know how the participating practices used these medical home payments?	Added to obtain information about the payment model under the state's initiative.
Provider Organizations	15-15b	What kinds of infrastructure or care processes do the Medicare medical home payments support at the PO level? At the practice level? Are participating practices engaging in any additional activities now that they are receiving Medicare and Medicaid medical home payments on top of its medical home payments from private payers? [If so:] What are those activities? [If not:] Why not?	Added to obtain information about the organization's support to practices.
Provider Organizations	16-16a	Do you think that Medicare's medical home payments are adequate to allow your physician organization and the practices you serve to continue to invest in medical home development and sustain effective medical home activities? What kinds of activities are the Medicare payments not sufficient to support but that could be beneficial?	Added to obtain information about the payment model under the state's initiative.
Provider Organizations	17	What are the strengths and weaknesses of the current payment methodology (since Medicare and Medicaid joined for this demonstration) for physician organizations? For practice?	Added to obtain information about the payment model under the state's initiative.

Protocol	Question #	New Question Added	Reason for Addition
Provider Organizations	18-18d	What types of health information technology capabilities does [name of physician organization] use to carry out its functions? For example, do you use web portals maintained by payers or electronic disease registries? Can you track services provided to patients? If so, how do you do this? To what extent can you readily exchange health information with primary care practices? Other practices/facilities (e.g., specialists, hospitals, long-term care facilities)? What are the major benefits of the health information technology that you use? What are the primary challenges you face, either because of any health information technology capabilities you are lacking or with the health IT that you have?	Added to obtain information about health information technology use.
Provider Organizations	19	What additional health IT features would help your physician organization do a better job assisting practices? Providing care coordination to patients?	Added to obtain information about health information technology use.
Provider Organizations	20-20e	We understand POs assist practices with collecting data and submitting reports to MiPCT. What types of data do practices collect? Chronic condition data? Quality and safety data? How does your PO assist in the data collection and submission? What do you think practices usually do with these quality results? What specific changes, if any, have participating practices made based on these results? How is this different from what practices did before January 2012 as part of BCBSM's PCIP PCMH initiatives?	Added to obtain information about data collection activities.
Provider Organizations	21-21c	Do you monitor practice's utilization and cost information? [If yes:] What do you monitor? What do you do with the data you collect? Do you provide feedback to practices?	Added to obtain information about the organization's utilization and cost data monitoring.
Provider Organizations	22-22b	Does [name of physician organization] hire care managers to provide care coordination? [If yes:] Please describe the services you provide. [If no:] Why not?	Added to obtain information about the organization's activities related to care managers.

Protocol	Question #	New Question Added	Reason for Addition
Provider Organizations	23-23aii	How do you identify people who need help or how do they get connected with care managers? Are there any differences in how you identify or are assigned Medicare or Medicaid beneficiaries, or other special populations, for care coordination services? Special populations can include: Medicare and Medicaid dual eligible; children; racial and ethnic subgroups; people living in rural or inner-city areas; and persons with chronic illnesses, mental illnesses, and disabilities. [If yes:] Please describe. [If no:] Why not?	Added to obtain information about the organization's care coordination activities.
Provider Organizations	24	How do care coordinators coordinate patient care between the primary care practices you work with and other providers or facilities, such as hospitals, long-term care facilities, medical or surgical specialists, and behavioral health providers?	Added to obtain information about the organization's care coordination activities.
Provider Organizations	25-25e	Do you, and if so how do you: Follow up with patients after they are discharged from a hospital? ER? Perform medication reconciliation? Provide linkages to community services, or social services? Work with patients to address challenges they may face accessing care? Work with patients to address challenges they may face caring for themselves?	Added to obtain information about the organization's care coordination activities.
Provider Organizations	26-26c	What are some reasons why you might contact patients? How do the y react when you contact them? How successful are these contacts with patients? To what extent do you assist patients in getting them access to non-clinical supports (e.g., transportation to doctor appointments, social or community-based health services) that could benefit their health or access to needed health care?	Added to obtain information about the organization's care coordination activities.
Provider Organizations	27-27c	To what extent are you in communication with patient's family members or other caregivers? What are some reasons why you might contact them? How do they react when you contact them? How successful are these contacts?	Added to obtain information about communicating with patients' families.
Provider Organizations	28-28b	What are some reasons why you might contact other providers, practices, or facilities (e.g., hospitals, pharmacies)? How do they react when you contact them? How successful are these contacts with other providers, practices, or facilities?	Added to obtain information about the organization's care coordination activities.

Protocol	Question #	New Question Added	Reason for Addition
Provider Organizations	29-29b	How do you track and manage information you receive from patients, their caregivers, and their other providers? How are patients' practice clinicians and staff made aware of pertinent information you gather from these various sources? How does this information get incorporated into the patient's medical records?	Added to obtain information about the organization's care coordination activities.
Provider Organizations	30-30b	What major areas will your physician organization be focusing on in the next year, or what changes will you be making? What do you see as the facilitators (or critical factors) of successful implementation? What do you see as the barriers or major challenges to implementing these changes?	Added to obtain information about the organization's future plans.
Provider Organizations	31-31a	What advice would you give to other states or physician organizations if the Michigan Primary Care Transformation Project were to be extended or expanded to include them?	Added to obtain the respondent's advice to others.
Provider Organizations	32	Given what you know now, what would you have done differently, both prior to and after Medicare and Medicaid's involvement in the Michigan Primary Care Transformation Project?	Added to obtain general information about the state's initiative.
Provider Organizations	33	Is there anything we have no discussed about the Michigan Primary Care Transformation Project or about the Medicare MAPCP Demonstration that you feel would be important for our National Evaluation Team to know?	Added to obtain information that the respondent thinks might be important but was not covered during the interview.
SASH Coordinators/ SASH Wellness Nurses	1	How long have you been with [name of organization]?	Added to obtain information about the respondent's background and responsibilities.
SASH Coordinators/ SASH Wellness Nurses	2	Please tell me about your role with the SASH program.	Added to obtain information about the respondent's background and responsibilities.
SASH Coordinators/ SASH Wellness Nurses	3	How long have you served in this role?	Added to obtain information about the respondent's background and responsibilities.

Protocol	Question #	New Question Added	Reason for Addition
SASH Coordinators/ SASH Wellness Nurses	4	Were you previously with a similar kind of organization?	Added to obtain information about the respondent's background and responsibilities.
SASH Coordinators/ SASH Wellness Nurses	5-5a	Please tell me about the staff composition of your SASH team. Please describe the mix of health care professionals and other team members or staff in your [name of organization].	Added to obtain background information about the organization.
SASH Coordinators/ SASH Wellness Nurses	6	[For SASH Wellness Nurses:] We understand that the primary responsibilities of a wellness nurse is to provide in-person coaching on proper medication management, monitor vital signs to look for early warnings of health complications, and provide intensive self-care counseling and education post-discharge from hospitals and nursing homes. Do you have any other primary responsibilities?	Added to obtain background information about SASH wellness nurses.
SASH Coordinators/ SASH Wellness Nurses	7	[For SASH Coordinator:] We understand that the primary responsibilities of a SASH coordinator includes providing in-person needs assessments, motivational coaching to help residents meet their personal health aging goals, daily visits with high-risk residents to ensure medication compliance, and social services coordination. Do you have any other primary responsibilities?	Added to obtain background information about SASH coordinators.
SASH Coordinators/ SASH Wellness Nurses	8	Where do you physically work?	Added to obtain information about the respondent's activities.
SASH Coordinators/ SASH Wellness Nurses	9	From your perspective, what are the most significant problems that practices involved in the Blueprint face in serving Medicare beneficiaries in Vermont?	Added to obtain information about the respondent's perspective on the state's initiative.
SASH Coordinators/ SASH Wellness Nurses	10	From your perspective, what are the most significant problems that Medicare beneficiaries face in Vermont?	Added to obtain information about the respondent's perspective on the state's initiative.

Protocol	Question #	New Question Added	Reason for Addition
SASH Coordinators/ SASH Wellness Nurses	11-11c	Given the challenges faced by practices and beneficiaries, what are the strengths and weaknesses of the Blueprint for Health initiative? How well do you think implementation of the Blueprint for Health is going? Do you think the entrance of Medicare has enhanced the initiative? What new opportunities for improvement od you anticipate in the future, if any?	Added to obtain information about the respondent's perspective on the state's initiative.
SASH Coordinators/ SASH Wellness Nurses	12	How do SASH staff coordinate patient care with primary care practices?	Added to obtain information about how the organization coordinates with practices.
SASH Coordinators/ SASH Wellness Nurses	13	How do you coordinate patient care between the primary care practices you work with and the other providers or facilities, such as hospitals, long term care facilities, medical or surgical specialists, and behavioral health providers?	Added to obtain information about how the organization coordinates with practices.
SASH Coordinators/ SASH Wellness Nurses	14	What kind of services do you provide to practices in your area?	Added to obtain information about the organization's activities.
SASH Coordinators/ SASH Wellness Nurses	15-15a	Does your SASH team interact with care coordinators in any of the practices in your area? If so, what is the nature of the interaction? Are there coordination issues?	Added to obtain information about how the organization coordinates with practices.
SASH Coordinators/ SASH Wellness Nurses	16	What have been the challenges of working with practices in your area? What is working well?	Added to obtain information about how the organization coordinates with practices.

Protocol	Question #	New Question Added	Reason for Addition
SASH Coordinators/ SASH Wellness Nurses	17-17e	Please describe how you coordinate with the CHTs for Medicare beneficiaries that are also participating in the SASH Program? What kinds of information does your SASH team exchange with the CHT team or vice versa? How do you interact with the CHT team members? What is the nature of the interactions? Are there coordination issues? Is there joint decision making with the CHT teams on who will be doing what with which patients? How do you communicate with the CHT team members? What have been challenges of working with the CHT teams?	Added to obtain information about how the organization coordinates with CHTs.
SASH Coordinators/ SASH Wellness Nurses	18-18e	Do you do any coordination with the Medicaid Care Coordinators for Medicaid patients with complex care needs? What kind of information do you exchange with the Medicaid CCs or vice versa? How do you interact with the Medicaid CCs? What is the nature of the interaction? Are there coordination issues? Is there joint decision making with the Medicaid CCs on who will be doing what with these patients? How do you communicate with the Medicaid CCs? What have been the benefits or challenges of working with the Medicaid CCs?	Added to obtain information about how the organization coordinates with Medicaid CCs.
SASH Coordinators/ SASH Wellness Nurses	19	How do you identify people who need help or how do they get connected with a SASH team?	Added to obtain information about how people are connected to SASH.
SASH Coordinators/ SASH Wellness Nurses	20-20h	Do you, and if so how do you: Assign a staff member within your SASH team to a patient? Follow up with patients after they are discharged from a hospital? ER? Perform medication reconciliation? Coordinate care with specialists? Provide linkages to other services and facilities like long-term care, mental health, community services, or social services? Work with patients to address challenges they may face accessing care? Working with patients to address challenges they may face caring for themselves? Other?	Added to obtain information about the organization's activities.
SASH Coordinators/ SASH Wellness Nurses	21	What are patients' reactions when you contact them?	Added to obtain information about the organization's communications with patients.

Protocol	Question #	New Question Added	Reason for Addition
SASH Coordinators/ SASH Wellness Nurses	22	Are there any special issues or challenges to reaching Medicare beneficiaries? If so, please describe briefly.	Added to obtain information about the organization's communications with patients.
SASH Coordinators/ SASH Wellness Nurses	23-23a	What percentage of your patients have language literacy problems? How do you communicate with patients who have language or literacy problems?	Added to obtain information about potential literacy problems with patients.
SASH Coordinators/ SASH Wellness Nurses	24	To what extent do you interact with caregivers and family members of Medicare beneficiaries? What is the nature of these interactions?	Added to obtain information about the organization's interactions with family members and caregivers.
SASH Coordinators/ SASH Wellness Nurses	25	What strategies have the [SASH Coordinator/SASH wellness nurse]s used to engage patients more in their care?	Added to obtain information about patient engagement.
SASH Coordinators/ SASH Wellness Nurses	26	To what extent are patients, their families, and/or their caregivers actually able to participate more effectively in decisions concerning their care as a result of the Blueprint for Health initiative? Care you provide an example or do you have any early data on this?	Added to obtain information about patient engagement.
SASH Coordinators/ SASH Wellness Nurses	27-27a	How are you teaching self-management to patients? To what extent are patients actually better able to self-manage their health conditions or engage in healthy behaviors as a result of the Blue-print for Health initiative? Care you provide an example or do you have any early data on this?	Added to obtain information about patient self-management.
SASH Coordinators/ SASH Wellness Nurses	28	What role does your SASH team have in monitoring or improving quality of care and patient safety?	Added to obtain information about the organization's quality and patient safety activities.
SASH Coordinators/ SASH Wellness Nurses	29	Are you involved in the EQiuP activities? If so, how?	Added to obtain information about the organization's involvement in EQiuP activities.

Protocol	Question #	New Question Added	Reason for Addition
SASH Coordinators/ SASH Wellness Nurses	30	Do you use clinical data from the DocSite clinical registry for any quality of care or patient safety improvement activities? If so, for what purpose?	Added to obtain information about the use of clinical data from DocSite.
SASH Coordinators/ SASH Wellness Nurses	31	Does your CHT receive any other type of performance data on quality and safety?	Added to obtain information about other performance data.
SASH Coordinators/ SASH Wellness Nurses	32-32eiv	We know that as part of the Vermont Blueprint for health, practices are required to enter into agreements with Vermont Information Technology Leaders (VITL) and demonstrate progress toward being able to communicate with the Vermont statewide health information exchange (VHIE) and the DocSite clinical registry. Are you also required to use DocSite? [If yes:] Are you currently using DocSite? Have there been any challenges to using DocSite? Do you submit clinical data to DocSite? If so, what data? What information or services have you used from DocSite? The visit planner (individualized visit plans based on age, gender, and diagnosis that provide guideline based recommendations for annual health maintenance, prevention, and chronic disease treatment)? The integrated health record which contains clinical information for patients receiving care also from other providers? Populations level reports? If so, what kinds of reports? Comparative performance reports? If so, at what level (providers within a practice, across independent practices and organizations, or across HSAs within the state)?	Added to obtain information about health information technology use.

Protocol	Question #	New Question Added	Reason for Addition
SASH Coordinators/ SASH Wellness Nurses	33-33d	What types of other health information technology capabilities do SASH staff use to carry out their functions? For example, do you use web portals maintained by payers or referral tracking databases? Can you track services provided to patients? If so, how do you do this? To what extent can you readily exchange health information with the practices you work with? Other practices/facilities (e.g., specialists, hospitals, long-term care facilities)? What are the major benefits of the health information technology that you use? What are the primary challenges you face, either because of any health information technology capabilities you are lacking or with the health IT that you have?	Added to obtain information about health information technology use.
SASH Coordinators/ SASH Wellness Nurses	34	What additional health IT features would help your SASH team do a better job assisting/communicating with patients? Practices?	Added to obtain information about health information technology use.
SASH Coordinators/ SASH Wellness Nurses	35-35c	Now I want to talk to you about the beneficiary utilization files that RTI is producing for practices in the demonstration. The utilization files are Excel files that are posted on the MAPCP Web Portal that show all of the assigned beneficiaries for the quarter for each practice, the severity level (HCC risk score), disease status for diabetes and ischemic vascular disease, some quality measures, and hospital and ER utilization (dates, principal diagnosis, hospital name). Do you have access to these files? [If yes:] What aspects or features of the beneficiary utilization files do you find most useful? Is there information from Medicare claims that could be added to make them more useful? How are you using these files? Do you receive utilization files from any other entity? If so, who?	Added to obtain information about RTI's beneficiary utilization files.

Protocol	Question #	New Question Added	Reason for Addition
SASH Coordinators/ SASH Wellness Nurses	36-36b	Now I want to talk to you about the Practice Feedback Reports that RTI is producing for practices in the demonstration. These are PDF reports summarizing each practice's performance on a selection of quality measures that are posted quarterly to the MAPCP Web Portal. Do you have access to these reports? [If yes:] What aspects or features of the Practice Feedback Reports do you find most useful? How are you using these reports? Do you receive feedback repots like these from any other entity? If so, who?	Added to obtain information about RTI's Practice Feedback Reports.
SASH Coordinators/ SASH Wellness Nurses	37	Are there other performance monitoring reports that you receive?	Added to obtain information about other performance monitoring reports.
SASH Coordinators/ SASH Wellness Nurses	38	Are the payments you're receiving through the Blueprint for Health sufficient to support the needs of your patients and in working with the community and community health teams to provide services?	Added to obtain information about the payment model under the state's initiative.
SASH Coordinators/ SASH Wellness Nurses	39	Is there anything we have not discussed about the Blueprint for Health or about the Medicare MAPCP Demonstration that you feel would be important for our Evaluation Team to know?	Added to obtain information that was not already covered in the interview.

Protocol	Question #	New Question Added	Reason for Addition
Organized Delivery System	27-27b	Since Medicare joined the Chronic Care Initiative In January 2012, what impacts has it had on patients? Is there evidence of improvements in: access to care? coordination of care? (e.g. care transitions). Patient and family caregiver participation or behavior (e.g. patients engaging more in decisions and managing their care, use of patient and family advisory boards for practice quality improvement efforts). Increased delivery of preventive services? (e.g. cancer screenings, smoking cessation, weight management, influenza vaccination). Reduced use of acute care? (e.g. emergency department visits, hospitalizations, readmissions). Improved health care quality, patient safety, and patient experience and/or satisfaction? Other? If Medicaid participation in [state-specific name of MAPCP demonstration] prior to Medicare joining the initiative in [2011/2012], what impact has the initiative had on Medicaid beneficiaries and special populations? Special populations can include: Medicare and Medicaid dual eligibles; children; racial and ethnic subgroups; people living in rural or inner-city areas; and persons with chronic illnesses, mental illnesses and disabilities.	Added to obtain information about impacts on care.