MULTI-PAYER ADVANCED PRIMARY CARE PRACTICE DEMONSTRATION EVALUATION

INTERVIEW PROTOCOL

Medical Home Practices (Physicians, Office Managers and Other Staff)

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Introduction

Thank you for making time to speak with us today. As we mentioned in our email to [name of our contact in their office / clinic / hospital], we are researchers from RTI, the Urban Institute, and the National Academy for State Health Policy (NASHP), evaluating the Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration. We'd like to focus on learning about the period after Medicare joined the state's initiative and your thoughts on the future. Since we're asking about a number of different periods of time, we have created a visual timeline and logic model to differentiate each time period *[show the respondent the state's timeline and logic model]*.

We are particularly interested in the impact of the initiative on Medicare and Medicaid beneficiaries generally and special populations (such as those dually eligible for Medicare and Medicaid) specifically. We understand that some changes are system wide and may not affect these groups differently, but other changes that payers or practices make may be tailored to these groups to some degree and have different impacts on these patient populations.

We'd like your candid views about this initiative. We want to assure you that we will not quote you by name without getting back in touch with you to get your permission first. We would like to record our conversation, to ensure our notes from today are complete. Is this OK with you? Do you have any questions before we start the interview?

About the Respondent

[Try to obtain as much of this information as possible through Googling, reviewing the provider's MAPCP application to the state, and/or our initial phone call to schedule the interview.]

1. *[Before Visit]* What is your role in this [office / clinic / hospital]?
    a. *[Before Visit]* [If physician:] Are you salaried? Are you a part-owner?
2. *[Before Visit]* How long have you worked here?
3. *[Before Visit]* Who owns this [office / clinic / hospital]?
4. *[Before Visit]* Is this a single medical specialty or a multi-specialty group?
    a. *[Before Visit] What* are this [office / clinic / hospital]'s medical specialties? (e.g., family medicine, internal medicine, pediatrics)
5. *[Before Visit]* Setting aside medical assistants, roughly how many physicians work here? Nurse practitioners / physicians assistants? Registered nurses? Others (e.g., social worker, pharmacists)?
6. *[Before Visit]* Roughly how many patient visits does your [office / clinic / hospital] log per year?

7. *[Before Visit]* Can you give us an estimate of your [office / clinic / hospital]'s payer mix – in terms of what percent of your patients are insured through Medicaid vs. Medicare vs. private insurance vs. uninsured?

Changes to How Care is Delivered

[Note to interviewer: try to ask about (1) the time it took to implement any practices changes discussed; and (2) the cost of implementing or sustaining any practices changes discussed]

8. What do you think are the strengths and weaknesses of the medical home model of care?

    a. [If needed:] What do you think health care providers see as the main strengths and weaknesses of the model?

    b. *[If needed:]* What do you think patients and families or caregivers see as the main strengths and weaknesses of the model?

    c. *[If needed:]* What about Medicare beneficiaries, specifically?

    d. *[If needed:]* Medicaid beneficiaries?

    e. *[If needed:]* Other special populations of patients (e.g., dual eligibles, patients with chronic conditions)?

9. *[Before Visit]* Are you recognized as a medical home?

    [If no:]

    a. *[Before Visit]* Is your practice in the process of applying to be recognized as a medical home?

    [If yes:]

    b. *[Before Visit]* When did you first become recognized as a medical home?

    c. How developed were your medical home capabilities when you first became recognized? For example, if assessed using some kind of medical home tool like NCQA, what recognition level did your [office / clinic / hospital] qualify for?

    d. Has your [office / clinic / hospital]'s medical home score or level increased since joining the [state initiative] or is this one of your goals over the next year?

    e. 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)?

f. What additional major changes did your [office / clinic / hospital] make after joining the [state initiative] but before Medicare began participating in it?

g. What changes (if any) have you made, or do you plan to make over the next year, now that Medicare (and Medicaid, if applicable) is also participating in the [state initiative]?

10. Beyond medical home recognition, what did your [office / clinic / hospital] have to do to join [name of state]'s [state-specific name of MAPCP demonstration]?

11. What changes (if any) have you made, or do you plan to make over the next year, now that Medicare (and Medicaid, if applicable) is also participating in this initiative?

12. Which of these changes have been most challenging, or do you think will be the most challenging, to incorporate into your [office / clinic / hospital]'s day-to-day operations? *[Optional]* What made or makes them challenging to adopt?

    a. What changes is your [office / clinic / hospital] still working on incorporating into your day-to-day operations over the next year?

13. How have your interactions with patients and families or caregivers changed since you became a medical home, —before, during, and after a visit?

    a. Has your after-hour availability changed?

        i. *[If so:]* Please describe.

        ii. *[If not:]* Why not?

    b. What efforts has the practice undertaken to improve patient self-management skills and/or engage in care planning and shared decision-making?

    c. 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?

    d. 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?

    e. To what extent do you involved patients and families or caregivers in practice quality improvement or redesign efforts?

    f. 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.

14. *[Before Visit]* Do you use a dedicated care coordinator, who is either on-staff in your [office / clinic / hospital] or employed by some other organization?

    [If yes:]

    a. What do they do? What kind of services do they provide to your [office / clinic / hospital] and/or your patients?

    b. What specific types of patients does your care coordinator 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?

    c. How do you communicate with your care coordinator?

    d. What have been the benefits of working with a care coordinator?

    e. What have been some drawbacks of using a care coordinator?

    [If not:]

    f. Why not? Who coordinates care for your patients?

15. *[Before Visit]* Does your practice work with a community health [team / network] and/or develop linkages with other local community health resources?

    [If yes:]

    a. What do these community health [team/network] do and/or how do you makes linkages with other local community health resources? What kind of services do they provide to your [office / clinic / hospital] and/or your patients?

    b. 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?

    c. How do you communicate with your community health [team / network] and/or other local community resource(s)?

    d. What have been the benefits of working with a community health [team / network] and/or other local community resource(s)?

    e. What have been some drawbacks of using a community health [team / network] and/or working with other local community health resources?

[If not:]

f. Why not?

16. *[Before Visit]* What technical assistance or non-financial resources does your [office / clinic/ hospital] use or receive as a result of participating in [name of state]'s [state-specific name of PCMH initiative]? (e.g., participating in [name of state-specific learning collaborative], [practice coaches if offered in that state], [other state-specific resources offered through the MAPCP demo], non-MAPCP resources)

    a. Have you found [these resources / this assistance] to be useful? In what ways have they been useful/not useful?

    b. *[Optional]* What could be improved?

Health IT

17. *[Before Visit]* Do you use an electronic disease registry? An electronic disease registry is an organized system for collecting, storing, and analyzing information on patients with a particular disease, condition or risk factor, or prior exposure to substances or circumstances known or suspected to cause adverse health effects. *[If yes:]*

    a. *[Before Visit]* What type of electronic disease registry do you use?

    b. *[Before Visit]* Does your [office / clinic / hospital] have access to other kinds of registries (e.g. immunization registries, cancer registries) maintained by the state?

    [If not:]

    c. Why not?

18. *[Before Visit]* Other than the disease registry, what types of health information technology do you have?

    a. [If unclear whether they have an EHR, based on prior response:] Do you have an electronic health record (EHR)?

        i. *[If so:]* Would you describe it as fairly basic or more fully functional?

        ii. *[If not:]* Why not?

    b. What health IT does your [office / clinic / hospital] use to coordinate care or deliver evidence-based medicine to Medicare or Medicaid patients or special populations of patients, such as those with a particular chronic condition?

19. 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?

    a. *[If yes:]* How does your [office/clinic/hospital] typically provide medical records to other providers and facilities? (e.g., by mail? fax? email? electronic health information exchange? hard copies conveyed to other providers through patients?)

    b. *[If not:]* Why not?

20. 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)?

    a. *[If yes:]* How does your [office/clinic/hospital] typically provide medical records to other providers and facilities? (e.g., by mail? fax? email? electronic health information exchange? hard copies conveyed to other providers through patients?)

    b. *[If not:]* Why not?

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?

22. How have EHRs and other health IT changed the way your [office / clinic / hospital] delivers care?

    a. What particular features or capabilities have been especially helpful?

    b. What has been difficult about using EHRs or other new health IT tools or systems?

23. What other steps has your [office / clinic / hospital] taken to obtain health information about your patients on a more frequent or timely basis? (e.g., communicate with specialists and hospitals, ask more of patients/caregivers)

24. To what extent will the medical home payments help support your EHR and health IT infrastructure development, if at all?

    a. 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?

Payment

25. *[Before Visit]* We understand that as a participant in [name of state]'s [state-specific name of PCMH initiative], your [office / clinic / hospital] receives payment for [insert state-specific description of what practices receive payments for, how frequently, etc.]. For your [office / clinic / hospital], how much additional income has your [office / clinic / hospital] received in total from these medical home payments since [2011/2012]—when Medicare joined the initiative?

    a. *[Before Visit]* What percentage of this do you receive from Medicare?

    b. *[Before Visit]* What percentage of this do you receive from Medicaid?

    c. *[Before Visit]* What percentage of this do you receive from private payers?

26. Prior to Medicare joining [name of state]'s [state-specific name of PCMH initiative] in [2011/2012], your [office / clinic / hospital] received private payer [and Medicaid (if joined prior to Medicare's involvement)] payments to engage in medical home-related activities. How did your [office / clinic / hospital] use those medical home payments?

    a. What additional changes did your [office / clinic / hospital] make after it started receiving medical home payments from Medicare?

        i. *[If so:]* What are those changes?

        ii. *[If not:]* Why did you not make any additional changes?

27. Are Medicare's medical home payments adequate for allowing you to continue to invest in medical home development and sustain effective medical home activities? Why or why not?

Performance Monitoring

28. What types of quality and safety measurement did your [office / clinic / hospital] engage in under [name of state]'s [state-specific name of PCMH initiative] prior to [2011/2012]—when Medicare joined the initiative? For example, collecting and sharing data on clinical quality measures or paying a vendor to collect patient experience surveys?

    a. Have there been any changes since Medicare (and Medicaid if applicable) joined the initiative in [2011/2012]? If so, what were those changes? If not, why not?

        i. Do you currently collect any **preventive service measures**? If so, which ones? For example, cancer screening, smoking cessation, weight management, influenza vaccination, or pneumonia vaccination?

        ii. Do you currently collect any **chronic condition measures**? If so, which ones?

        iii. Do you currently collect any **safety measures**? If so, which ones? For example, do you measure and monitor follow-up after hospital discharge or medication reconciliation?

b. What type of results do you focus upon in these quality measurement efforts?

    i. Are these quality results broken out by payer type (e.g., Medicare, Medicaid, commercial payers?) or demographic (e.g., race/ethnicity), language, gender or disability categories?

c. What does your [office / clinic / hospital] do with these quality results?

d. *[If not already identified:]* What specific changes, if any, has your [office / clinic / hospital] made based on these results?

    i. Have you undertaken any special initiatives targeted at Medicare, Medicaid, or other special patient populations? Why or why not?

29. What aspects of the [state-specific name of practice feedback reports] you receive from [name of state / RTI] have been most useful in helping your [office / clinic / hospital] change the way you deliver care?

    a. What features are not as helpful, or need improvement?

30. Do you monitor utilization and cost information?

    [If yes:]

    a. What do you monitor?

    b. What do you do with the utilization data you collect?

<u>Outcomes</u>

[Note to interviewer: (1) Try to ask respondents to identify medical home features that contributed to the observed impacts, or features that could be added to the initiative to improve outcomes. (2) More specific examples of impacts to care might be discussed during the interview. For example, referrals to community resources and specialists are examples of care coordination. Other more specific examples that may be discussed in this section are: timeliness and continuity of care, coordination with specialists (physician and mental health), medication reconciliation, discussion of current and potential changes to a patient's drug regimen, shared decision-making, patient self-management, provision of information such as test results to patients in a way that is easy to understand, health literacy, discussion of patient medical history, proactive care (e.g. generating lists of patients who need to come in for an office visit), and active reminders about tests, treatment, and/or appointments.]

31. Since the initiative began in [year that the state initiative began], what impacts has the [state-specific name of PCMH initiative] had on your patients?

    a. Is there evidence of improvements in:

        i. Access to care?

        ii. Coordination of care? (e.g., care transitions)

iii. Patient and family or caregiver participation or behavior? (e.g., patients engaging more in decisions and managing their care)

iv. Increased delivery of preventive services? (e.g., cancer screenings, smoking cessation, weight management, influenza vaccination)

v. Reduced use of acute care? (e.g., emergency department visits, hospitalizations, readmissions)

vi. Improved health care quality, patient safety?

vii. Patient experience and/or satisfaction?

viii. Other?

ix. To what extent do you see similarities or differences in impact on publicly (i.e., Medicare, Medicaid, and special populations) versus the privately or commercially insured?

1. To what extent do you see similarities or differences in impact among the publicly insured? For example, do you see different impacts on Medicare versus Medicaid beneficiaries or any particular special populations?

Overall Impressions

32. What do you see as the pros and cons of participating in [name of state]'s [state-specific name of PCMH initiative]?

33. What advice do you have for [name of state] state officials or CMS to improve the [state-specific name of PCMH initiative]?

    a. *[If their advice is not generalizable to other states:]* What advice do you have for state officials setting up multi-payer medical home initiatives in other states?

    b. Any *advice* for other practices?

34. Is there anything else about [name of state]'s [state-specific name of PCMH initiative] and its potential impact on your [office / clinic / hospital] or Medicare and Medicaid beneficiaries that we haven't covered that would be important for our team to know?