MULTI-PAYER ADVANCED PRIMARY CARE PRACTICE DEMONSTRATION EVALUATION

INTERVIEW PROTOCOL

Local Chapters of Physician and Clinical Professional Associations

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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 organization], 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 the 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 the [name of state] chapter of the [name of organization]?

2. *[Before Visit]* Can you give us an estimate of how many are represented by the [name of state] chapter of [name of organization]?

3. *[Before Visit]* How long have you been with [name of organization]?

4. *[Before Visit]* How has your organization been involved in planning or implementing [name of state]'s [state-specific name of PCMH initiative]? (e.g., did you advocate for its implementation? Notifying your members about the initiative and encouraging their participation?

5. [*Before Visit*] When did the [name of organization] become involved in the [state-specific name of PCMH initiative]? Was your organization involved prior to CMS joining the initiative?

Medical Home Assessment or Recognition Tool

6. We understand your state uses [name of state's medical home assessment or recognition tool]. Why was that tool selected or developed?

    a. How well do you feel it assesses a practice's medical home capabilities?

    b. How is this medical home assessment or recognition information used? For example, does the state and/or your organization use it guide to learning collaborative activities? To determine practice payment levels?

Practice Transformation/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]

For most of the questions we'll be asking you today, we'd like you to answer on behalf of the [health professional members of organization] represented by the [name of state] chapter of [name of organization] that is participating in [name of state]'s [state-specific name of PCMH initiative].

7. Please describe the changes that practices have made as a result of participating in [name of state]'s [state-specific name of PCMH initiative]? (e.g., focusing on patients with multiple chronic conditions or high risk patients, using new care processes, adopting new health IT tools, interacting differently with patients)

    a. What additional changes (if any) have participating practices made because Medicare (and Medicaid, if applicable) joined this initiative?

    b. Which of these changes have been the most challenging for practices to incorporate into their day-to-day operations?

        i. What made them challenging to adopt?

        ii. What changes are practices still working on?

8. To what extent have practices participating in [name of state]'s [state-specific name of PCMH initiative] improved:

    a. Access, such as same-day appointments or extended evening and weekend hours?

    b. Care coordination and care transitions with other practices, hospitals, and other nearby health providers such as mental health facilities or nursing homes?

    c. Linkages with community health [teams / networks] and resources?

    d. 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?

9. *[Before Visit]* Do practices participating in [name of state]'s [state-specific name of PCMH initiative] use a dedicated care coordinator, who is either on-staff in their [practice / clinic / hospital] or employed by some other organization?

    a. What do the care coordinators do? What kind of services do they provide to the practice and/or the practice's patients and families?

    b. How do care coordinators work with specialists, hospitals, mental health and nursing home facilities, and community services?

    c. Does this differ among Medicare beneficiaries, Medicaid beneficiaries, or special populations?

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

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

10. Overall, what do you think are the strengths and weaknesses of the medical home model of care promoted by [name of state]'s [state-specific name of PCMH initiative] starting in [2011/2012]—when Medicare joined the initiative?

    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 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? 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.)

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

    a. Which of these resources have your members found to be useful in helping them change the way they deliver care?

    b. What could be improved?

Health IT

12. *[Before Visit]* What types of health IT capabilities do practices participating in [name of state]'s [state-specific name of PCMH initiative] typically have?

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

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

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

    b. Do practices usually have the ability to create and maintain an electronic disease registry? Please explain briefly.

    c. Do practices have access to other kinds of registries (e.g. immunization registries, cancer registries) that may be maintained by the state? Please explain briefly.

    d. What other health IT do practices participating in [name of state]'s [state-specific name of PCMH initiative] typically use to coordinate care or deliver evidence-based medicine to Medicare or Medicaid patients or to special populations of patients, such as those with a particular chronic condition?

13. *[Before Visit]* How do most practices in [name of state]'s [state-specific name of PCMH initiative] exchange medical records with other providers? (e.g., by mail? fax? email? electronic health information exchange? hard copies conveyed to other providers through patients?)

14. How have EHRs and other health IT changed the way practices participating in [name of state]'s [state-specific name of PCMH initiative] deliver care, if at all?

    a. What particular features or capabilities of EHRs or other IT tools or systems have been especially helpful?

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

15. To what extent are practices participating in Medicaid and Medicare EHR incentive programs and technical assistance through the regional extension centers (RECs) to improve their EHR capacity?

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?

Payment

17. Prior to Medicare joining [name of state]'s [state-specific name of PCMH initiative], participating practices received payments from Medicaid and private payers to engage in medical home-related activities. How did participating practices use these medical home payments?

    a. Are participating practices engaging in additional activities now that it is receiving Medicare [and Medicaid (if joined at the same time as Medicare)] medical home payments on top of its private payer [and Medicaid (if joined prior to Medicare's involvement)] medical home payments?

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

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

18. Are Medicare's medical home payments adequate to allow practices to continue to invest in medical home development and sustain effective medical home activities?

    a. What kinds of infrastructure or care processes do the Medicare medical home payments support?

    b. What kinds of activities are the Medicare payments not sufficient to support but that could be beneficial?

Performance Monitoring

19. *[Before Visit]* What types of quality and safety measurement do practices engage in under [name of state]'s [state-specific name of PCMH initiative] prior to [2011/2012]—when Medicare joined the initiative? For example, do they collect and share data on clinical quality measures or pay a vendor to administer patient experience surveys?

    a. Have there been any changes with the addition of Medicare (and Medicaid if applicable)?

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

        ii. Do practices currently collect any **chronic condition data**? If so, which ones?

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

        iv. How aligned are the state's clinical quality measure and other reporting requirements aligned with those required for other CMS programs?

b. What type of results do they focus on in these quality measurement efforts?

   i. Are these quality results broken out by payer type (e.g., Medicare, Medicaid, commercial payers?)

   ii. Are these quality results broken down by patient demographics (race/ethnicity), gender, language, or disability status?

c. What do you think practices usually do with these quality results?

d. *[If not already identified:]* What specific changes, if any, have participating practices made based on these results?

   i. Have participating practices taken any special actions targeted at Medicare, Medicaid, or other special patient populations?

   ii. Are there any special issues or challenges to reaching Medicare or Medicaid beneficiaries or special populations? Please describe briefly.

20. Practices participating in [state-specific name of PCMH initiative] receive a [state-specific name of practice feedback reports] from [name of state / RTI]. What do you think practices usually do with these results?

    a. What aspects of those [state-specific name of practice feedback reports] do you believe have been most useful in helping participating practices change the way they deliver care?

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

    c. *[If not already identified:]* What specific changes, if any, have participating practices made based on these results?

21. Do you monitor practice's utilization and cost information?

    [If yes:]

    a. What do you monitor?

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

    c. Do you provide feedback to practices?

<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.]

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

<u>Overall Impressions</u>

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

24. What advice do you have for [name of state] state officials or CMS?

    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 practices (participating in this initiative)?

25. What changes do you anticipate practices making in the next year to improve care delivery and outcomes for Medicare and Medicaid beneficiaries?

    a. What will help practices succeed in implementing these changes?

    b. What do you see as the barriers or major challenges in implementing these changes?

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