MULTI-PAYER ADVANCED PRIMARY CARE PRACTICE DEMONSTRATION EVALUATION
INTERVIEW PROTOCOL

NC Division of Aging and Adult Services (DAAS) & Care Managers

PRA Disclosure Statement

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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 practice / clinic / hospital], we are researchers from RTI, the Urban Institute, and the National Academy of State Health Policy (NASHP), evaluating the Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration.

As previously mentioned in the email we sent you when we set up the interview, we'd like your candid views about this initiative. Specifically, 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 also 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.

As described in the one-page attachment to our email we sent to you to set up the interview, our evaluation is being funded by the Centers for Medicare and Medicaid Services (CMS). As a condition of participation, CMS expects state staff and participants to cooperate with the evaluation team, but ultimately your decision to participate in this aspect of the study is voluntary. If you do not wish to participate in this interview or answer specific questions, please let us know immediately.

We believe there are minimal risks to you from participation, and every effort will be made to protect your confidentiality. We want to assure you that we will not quote you by name. We will use some quotes in reports, but quotes will not be attributed to an individual or his/her organization.

There are no direct benefits to you from participating in this study. But your insights will be used by federal and state policymakers to better understand the effects of the medical home model on Medicare and Medicaid beneficiaries as well as the challenges involved in running a medical home initiative and becoming and maintaining a medical home. The Institutional Review Boards (IRB's) at RTI International and the Urban Institute have reviewed this research.

Finally, we would like to record our conversation, to ensure our notes from today are complete.

Are these interview conditions OK with you? Do you have any questions before we begin?

[Note to Interviewer: Care Manager questions are blocked together in the first part of the protocol, while the DAAS questions are blocked at the end. Please use accordingly.]

Background (Care Managers)

1. Are you employed by the [name of network]?

2. How long have you worked at [name of network]?

3. With how many practices or health centers do you work?

    a. For how many patients do you coordinate care per month?

    b. Which insurers do your patients represent?

4. What kind of services do you provide to your practices and/or your patients?

    a. What specific types of patients do you focus on? (e.g., patients with comorbidities, Medicare and Medicaid dual eligibles; children; racial and ethnic subgroups; people living in rural or inner-city areas; persons with chronic illnesses, mental illnesses, and disabilities.)

    b. How do you decide which patients to focus on?

5. How do you communicate with physicians and other staff in your practice?

    a. *[If not addressed above]:* What kind of information do you relay to providers for patients' care?

6. What training do you receive? Who provides it?

Health IT (Care Managers)

7. What kinds of health information technology do you use in case management?

8. How have EHRs and other health IT changed the way you manage specific cases?

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

    b. What technical assistance for the health IT is available to you?

The NC Demonstration (Care Managers)

9. What are some problems with how care is currently delivered to rural, aging, or chronically ill patients in North Carolina?

    a. To what extent do you see problems with:

        i. Patients having access to care when they need it? Could you give me an example of that?

ii. Effective communication between these patients and practice staff (including doctors and other staff)? Could you give me an example of that?

1. Does this include communication related to shared decision-making?

2. Does this include communication related to self-management?

iii. Quality of care? Could you give me an example of that?

iv. 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?

v. Patients being able to better able to self-manage their health and medical conditions?

b. Do you see any major differences for Medicare beneficiaries, Medicaid beneficiaries, or other special populations?

10. 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?

    a. How does the NC demonstration improve care for these special populations? Could you give me an example of that?

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

12. How do you coordinate with BCBS case managers?

13. 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?

    a. [*If Yes*:] What it helpful? In what ways?

Beneficiary Experience with Care (Care Managers)

[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, 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.]

14. In the NC Demonstration practices, is there evidence of improvement in:

    a. Access to care;

    b. Coordination of care,

    c. Increased adherence to preventive services?

    d. Reduced acute care utilization, like ED visits, hospitalizations, readmissions?

    e. Patient experience/satisfaction?

    f. Self-management of health conditions?

    g. Engagement in healthy behaviors?

    h. Shared decision making between primary care providers and patients, their family members, and/or caregivers?

    i. Health?

    j. Other?

Recommendations / Conclusions (Care Managers)

15. What recommendations do you have to improve the NC demonstration?

16. 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?

17. Is there anything else you would like to share about the NC demonstration that we did not cover today?

Background (NC DAAS)

1. Could you tell us a little about your role?

    a. How long have you worked at the DAAS?

    b. What has your role been in the NC multi-payer medical home demonstration?

The NC Demonstration (NC DAAS)

[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, 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.]

2. What are some problems with how care is currently delivered to rural, aging, or chronically ill patients in North Carolina?

    a. To what extent do you see problems with:

        i. Patients having access to care when they need it? Could you give me an example of that?

        ii. Effective communication between these patients and practice staff (including doctors and other staff)? Could you give me an example of that?

            1. Does this include communication related to shared decision-making?

            2. Does this include communication related to self-management?

        iii. Quality of care? Could you give me an example of that?

        iv. 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?

        v. Patients being able to better able to self-manage their health and medical conditions?

    b. Do you see any major differences for Medicare beneficiaries, Medicaid beneficiaries, or other special populations?

3. How has the NC Demonstration addressed some of these issues?

4. Which of these issues remain unaddressed by the NC Demonstration?

5. In the NC Demonstration practices, is there evidence of improvement in:

    a. Access to care;

    b. Coordination of care,

    c. Increased adherence to preventive services?

    d. Reduced acute care utilization, like ED visits, hospitalizations, readmissions?

    e. Patient experience/satisfaction?

    f. Self-management of health conditions?

    g. Engagement in healthy behaviors?

    h. Shared decision making between primary care providers and patients, their family members, and/or caregivers?

    i. Health?

    j. Other?

Health IT (NCDAAS)

6. How has health IT changed care management in the practices that are participating in the demonstration?

Recommendations / Conclusions (DAAS)

7. 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?

8. If a colleague in another state was interested in advocating for a program like the NC demonstration, what advice would you give them?

9. 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?

    a. What are the facilitators of or barriers to their achievement?

10. Is there anything else you would like to share about the NC demonstration that we did not cover today?