MULTI-PAYER ADVANCED PRIMARY CARE PRACTICE DEMONSTRATION EVALUATION
INTERVIEW PROTOCOL

Community Health [Teams / Networks]

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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. 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?

Introduction/Background Questions

[Try to obtain as much of this information as possible through Googling, reviewing the community health team or network's MAPCP application to the state (if one exists), and/or our initial phone call to schedule the interview.]

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

2. *[Before Visit]* Please tell me about your roles and responsibilities with [name of organization].

    [If they have been there long:]

    a. *[Before Visit]* How long have you served in this role at [name of organization]?

        [If they have <u>not</u> been there long:]

    b. *[Before Visit]* Were you previously with a similar kind of organization?

3. *[Before Visit]* Please tell me about the staff composition of your [network or team].

    a. *[Before Visit]* Please describe the mix of health care professionals and other team members or staff in your [name of organization].

4. *[Before Visit]* What are your community health [team / network]'s primary responsibilities?

    a. *[If needed:] [Before Visit]* How does your [team / network] interact with practices?

    b. *[Before Visit]* How do you keep track of what care is delivered by what provider to which patients?

5. *[Before Visit]* Where are your community health [teams / networks] located? Where do your CHT staff physically work (e.g., on site at the practices)?

    a. *[Before Visit]* How about your care coordinators?

Progress / State Implementation

6. Prior to [2011/2012]—when Medicare [and Medicaid (if joined at the same time)] 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?

7. What were the most important features of [name of state]'s [state-specific name of PCMH initiative] implemented prior to [2011/2012]?

    a. What were the major strategies used to implement medical homes and how successfully were they implemented?

    b. Now that Medicare [and Medicaid (if 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?

        i. What changes were made to accommodate Medicare's participation, if any, or to accommodate the Medicare beneficiaries now being served by [state-specific name of PCMH initiative]?

8. How is the implementation of [name of state]'s [state-specific name of PCMH initiative] with Medicare's [and Medicaid (if joined at the same time)] involvement going so far?

    a. What has gone well?

    b. What hasn't gone so well?

9. What do you think are the strengths and weaknesses of [name of state]'s [state-specific name of PCMH initiative]?

10. What new or persistent challenges do you anticipate in the future, if any?

11. What new opportunities for improvement do you anticipate in the future, if any?

Payment and Infrastructure

12. *[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?

13. What are the strengths and weaknesses of the current payment methodology (post Medicare [and Medicaid (if joined at the same time)] joining for this demonstration) for community health [teams / networks]?

14. Are the payments sufficient to support strong collaboration or linkages between primary care practices and community health teams and ultimately better quality and utilization/cost outcomes?

Health Information Technology

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 participating practices or referral tracking databases developed by the community health [team / network]?

    a. Can you track services provided to patients? If so, how do you do this?

    b. To what extent can you readily exchange health information with primary care practices? Other practices/facilities (e.g., specialists, hospitals, long-term care facilities)?

    c. What are the major benefits of the health information technology that you use?

    d. 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?

16. Has your participation in the [name of state]'s [state-specific name of PCMH initiative] changed the amount or frequency with which you use health information technology?

    a. *[If yes:]* Please explain.

    b. *[If no:]* Why not?

17. What additional health IT features would help your community health [teams / networks] do a better job assisting/communicating with patients? Practices?

Community Health [Team / Network] Transformation

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

18. What kinds of structural or organizational changes did [name of organization] make pre-[2011/2012]--before Medicare [and Medicaid (if joined at the same time)] became involved

in [name of state]'s [state-specific name of PCMH initiative]—in an effort to support the medical home model?

a. What additional changes are you working on making now that Medicare [and Medicaid (if joined at the same time)] [is/are] involved in the [state-specific name of PCMH initiative]?

b. How likely do you feel that you will be able to implement all of these changes successfully?

c. What are the major challenges to implementing these additional changes?

Access to Care and Coordination of Care

[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, timeliness of care is an example of access to care. Other more specific examples that may be discussed in this section include: discussion of current and potential changes to a patient's drug regimen, 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.]

19. 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 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 you identify people who need help or how do they get connected with [name of your organization]?

    a. Are there any differences in how you identify or are assigned Medicare or Medicaid beneficiaries, or other special populations?

        i. [If yes:] Please describe.

        ii. [If no:] Why not?

20. How familiar are you with Medicare's beneficiary assignment process? [Note to interviewer: please briefly describe the process if the interviewee is not familiar with it using the evaluation team's formal description]

    a. How do you use these beneficiary assignment lists when identifying which patients to provide services to?

    b. Does your program limit community health [team / 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.

c. How are patients transitioning between two practices participating in the demonstration identified and handled by the community health [team / network]? Please describe briefly.

d. What about patients transitioning from participating practices to non-participating practices or vice versa? How are these patients identified and handled by community health [team / network]?

e. How does [name of organization] coordinate patient care with primary care practices and other providers or facilities?

21. Do you, and if so how do you:

a. Assign a staff member within your community health [team / network] to a patient and/or their family or caregiver?

b. Follow up with patients and/or their family or caregiver after they are discharged from a hospital? ER?

c. Perform medication reconciliation?

d. Coordinate care with specialists (e.g., physical and mental health)?

e. Provide linkages to other services and facilities like long-term care, mental health, community services, or social services?

f. Work with patients to address challenges they may face accessing care?

g. Work with patients and families or caregivers to address challenges they may face caring for themselves?

h. Work with special populations such as the mentally ill to address any challenges they may face?

i. *Other?*

ii. *[Optional]* Are there any differences in how you coordinate care for Medicare or Medicaid beneficiaries, or other special populations?

1. *[If yes:]* Please describe.

2. *[If no:]* Why not?

22. How do you communicate with patients who do not speak or cannot read English?

a. Does [name of organization] screen for language or literacy problems?

i. *[If yes:]* When and how are people screened? (e.g., by the community health [team / network] at the first visit? With what health literacy tool or survey instrument?)

ii. *[If no:]* How do you identify people with language or literacy problems?

b. Does [name or organization] arrange for translators or other services or information products?

c. Are there any differences in how you communicate with patients who do not speak or read English when they are Medicare or Medicaid beneficiaries, or other special populations? Please describe.

Beneficiary Experience with Care

[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, shared decision-making is an example of beneficiary experience with care. Other more specific examples that may be discussed in this section include: provision of information such as test results to patients in a way that is easy to understand and health literacy.]

23. What strategies has [name of organization] used to engage patients more in their care?

    a. 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 [name of state]'s [state-specific name of PCMH initiative]? Can you provide an example or do you have any early data on this?

24. How are you teaching self-management to patients?

    a. To what extent are patients actually better able to self-manage their health conditions or engage in healthy behaviors as a result of [name of state]'s [state-specific name of PCMH initiative]? Can you provide an example or do you have any early data on this?

25. 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?

26. Are there any special issues or challenges to reaching Medicare or Medicaid beneficiaries, or special populations, in an effort to improve quality and safety? If so, please describe briefly.

27. To what extent do you interact with caregivers and family members of Medicare beneficiaries? What is the nature of these interactions?

    a. 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 the electronic or paper medical record?

Quality of Care and Patient Safety

Now we'd like to discuss health care quality and patient safety with you. Please comment on patients overall, but also on whether there are any differences for Medicare or Medicaid beneficiaries or special populations of patients.

28. *[Optional]* What quality and safety data did your community health [team / network] or your assigned practices begin collecting and sharing as a result of participating in [name of state]'s [state-specific name of PCMH initiative]?

    a. 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?

        i. Which preventive care service data do your community health [team / network] or your assigned practices collect or share (e.g. cancer screening, smoking cessation, weight management, influenza vaccination, pneumonia vaccination)? Please describe briefly.

        ii. Are there any chronic conditions your community health [team / network] or your assigned practices collect or share data on?

29. Does [name of organization] or its assigned practices receive feedback on its quality and safety, such as [state-specific name of practice feedback reports] (if applicable), documenting quality and safety measures and comparative performance?

    [If yes:]

    a. What quality and safety measures are reported back to you?

        i. Which of these are measures did you receive feedback on prior to [2011/2012)—before Medicare joined the [state-specific name of PCMH initiative]?

        ii. Which of these measures (if any) did you begin to receive feedback on in [2011/2012]--when Medicare [and Medicaid (if joined at the same time)] joined the [state-specific name of PCMH initiative]?

    b. 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?

    c. What entity provides you with these reports, and how often?

    d. How do you use the information provided in these reports?

e. What are the most useful features of the quality measure reports you receive?

    i. How could these quality measure reports be made more useful to you?

[If no:]

f. If you were to receive a quality measure report, what quality measures would be the most useful to you?

g. If you were to start receiving these types of data on your Medicare patients, how might you use it?

30. *[Before Visit]* Does [name of organization] 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:]

a. What other measures (e.g., utilization) are reported back to you?

    i. Which of these are measures did you receive feedback on prior to [2011/2012)—before Medicare joined the [state-specific name of PCMH initiative]?

    ii. Which of these measures (if any) did you begin to receive feedback on in [2011/2012]--when Medicare [and Medicaid (if joined at the same time)] joined the [state-specific name of PCMH initiative]?

b. 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?

c. What entity provides you with these reports, and how often?

d. How do you use the information provided in these reports?

e. What are the most useful features of the quality measure reports you receive?

    i. How could these quality measure reports be made more useful to you?

[If no:]

f. If you were to receive a quality measure report, what quality measures would be the most useful to you?

g. If you were to start receiving these types of data on your Medicare patients, how might you use it?

Wrap-up

31. What major areas will your community health [team / network] be focusing on in the next year, or what changes will you be making?

    a. What do you see as the facilitators (or critical factors) of successful implementation?

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

1. What advice would you give to other states or community health [teams / networks] if the [state-specific name of PCMH initiative] were to be extended or expanded to include them?

    a. What advice would you give to CMS (Medicaid and Medicare)? Any particular advice on community health [teams / networks] and how to use them?

2. Given what you know now, what would you have done differently, both prior to and after Medicare's [and Medicaid (if joined at the same time)] involvement in [name of state]'s [state-specific name of PCMH initiative]?

3. *[Optional]* Is there anything we have not discussed about the [state-specific name of PCMH initiative] or about the Medicare MAPCP Demonstration that you feel would be important for our National Evaluation Team to know?

    a. *[If yes:]* Please describe.