

Appendix A Site Visit Materials

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Appendix A-1 Description of Site Visits

To fully understand the implementation of the Frontier Care Coordination Network, the Altarum Team will conduct site visits to the grantee facilities and interview staff, partners, and clients. Task 4 will be led by Alana Knudson, PhD supported by Shena Popat, BA, BS.

We plan to interview Heidi Blossom, RN, MSN, the Care Transitions Coordinator, who is based in the Montana Health Research and Education Foundation (MHREF) in Helena, the MHREF Grants Director, the Montana Department of Health and Human Services Program Manager, and Kris Juliar, MPH, the Director of the Montana Office of Rural Health. We will also interview Victoria Cech, Director of Grants and Program Development at the Association of Montana Health Care Providers. In addition, at each of the frontier CAH sites, we will interview the community health workers (CHWs), the hospital administrator, and the local providers (including physicians, nurse practitioners, physician assistants, and other key staff). We will also conduct interviews with clients and families who are currently working with the CHW at each frontier site. While on site, we will also allocate time for standardizing notes and write-ups to facilitate future use of the information and allow for timely clarification if necessary. We will maximize our driving time by conducting team meetings “on the road” to adjust the interview guides and any other aspects of the site visit as needed.

Below is a table for the two proposed site visits based on our experiences conducting site visits in Montana with frontier and tertiary providers. During the course of this evaluation, we will conduct one site visit with each frontier and tertiary provider -- the site visits will occur during Years 1 and 3. In addition, we will conduct telephone interviews in Year 2 to capture at least two years of data from all participants, network partners, and other key stakeholders. The list of specific sites will be tailored to current program participants at the time site visits are scheduled.

	Frontier CAHs	Tertiary Providers	Additional Interviews
Site Visit 1 - Year 1	Rosebud Health Care Center, Forsyth McCone County Health Center, Circle Roundup Memorial Healthcare, Roundup Wheatland Memorial Healthcare, Harlowton Pioneer Medical Center, Big Timber	Billings Clinic, Billings	Care Transition Coordinator, MHREF Staff, MORH staff
Telephone Interviews - Year 2	Liberty Medical Center, Chester McCone County Health Center, Circle Missouri River Medical Center, Fort Benton Pioneer Medical Center, Big Timber Roundup Memorial Healthcare, Roundup Rosebud Health Care Center, Forsyth Sheridan Memorial Hospital, Plentywood Teton Medical Center, Choteau Wheatland Memorial Healthcare,	Benefis Health System, Great Falls St. Patrick Hospital Missoula Billings Clinic, Billings	Care Transition Coordinator, MHREF Staff, MORH staff, MHA Director of Grants and Program Development

	Frontier CAHs	Tertiary Providers	Additional Interviews
	Harlowton Mineral Community Hospital, Superior* Granite County Medical Center, Philipsburg*		
Site Visit 2 – Year 3	Missouri River Medical Center, Fort Benton Liberty Medical Center, Chester Teton Medical Center, Choteau Mineral Community Hospital, Superior* Granite County Medical Center, Philipsburg*	Benefis Health System, Great Falls	Care Transition Coordinator, MHREF Staff, MORH staff, MHA Director of Grants and Program Development

* To-date has yet to start implementing the program.

The Altarum team will submit a site visit report containing a summary of synthesized analysis of all interview transcripts, observations, and data collected during the visit, and will identify any additional follow-up telephone interviews or data collection that will be required. In addition, the report will identify any opportunities to make adjustments to the following site visits' interview protocols, list of interview subjects, and/or data to be collected. Lastly, information and data gathered from the site visits will be incorporated into the Final Evaluation Report.

Appendix A-2: Advance Letter

Via Email

Dear Interviewee:

On behalf of the Office of Rural Health Policy, the Altarum Institute, IMPAQ International and the NORC Walsh Center for Rural Health Analysis are conducting an evaluation of the Frontier Community Health Care Network Coordination Grant. The grant is supporting the training and placement of community health workers in several Montana critical access hospitals to facilitate the coordination of care for clients.

The interview will be conducted either in-person or by telephone and will last no longer than one hour. Your participation will provide increased understanding and perspectives on access to quality care, adequate compensation, and regulations that allow for the integration and delivery of high quality care in frontier areas. With your permission, we will record the interview to assist us in taking notes and summarizing the discussion.

Findings from this evaluation will be included in reports for ORHP that may be publicly available. In those reports, data or quotations will not be linked to the identity of a particular respondent or organization.

If you have questions about this study, please contact me at knudson-alana@norc.org or at 301-634-9326. Shena Popat from NORC will be contacting you within the next few days to schedule a telephone interview. For questions about your rights as a study participant, you may call the NORC Institutional Review Board Administrator at 773-256-6000.. You may also contact Sarah Bryce in HRSA's Office of Rural Health Policy at 301-443-5982.

Thank you for your participation in this very important study.

Sincerely,

Alana Knudson, PhD

Co-Director, NORC Walsh Center for Rural Health Analysis

Appendix A-3: Informed Consent

Good morning/afternoon. My name is Alana Knudson and I am a researcher at the NORC Walsh Center for Rural Health Analysis. Altarum Institute, IMPAQ International and the Walsh Center have been contracted by the HRSA Office of Rural Health Policy to ascertain your unique perspective on the Frontier Community Health Care Network Coordination Grant. The grant is supporting the training and placement of community health workers in several Montana critical access hospitals to facilitate the coordination of care for clients.

This interview will last no more than one hour. There are no risks associated with your participation. Your participation is voluntary, and you may skip questions, and stop the interview at any time without any adverse consequences. Your answers will only be reported in aggregate form, and will not identify you or your organization. Your responses will be used in a final report for ORHP. If you have any questions about your rights as a participant in this research project, please call the NORC Institutional Review Board Administrator at 773-256-6000.

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Do you consent to participate in this interview? [All parties on line must say "yes" to proceed.]

Do you have any questions for me?

[If "yes" then proceed. If "no" then terminate interview.]

[BEGIN RECORDING]

NORC would like to record this interview in order to ensure our notes are as accurate and comprehensive as possible. This recording will be deleted at the end of the project. Do you consent to have this interview recorded?

[If all parties indicate "yes" then proceed, and continue to record the interview.]

[If "no" then say: "That's fine. Please be patient as I take notes." Then, stop and delete the recording.]

Appendix A-4: Hospital Administrator Interview Protocol

Interview Guide

1. How long have you been the CEO/administrator at this facility?
2. Has your career primarily been in CAH facilities?

Overview of Clients and Services

3. What proportion of your CAH clients are Medicare patients?
4. What proportion of your clients is covered by Medicaid?
5. What proportion of care is covered by private insurance?
6. What proportion of care is uncompensated?

Care Coordination

7. What hospital serves as your referral hospital?
8. Do you receive referrals from other facilities?
9. How does the coordination of care between your two facilities and individual care providers work? (e.g., written communication, oral communication, faxes, EHRs, or regularly scheduled meetings)
10. What is the CAH's relationship with other CAHs, networks, and referral hospitals?
11. How is care coordination achieved within your facility (e.g., case manager, transition coach, etc.)?
12. How are Community Health Workers used to integrate health care services and other health related social services for Medicare beneficiaries? For Medicaid beneficiaries? For privately insured clients? For uninsured clients?
 - a. What are some care coordination practices that have worked well?
 - a. What are some lessons learned?
13. For what reasons would a client be transferred out of the frontier community?
 - a. Client/family preference;
 - b. Availability of beds/services;
 - c. Cost;
 - d. Complexity of needed services; or
 - e. Other? (Please explain)
14. What are the unmet needs of the community (e.g., specialty care, assisted living, home health, meals on wheels, behavioral health)?
 - a. How do these unmet needs impact the community?
15. What additional agreements (e.g., HIPAA data sharing, state and/or regional, business partner, ACO partner, other?) would enhance care coordination?

Summary Questions

16. Do you have any suggestions for improving the coordination of care for your community's clients?
17. Is there anything else you would like to share regarding how to improve providing coordinated, integrated, high-quality health care to your clients or any suggestions on how to make the role of CHWs more valuable?

Thank you for taking the time to share your experience and ideas with us. We greatly appreciate your input.

Appendix A-5: Primary Care Provider Interview Protocol

This includes physicians, nurse practitioners, physician assistants, and other key staff.

Interview Guide

1. How long have you been a health care provider in this community?
2. Has your career primarily been in rural hospitals?
3. Could you please describe your medical education and training background?

Types of Clients

4. What proportion of the clients that you see are Medicare beneficiaries?
5. What proportion of your Medicare clients has at least one chronic condition?
6. What are the top five chronic conditions among your Medicare clients that you treat most frequently?
7. What proportion of your non-Medicare patients has chronic conditions?
 - a. What are the most prevalent chronic conditions among these clients?
8. Which client conditions do you think would best benefit from care coordination?

Care Coordination

9. How often do you refer your clients to providers outside of your community?
10. What facilities do you most often transfer clients to?
11. How often are these referrals made because of the following (seldom, occasionally, or frequently):
 - a. Client/family requests a referral
 - b. Availability of beds/services locally;
 - c. Cost;
 - d. Complexity of needed services; or
 - e. Other (Please specify)?
12. How does the coordination of care between your facility, the other facility and individual care providers work? (e.g., written communication, oral communication, faxes, EHRs, or regularly scheduled meetings)
 - a. Do you use EHRs?
 - b. How would you like to use EHRs for the purpose of care coordination?
13. Are you aware of the CAH's relationship with other CAHs, networks, and referral hospitals?
14. After a client is referred to another provider, does the client usually return to you for their primary care needs?
15. Does the referral provider usually communicate with you regarding the coordination of care for the client?

- a. If yes, how?
 - i. Is this coordination effective in providing high quality, integrated health care?
 - ii. Has the CHW helped to facilitate the communication between you and the referral provider?
 - iii. Please provide an example of how this coordination worked well.
- b. If not, why?
 - i. Is there and impact on client care? (e.g., medication reconciliation)
 - ii. Could the CHW role be improved or changed to help facilitate better communication with the referral provider?
 - 1. If so, how?

16. When discharging clients to their home, how is care coordinated?

- a. Who leads the discharge planning discussions? (E.g., director of nursing, provider, CHW, other?)
- b. What types of care plans/discharge plans are in place?
- c. Is this information readily available to the CHWs? If so, where is it located?
- d. Can you think of anything your clients should be discharged home with that they currently are not receiving?

17. Do you facilitate the coordination of care with other health care services/programs, such as home health, hospice, nursing home, and ambulatory care providers?

18. What would you say are essential elements for coordinated care?

19. Has care coordination improved within your facility since the implementation of the CHW program?

20. Are CHWs used to integrate health care services and other health related social services for Medicare clients?

- b. What practices have worked well?
- c. What are some lessons learned?

Quality of Care

21. How does the role of the CHW impact the quality of care provided in your practice?

- a. How does the CHW role impact the following:
 - i. Client care
 - ii. Coordination of services
 - iii. Staff time
 - iv. Use of resources (e.g., decrease the amount of duplicative tests)
- b. How does the CHW role impact quality initiatives?

Overall Questions

22. Is there an agreement in place between your facility and the referral facility to allow client data sharing to enhance care coordination?
 - a. How do these agreements affect the delivery of care?
23. If you could design the ideal care coordination model, what features would it include and why?

Summary Question

24. Is there anything else you would like to share regarding how to improve care coordination for your clients?

Thank you for taking the time to share your experiences and ideas with us. We greatly appreciate your input.

Appendix A-6: Community Health Worker Interview Protocol

Interview Guide

1. How long have you resided in this community?
2. What is your educational/training background?

Training

3. Was the initial training workshop sufficient to begin your role as a community health worker?
4. What components of the training have been most useful?
5. Are there any components of the training that were not useful?
6. Are there additional topics you would like added to the training?
7. Is there sufficient ongoing support and training?
8. Do you have any recommendations for future trainings?

Client Recruitment

9. How have you recruited clients into the care coordination program?
10. What has worked well to recruit clients?
11. How have you overcome challenges to client recruitment?
12. Do you receive any inappropriate referrals? (for services you cannot provide)

Medicare Clients

13. How many clients have you seen in the past year?
14. What proportion of these clients that you saw are Medicare beneficiaries?
15. What proportion of these clients is Medicaid?
16. Do any of your clients have private insurance coverage?
17. What proportion of your clients has at least one chronic disease?
18. What are the top five chronic diseases among the clients that are enrolled in the care coordination program?

Care Coordination

19. Please describe the types of care coordination activities that you have performed.
20. How often do you interact with the Care Transitions Coordinator?
21. How does the coordination of care between your facility, referral facilities and individual care providers work? (e.g., written communication, oral communication, faxes, EHRs, or regularly scheduled meetings)
 - a. How do you use EHRs?
 - b. How would you like to use EHRs?
22. After a client is referred to another provider, what is your role?
23. Will a referral provider communicate with you directly regarding the coordination of care for the client?
 - a. If yes, how?
 - i. Please provide an example of how this coordination worked well.
 - b. If not, why?
 - i. What happens to the client's care? (e.g., medication reconciliation)
 - ii. Please provide an example of how this lack of coordination negatively impacted your client.
24. How do you coordinate care with other health care services/programs, such as home health, hospice, nursing home, and ambulatory care providers? (e.g., making appointments, connecting client to providers, following up with clients to make sure they have transportation to go to an appointment, etc.)
25. Does your role involve integrating health care services and other health related social services clients may need such as Meals on Wheels?
26. What tasks or services do most clients need your help to coordinate?
27. What are some examples of times you felt your role was effective?
28. What are some lessons learned?

Overall Community Care Questions

29. Are there unmet health care needs for the clients enrolled in the care coordination program (e.g., specialty care, assisted living, home health, meals on wheels, behavioral health)?

a. If so, how can they be met?

30. Are there unmet non-health care needs you have seen which impact the client's ability to be successful in his/her living situation?

Summary Question

31. Are there any other issues we have not discussed pertaining to your role and experiences as a CHW?

Thank you for taking the time to share your experience and ideas with us. We greatly appreciate your input.

Appendix A-7: Care Transitions Coordinator Interview Protocol

Interview Guide

1. Please tell us about your educational and training background?

Training

2. What was your role in the initial training of the community health workers?
3. What are the strengths of the training?
4. Are there any weaknesses in the training?
5. What is your role in ongoing support and training?
6. Would you change anything in future trainings?

Client Recruitment

7. What practices are used to recruit clients into the care coordination program?
8. What are challenges to client recruitment?
9. Are there any lessons learned for client recruitment?
10. How long are clients retained in the care coordination program?
 - a. What types of health-related situations usually attract clients into the program (e.g., episodic event, chronic conditions, transition between care, other?)?

Care Coordination

11. Please describe the types of care transitions activities that you have performed.
12. How often do you interact with the local CHWs?
 - a. Please describe the support given to CHWs.
13. Are you evaluating the CHWs?
 - a. If yes, what criteria are used?
 - b. How often are you collecting information about the CHWs?
14. Do you have a role after a client is referred to another provider?

15. Does the referral provider communicate with you regarding how well the care coordination approach worked?
 - a. If yes, how? (e.g., communicate with the frontier provider, communicate with the referral provider, communicate with the client and/or family)
 - i. Is this coordination effective in providing high quality, integrated health care?
 1. Please provide an example of how this coordination worked well.
 - ii. Does the care coordination save the client and/or insurer money?
 1. If so, how?
 - b. If not, why?
 - i. How do you evaluate the effectiveness of the care coordination provided by the CHW?
16. How is care coordinated with other health care services/programs, such as home health, hospice, nursing home, and ambulatory care providers?
17. Does your role involve assisting CHWs integrate health care services and other health related social services for clients?
18. What are some promising practices?
19. What are some lessons learned from your role as a care transitions coordinator?

Summary Question

20. Are there any other issues we have not discussed pertaining to your role as care transitions coordinator?

Thank you for taking the time to share your experience and ideas with us. We greatly appreciate your input.

Appendix A-8: Grantee Interview Protocol

This includes staff from the Montana Department of Public Health & Human Services (MT DPPHS) and Montana Health Education and Research Foundation (MHREF).

Interview Guide

1. Please describe your position and role within the grant administration.

Training

2. What was your role in the initial training of the community health workers?
3. What are the strengths of the training?
4. Are there any gaps in the initial training that should be addressed in subsequent training?
5. What is your role in ongoing support and training?
6. What is your role in evaluation of the program?
7. Would you change anything in future trainings?

Program Administration

8. Please describe the grant program goals and objectives.
 - a. What grant program goals and objects have been completed or are in progress?
9. Do you collect progress reports or other ongoing information from the care transitions coordinator or community health workers?
 - a. If yes:
 - i. How often is data collected?
 - ii. What types of data are collected?

Summary Question

10. Are there any other issues we have not discussed pertaining to your role in this grant program?

Thank you for taking the time to share your experience and ideas with us. We greatly appreciate your input.

Appendix A-9: Beneficiary Focus Group or Interview Protocol

General Discussion Guide (Will be customized for each site)

1. Where do you usually go to see a physician, a nurse practitioner, or physician assistant?
2. Why do you choose to get your care from this health care provider? (prompts listed below)
 - a. Require specialty care
 - b. Convenient for family
 - c. Transportation
 - d. Shopping
 - e. Access to a pharmacist
 - f. Other?
3. Is high quality health care available locally?
 - a. Do you seek care locally?
 - i. Why or why not?
 - b. Are there services that should be provided locally but are not currently available?
 - c. Does your local care provider receive information from other providers (e.g., specialists) to support your health care needs? (Prompt: share your health records, lab results, medication updates, therapy regimens, other?)
4. Do you seek care in a neighboring community?
 - a. Where do you go?
 - b. Why do you go there for care? (Prompts: need specialty care, more technology, more convenient for family, we shop there for other things, etc.)
 - c. How far away do you travel?
 - d. How do you get there? (Prompts: personal transportation, ride with family or friend, county Sr. bus, Greyhound bus, other?)
 - e. Are there services you would rather travel to obtain?

- f. Do you ever receive care using telemedicine?
 - i. If so, do you like it? Why or why not?
 - g. Do your other health care providers coordinate care with your local health care provider? (e.g., home health care, therapy, etc.)
5. What have been the biggest challenges in accessing health care services that you need?
- a. Hard to make appointments?
 - b. Have to wait a long to get an appointment?
 - c. Problems getting information about available services?
 - d. Hard to get to the facility? (transportation)
 - e. Billing issues?
 - f. Health insurance coverage issues?
6. Have you ever spoken with [name], the community health worker, regarding your care?
- a. Did the community health worker help you?
 - i. If so, how?
 - ii. If not, what help do you need that you did not receive?
 - b. Are there other services that would be beneficial for coordinating your health care? (e.g., person to coordinate transportation, health care person who could translate information, other?)
 - c. Would you recommend using a community health worker to your friends?
 - i. Why or why not?
7. Do you have any other comments to share about healthcare?

Thank you for taking the time to share your experiences and ideas with us. We greatly appreciate your input