Table 1
Interview Questions

Questions asked in the Qualitative Interviews:
1. In your SMHA (VISN or HMO), is there a routine or periodic effort to systematically monitor in your patients the development of a range of cardio-metabolic adverse effects of SGAs?
2. If Yes, what potential adverse events are monitored (check all that apply): Weight change; BMI change; blood pressure; fasting blood glucose; HgbA1c; total cholesterol; HDL; LDL; triglycerides; waist circumference
3. What is the screening protocol? (Timing of collection/recollection and reporting of vitals or labs)
4. Besides being available in the medical record, are these results captured in a relational data base (RDB) or an electronic health record (EM/HR) which can be transferred into a statistical or relational data base file for aggregate data analysis? If yes, please describe.
5. What individual patient data are associated with the screening results in the RDB or EHR? Unique case number ; age; gender; ethnicity/race; primary diagnosis; SGA; dosage; co-prescribed psychotropic medication; anything else.
6. How does your SMHA plan to analyze these data to monitor compliance or types of adverse events associated with SGA treatment?
7. Has your SMHA estimated the cost of these monitoring/surveillance efforts (e.g., blood draw, lab fees, or data entry costs)?
8. How are these additional screening costs handled? Service is billable; volunteers are used; anything else?

9. Has your SMHA generated any reports of these screening costs or of the adverse events identified?
10. If No monitoring system is being used, what are the major obstacles to planning and implementing these surveillance efforts (check all that apply)? Deciding what to monitor; initial staff costs; reimbursement for clinical time/labs performed; data entry into a relational data base; costs of analyzing and reporting the aggregate surveillance data; primary care referrals for follow-up of positive results; anything else?

Table 1
Interview Questions and Responses by Type of Service system

Questions asked	SMHA Responses	VA Responses	HMORN Responses
In your SMHA, is there a routine or periodic effort to systematically monitor in your patients/clients the development of a range of cardio-metabolic adverse effects of SGAs?	Only three SMHAs reported that they were currently implementing components of cardio-metabolic screening criteria at baseline, predominantly when patients were started on the antipsychotics in state-operated inpatient facilities. Since most of these patients were discharged within a one to three weeks of starting antipsychotic treatment, their follow-up became the responsibility of local treatment clinics or physicians, who were not required to routinely collect or report the follow-up results to the SMHA, a centralized information system, or an electronic medical/health record.		
If Yes, what potential adverse events are monitored (check all that apply): Weight change; BMI change; Blood pressure; Fasting blood glucose; HgbA1c; Total cholesterol; HDL; LDL; Triglycerides; Waist circumference	Only one state had instituted the ADA/APA cardio-metabolic screening criteria at baseline with periodic follow-up in 2010, and had a reporting system in place to receive the dates and lab results over time for patients of all ages, and had an approved Medicaid reimbursement rate for staff to perform the periodic screenings on weight; BMI; blood pressure; HgbA1c.		
What is the screening protocol? (Timing of	One state collecting data every		

collection/recollection and reporting of vitals or labs)	six months.		
Besides being available in the medical record, are these results captured in a relational data base (RDB) or an electronic health record (HER) which can be transferred into a statistical or relational data base file for aggregate data analysis? If yes, please describe.	One state collecting data was inputting to an RDB which can be transferred into a statistical package for analysis. All state authorities had notified individual providers/ practitioners of the ADA/APA guidelines, but the majority did not have data systems which would allow the routine collection of these new data elements on BMI and lab results over time or produce reports of incidence rates of positive screening results.		
What individual patient data are associated with the screening results in the RDB or EHR? Unique case number ; Age; Gender; Ethnicity/race; Primary diagnosis; SGA; Dosage; Co-prescribed psychotropic medication; Anything Else.	One state collecting data on unique case number, primary diagnosis, and SGA dosage. Unique identifier could be used to merge other client, service, or cost data with monitoring results.		
How does your SMHA plan to analyze these data to monitor compliance or types of adverse events associated with SGA treatment?	No reports were available regarding the incidence rates for positive screenings on any of the cardio-metabolic criteria per time period (e.g., six month intervals).		
Has your SMHA estimated the cost of these monitoring/surveillance efforts (e.g., blood draw, lab fees, or data entry costs)?	No reports available.		
How are these additional screening costs handled? Service is billable; Volunteers are used; Anything Else?	Service is billable through Medicaid.		
Has your SMHA generated any reports of these screening costs or of the adverse events identified?	Not yet planned.		
If No monitoring system is being used, what are the major obstacles to planning and implementing these	SMHAs collecting no monitoring data reported major		

surveillance efforts (check all that apply)? Deciding what to monitor; Initial staff costs; Reimbursement for clinical time/labs performed; Data entry into a relational data base; Costs of analyzing and reporting the aggregate surveillance data; Primary care referrals for follow-up of positive results; Anything Else?	obstacles to be: deciding what to monitor; initial staff costs; reimbursement for clinical time/labs performed; data entry into a relational data base; costs of analyzing and reporting the aggregate surveillance data; primary care referrals for follow-up of positive results; and lack of state control over contracted provider agencies.		