The Medical Home Index: Pediatric
Measuring the Organization and Delivery of Pediatric Primary Care for All Children, Youth and Families

The Medical Home Index (MHI) is a validated self-assessment and classification tool designed to translate the broad indicators defining the medical home (accessible, family-centered, comprehensive, coordinated, etc.) into observable, tangible behaviors and processes of care within any office setting. It is a way of measuring and quantifying the "medical homeness" of a primary care practice. The MHI is based on the premise that "medical home" is an evolutionary process rather than a fully realized status for most practices. The MHI measures a practice's progress in this developmental process.

The MHI defines, describes, and quantifies activities related to the organization and delivery of primary care for all children and youth. A population of vulnerable children and youth, including those with special health care needs, benefit greatly from having a high quality medical home. Medical Home represents the standard of excellence for pediatric primary care, this means the primary care practice is ready and willing to provide well, acute and chronic care for all children and youth, including those affected by special health care needs or who hold other risks for compromised health and wellness.

You will be asked to rank the level (1-4) of your practice in six domains: organizational capacity, chronic condition management, care coordination, community outreach, data management and quality improvement/change. Most practices may not function at many of the higher levels (Levels 3 and 4). However these levels represent the kinds of services and supports which families report that they need from their medical home. A frank assessment of your current practice will best characterize your medical home baseline, and will help to identify needed improvement supports.

A companion survey to the Medical Home Index, the Medical Home Family Index (MHFI), is intended for use with a cohort of practice families (particularly those who have children/youth affected by a chronic health condition). The MHFI is to be completed by families whose children receive care from a practice with whom their child has been seen for over a year. The Medical Home Family Index provides the practice team with a valuable parent/consumer perspective on the overall experience of care.

Guidelines
CMHI tools are made available to you on our web site www.medicalhomeimprovement.org. When using these tools we request that you:
1) Inform CMHI in writing of your intent for use (e-mail is fine).
2) Make every effort to gain family feedback using the MHFI (or other tool). We believe that "medical homeness" cannot be fully measured without an analysis of the family perspective.
3) We would also appreciate you sharing data with us (in a confidential fashion). Most programs have done this by sending copies of the Medical Home Index and MHFI (with all practice and personal identifiers removed), or by simply sharing aggregate data.
Clinic Contact Information

Date

Clinic Name:

Street Address:

City: State: Zip Code:

Phone: Fax

Who took the lead in completing this form?

Who should we contact at your clinic if we have questions about your responses, or if responses are missing/incomplete?

Name (if different than the person who completed this form):

Title/Position/Role:

Best phone number to reach contact if different than above:

Contact E-mail:
The Medical Home Index: Pediatric
Measuring the Organization and Delivery of Pediatric Primary Care for All Children, Youth and Families

Describe your practice type/model

Number of clinicians: MD's __ ARNPs __ PA's __ Other __

Is there a care coordinator working at your practice who supports children, youth and families? ○ Yes ○ No

What is the estimated number of children that your practice cares for?

What is your patient panel size?

Can you estimate the percentage (total should = 100%) of children you care for who have:

1) __ % Public insurance only (Medicaid/Medicare)
2) __ % Private & Medicaid/Medicare
3) __ % Self/No pay
4) __ % Private insurance only
5) __ % Other

How familiar/knowledgeable are you about the concept of a medical home as defined by the American Academy of Pediatrics?

1) □ No knowledge of the concepts
2) □ Some knowledge/not applied
3) □ Knowledgeable/concept sometimes applied in practice
4) □ Knowledgeable/concepts regularly applied in practice

How familiar/knowledgeable are you about the elements of family-centered care as defined by the US Maternal and Child Health Bureau?

1) □ No knowledge of the concepts
2) □ Some knowledge/not applied
3) □ Knowledgeable/concept sometimes applied in practice
4) □ Knowledgeable/concepts regularly applied in practice

(Note: Any italicized words are defined in the glossary on page 15)
The Medical Home Index: Pediatric
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INSTRUCTIONS:
This instrument is organized under six domains:

1) Organizational Capacity  
2) Chronic Condition Management  
3) Care Coordination  
4) Community Outreach  
5) Data Management  
6) Quality Improvement

Each domain has anywhere from 2 -7 themes, these themes are represented with progressively comprehensive care processes and are expressed as a continuum from Level 1 through Level 4. For each theme please do the following:

First: Read each theme across its progressive continuum from Levels 1 to Level 4.
Second: Select the LEVEL (1, 2, 3 or 4) which best describes how your practice currently provides care for patients with chronic health condition
Third: When you have selected your Level, please indicate whether practice performance within that level is:
"PARTIAL" (some activity within level) or "COMPLETE" (all activity within that level).

For the example below, "Domain 1: Organizational Capacity, Theme 1.1 "The Mission..." the score for the practice is: "Level 3", "PARTIAL".

<table>
<thead>
<tr>
<th>Domain 1: Organizational Capacity: For CSHCN and Their Families</th>
</tr>
</thead>
</table>
| THEME: #1.1  
The Mission of the Practice |
| Level 1          | Level 2          | Level 3          | Level 4          |
| Primary care providers (PCPs) at the practice have individual ways of delivering care to children with special health care needs CSHCN; their own education, experience and interests drive care quality. | Approaches to the care of CSHCN at the practice are child rather than family-centered; office needs drive the implementation of care (e.g. the process of carrying out care). | The practice uses a family-centered approach to care (see page 15), they assess CSHCN and the needs of their families in accordance with its mission; feedback is solicited from families and influences office policies (e.g. the way things are done). | In addition to Level 3, a parent/practice "advisory group" promotes family-centered strategies, practices and policies (e.g. enhanced communication methods or systematic inquiry of family concerns/priorities); a written, visible mission statement reflects practice commitment to quality care for CSHCN and their families. |
| PARTIAL ☐ COMPLETE ☐ | PARTIAL ☐ COMPLETE ☐ | ☑ PARTIAL ☐ COMPLETE ☐ | PARTIAL ☐ COMPLETE ☐ |
### Domain 1: Organizational Capacity: For CSHCN and Their Families

<table>
<thead>
<tr>
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<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1.1 The Mission of the Practice</td>
<td>Primary care providers (PCPs) at the practice have individual ways of delivering care to children with special health care needs (CSHCN); their own education, experience and interests drive care quality.</td>
<td>Approaches to the care of CSHCN at the practice are child rather than family-centered; office needs drive the implementation of care (e.g. the process of carrying out care).</td>
<td>The practice uses a family-centered approach to care (see page15), they assess CSHCN and the needs of their families in accordance with its mission; feedback is solicited from families and influences office policies (e.g. the way things are done).</td>
<td>In addition to Level 3, a parent/practice &quot;advisory group&quot; promotes family-centered strategies, practices and policies (e.g. enhanced communication methods or systematic inquiry of family concerns/priorities); a written, visible mission statement reflects practice commitment to quality care for CSHCN and their families.</td>
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<tr>
<td>#1.2 Communication/Access</td>
<td>Communication between the family and the PCP occurs as a result of family inquiry; PCP contacts with the family are for test result delivery or planned medical follow-up.</td>
<td>In addition to Level 1, standardized office communication methods are identified to the family by the practice (e.g. call-in hours, phone triage for questions, or provider call back hours).</td>
<td>Practice and family communicate at agreed upon intervals and both agree on &quot;best time and way to contact me&quot;; individual needs prompt weekend or other special appointments.</td>
<td>In addition to Level 3, office activities encourage individual requests for flexible access; access and communication preferences are documented in the care plan and used by other practice staff (e.g. fax, e-mail or web messages, home, school or residential care visits).</td>
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<tr>
<td>#1.3 Access to the Medical Record</td>
<td>A policy of access to medical records is not routinely discussed with families; records are provided only upon request.</td>
<td>In addition to Level 1, it is established among staff that families can review their child's record (but this fact is not explicitly shared with families).</td>
<td>All families are informed that they have access to their child's record; staff facilitates access within 24-48 hours.</td>
<td>In addition to Level 3, practice orientation materials include information on record access; staff locate space for families to read their child's record and make themselves available to answer questions.</td>
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</table>

Instructions:  
A) Please select and circle one level from Levels 1, 2, 3, or 4 for each theme above (circle one).  
B) Then indicate whether you place your practice at a PARTIAL or COMPLETE ranking within that level (circle one).
# Domain 1: Organizational Capacity (continued): For CSHCN and Their Families

<table>
<thead>
<tr>
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<tbody>
<tr>
<td><strong>#1.4 Office Environment</strong>&lt;br&gt;Requires both MD &amp; key non-MD staff person's perspective.</td>
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<td></td>
<td>Special needs concerning physical access and other visit accommodations are considered at the time of the appointment and are met if possible.</td>
<td>Assessments are made during the visit of children with special health care needs and the needs of their families; any physical access &amp; other visit accommodation needs are addressed at the visit and are documented for future encounters.</td>
<td>In addition to Level 2, staff ask about any new or pre-existing physical and social needs when scheduling appointments; chart documentation is updated and staff are informed/prepared ahead of time ensuring continuity of care.</td>
<td>In addition to Level 3, key staff identify children scheduled each day with special health care needs, prepare for their visit and assess and document new needs at the visit; an office care coordinator prepares both office staff and the office environment for the visit; s/he advocates for changes (office/environmental) as needed.</td>
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<td>☐ Partial ☐ Complete</td>
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<tr>
<td><strong>#1.5 Family Feedback</strong>&lt;br&gt;Requires both MD &amp; key non-MD staff person's perspective.</td>
<td>Family feedback to the practice occurs through external mechanisms such as satisfaction surveys issued by a health plan; this information is not always shared with practice staff.</td>
<td>Feedback from families of CSHCN is elicited sporadically by individual practice providers or by a suggestion box; this feedback is shared informally with other providers and staff.</td>
<td>Feedback from families of CSHCN regarding their perception of care is gathered through systematic methods (e.g. surveys, focus groups, or interviews); there is a process for staff to review this feedback and to begin problem solving.</td>
<td>☐ Partial ☐ Complete</td>
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<tr>
<td><strong>#1.6 Cultural Competence</strong></td>
<td>The primary care provider (PCP) attempts to overcome obstacles of language, literacy, or personal preferences on a case by case basis when confronted with barriers to care.</td>
<td>In addition to Level 1, resources and information are available for families of the most common diverse cultural backgrounds; others are assisted individually through efforts to obtain translators or to access information from outside sources.</td>
<td>In addition to Level 2, materials are available and appropriate for non-English speaking families, those with limited literacy; these materials are appropriate to the developmental level of the child/young adult.</td>
<td>In addition to Level 3, family assessments include pertinent cultural information, particularly about health beliefs; this information is incorporated into care plans; the practice uses these encounters to assess patient &amp; community cultural needs.</td>
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<td>☐ Partial ☐ Complete</td>
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## Domain 1: Organizational Capacity (continued): For CSHCN and Their Families

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<th>Level 4</th>
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</thead>
<tbody>
<tr>
<td>#1.7 Staff Education</td>
<td>For all staff, an orientation to internal office practices, procedures and policies is provided.</td>
<td>In addition to Level 1, the practice supports (paid time/tuition support) continuing education for all staff in the care of CSHCN (children with special health care needs).</td>
<td>In addition to Level 2, educational information on community-based resources for CSHCN, including diagnosis specific resource information, is available for all staff.</td>
<td>In addition to Level 3, families of CSHCN are integrated into office staff orientations and educational opportunities as teachers or &quot;family faculty&quot;; support for families to take this role is provided.</td>
</tr>
<tr>
<td>#2.1 Identification of Children in the Practice with Special Health Care Needs</td>
<td>Requires both MD &amp; key non-MD staff person's perspective.</td>
<td>In addition to Level 1, lists of children with special health care needs are extracted electronically by diagnostic code.</td>
<td>A CSHCN list is generated by applying a definition (see pg. 15), the list is used to enhance care +/or define practice activities (e.g. to flag charts and computer databases for special attention or identify the population and its subgroups).</td>
<td>In addition to Level 3, diagnostic codes for CSHCN are documented, problem lists are current, and complexity levels are assigned to each child; this information creates an accessible practice database.</td>
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### Partial ### Complete

## Domain 2: Chronic Condition Management (CCM): For CSHCN and Their Families

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<tr>
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<th>Level 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>#2.1 Identification of Children in the Practice with Special Health Care Needs</td>
<td>Children with special health care needs (CSHCN) can be counted informally (e.g. by memory or from recent acute encounter); comprehensive identification can be done through individual chart review only.</td>
<td>Lists of children with special health care needs are extracted electronically by diagnostic code.</td>
<td>The team (including PCP, family, and staff) develops a plan of care for CSHCN which details visit schedules and communication strategies; home, school and community concerns are addressed in this plan. Practice back up/cross coverage providers are informed by these plans.</td>
<td>In addition to Level 3, the practice/teams use condition protocols; they include goals, services, interventions and referral contacts. A designated care coordinator uses these tools and other standardized office processes which support children and families.</td>
</tr>
<tr>
<td>#2.2 Care Continuity</td>
<td>Visits occur with the child's own primary care provider (PCP) as a result of acute problems or well child schedules; the family determines follow up.</td>
<td>Non-acute visits occur with families and their PCP to address chronic condition care; the PCP determines appropriate visit intervals; follow-up includes communication of tasks to staff and of lab and medical test results to the family.</td>
<td>In addition to Level 2, educational information on community-based resources for CSHCN, including diagnosis specific resource information, is available for all staff.</td>
<td>In addition to Level 3, families of CSHCN are integrated into office staff orientations and educational opportunities as teachers or &quot;family faculty&quot;; support for families to take this role is provided.</td>
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</table>

### Partial ### Complete
# Domain 2: Chronic Condition Management (continued): For CSHCN and Their Families

### THEME: Continuity Across Settings

#### #2.3

**Communication among the PCP, specialists, therapists, and school happens as needs arise for CSHCN.**

**Level 1**

- Partial
- Complete

**Level 2**

- Partial
- Complete

**Level 3**

- Partial
- Complete

**Level 4**

- Partial
- Complete

In addition to Level 3, a method is used to convene the family and key professionals on behalf of children with more complex health concerns; specific issues are brought to this group and they all share and use a written plan of care.

#### #2.4

**Specialty referrals occur in response to specific diagnostic and therapeutic needs; families are the main initiators of communication between specialists and their primary care provider (PCP).**

**Level 1**

- Partial
- Complete

**Level 2**

- Partial
- Complete

**Level 3**

- Partial
- Complete

**Level 4**

- Partial
- Complete

In addition to Level 3, the family has the option of using the practice in a strong coordinating role; parents as partners with the practice manage their child's care using specialists for consultations and information (unless they decide it is prudent for the specialist to manage the majority of their child's care).

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**Instructions:**

A) Please select and circle one level from Levels 1, 2, 3, or 4 for each theme above (circle one).

B) Then indicate whether you place your practice at a PARTIAL or COMPLETE ranking within that level (circle one).
## Domain 2: Chronic Condition Management (continued): For CSHCN and Their Families

### THEME:

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Level 2 (in addition to level 1)</th>
<th>Level 3 (in addition to level 2)</th>
<th>Level 4 (in addition to level 3)</th>
</tr>
</thead>
</table>
| # 2.5.1 Supporting the Transition to Adulthood  
* transition measure revised August, 2006. | **Pediatric and adolescent primary care providers (PCPs) adhere to defined health maintenance schedules for youth with special health care needs in their practice.** | **Pediatric and adolescent PCPs offer age appropriate anticipatory guidance for specific youth & families related to their chronic condition, self-care, nutrition, fitness, sexuality, and other health behavior information.** | **Pediatric and adolescent PCPs support youth & family to manage their health using a transition time line & developmental approach; they assess needs & offer culturally effective guidance related to:**  
  - health & wellness  
  - education & vocational planning  
  - guardianship and legal & financial issues  
  - community supports & recreation  
When youth transition from pediatrician to adult provider:  
**Pediatricians** help to identify an adult PCP and sub-specialists and offer ongoing consultation to youth, family and providers during the transition process.  
**Adult Providers** offer an initial "welcome" visit and a review of transition goals. | **Progressively from age 12, youth, family and PCP develop a written transition plan within the care plan; it is made available to families and all involved providers. Youth and families receive coordination support to link their health and transition plans with other relevant adolescent and adult providers/services/agencies (e.g. sub-specialists, educational, financial, insurance, housing, recreation employment and legal assistance).** |
| Families are responsible for carrying out recommendations made to them by their **PCP** when they specifically ask for family support or help. | The **practice** responds to clinical needs; broader social and family needs are addressed and referrals to support services facilitated. | The **practice** actively takes into account the overall family impact when a child has a chronic health condition by considering all family members in care; when families request it, staff will assist them to set up family support connections. | In addition to Level 3, the **practice** sponsors family support activities (e.g. skills building for parents of CSHCN on how to become a supporting parent); they have current knowledge of community or state support organizations and connect parents to them. |

© Center for Medical Home Improvement 2001; Transition to adulthood indicator #2.5.1 revised 2006
### Domain 3: Care Coordination For CSHCN and Their Families

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</thead>
<tbody>
<tr>
<td><strong>#3.1 Care Coordination /Role Definition</strong>&lt;br&gt;The family coordinates care without specific support; they integrate office recommendations into their child's care.</td>
<td>☐ Partial ☐ Complete</td>
<td>☐ Partial ☐ Complete</td>
<td>☐ Partial ☐ Complete</td>
<td>☐ Partial ☐ Complete</td>
</tr>
<tr>
<td><strong>#3.2 Family Involvement</strong>&lt;br&gt;The PCP makes medical recommendations and defines care coordination needs, the family carries these out.</td>
<td>☐ Partial ☐ Complete</td>
<td>☐ Partial ☐ Complete</td>
<td>☐ Partial ☐ Complete</td>
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<tr>
<td><strong>#3.3 Child and Family Education</strong>&lt;br&gt;&lt;em&gt;Requires both MD &amp; key non-MD staff person's perspective.&lt;/em&gt;</td>
<td>☐ Partial ☐ Complete</td>
<td>☐ Partial ☐ Complete</td>
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Practice staff offer a set of care coordination activities (*see page 16), their level of involvement fluctuates according to family needs/wishes. A designated care coordinator ensures the availability of these activities including written care plans with ongoing monitoring.

In addition to Level 3, children & families contribute to a description of care coordination activities; a care coordinator specifically develops and implements this practice capacity which is evaluated by families and designated supervisors.

In addition to Level 3, diverse materials and teaching methods are used to address individual learning styles & needs; education is broad in scope and learning outcomes are examined.
### Domain 3: Care Coordination (continued): For CSHCN and Their Families:

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<tr>
<td>#3.4 Assessment of Needs/Plans of Care</td>
<td>Presentation of CSHCN with acute problems determines how needs are addressed.</td>
<td>PCPs identify specific needs of CSHCN; follow-up tasks are arranged for, or are assigned to families &amp;/or available staff.</td>
<td>The child with special needs, family, and PCP review current child health status and anticipated problems or needs; they create/revise action plans and allocate responsibilities at least 2 times per year or at individualized intervals.</td>
<td>In addition to Level 3, the PCP/staff and families create a written plan of care that is monitored at every visit; the office care coordinator is available to the child and family to implement, update and evaluate the care plan.</td>
</tr>
</tbody>
</table>

- #3.4 Partial Complete
- Level 2 Partial Complete
- Level 3 Partial Complete
- Level 4 Partial Complete

| #3.5 Resource Information and Referrals | Requires both MD & key non-MD staff person’s perspective. | Information about resource needs and insurance coverage is gathered during regular family visit intakes; the practice addresses immediate family information and resource needs. | Using a listing of community, state, and national resources which cover physical, developmental, social and financial needs the practice responds to family requests for information; the family seeks out additional information & may share back lessons learned. | Significant office knowledge about family and medical resources and insurance options is available; assessment of family needs leads to supported use of resources and information to solve specific problems. | In addition to Level 3, practice staff work with families helping solve resource problems; a designated care coordinator provides follow up, researches additional information, seeks and provides feedback and assists with the family to integrate new information into the care plan. |

- #3.5 Partial Complete
- Level 2 Partial Complete
- Level 3 Partial Complete
- Level 4 Partial Complete

| #3.6 Advocacy | The PCP suggests that the family find support services & resources outside of the practice when specific needs arise (e.g. diagnosis specific support groups, disability rights organizations, or Parent Support and Information Centers). | All families of CSHCN are routinely provided with basic information about Parent to Parent groups, family support, and advocacy resources during scheduled practice visits. | The practice team identifies resources to the family for support and advocacy, facilitates the connections, and advocates on a family’s behalf to solve specific problems pertinent to CSHCNs. | In addition to Level 3, this team advocates on behalf of all CSHCN and their families as a population and helps to create opportunities for community forums, discussions or support groups which address specific concerns. |

- #3.6 Partial Complete
- Level 2 Partial Complete
- Level 3 Partial Complete
- Level 4 Partial Complete
## Domain 4: Community Outreach: For CSHCN and Their Families

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<tbody>
<tr>
<td>#4.1 Community Assessment of Needs for CSHCN</td>
<td>Primary care provider (PCP) awareness of the population of children with special health care needs CSHCN in their community is directly related to the number of children for whom the provider cares.</td>
<td>The practice learns about issues and needs related to CSHCNs from key community informants; providers blend this input with their own personal observations to make an informal and personal assessment of the needs of CSHCN in their community.</td>
<td>In addition to Level 2, providers raise their own questions regarding the population of CSHCN in their practice community(ies); they seek pertinent data and information from families and local/state sources and use data to inform practice care activities.</td>
<td>In addition to Level 3, at least one clinical practice provider participates in a community-based public health need assessment about CSHCN, integrates results into practice policies, and shares conclusions about population needs with community &amp; state agencies.</td>
</tr>
<tr>
<td>#4.2 Community Outreach to Agencies and Schools.</td>
<td>When the family, school or agency request interactions with the primary care provider (PCP) on behalf of a child's community needs, the provider responds, thereby establishing the practice as a resource.</td>
<td>In addition to Level 1, when a community agency or school requests technical assistance or education from the practice about CSHCN, the practice communicates, collaborates, and educates based upon availability and interest.</td>
<td>The practice initiates outreach to community agencies and schools that directly serve CSHCN (e.g., through representation on one or more advisory boards or committees); they advocate for improved community services and inter-organizational collaboration &amp; communication.</td>
<td>In addition to Level 3, the practice identifies needs of CSHCN &amp; their families; they work with families to sponsor activities that raise community awareness to resource and support needs (e.g., specialized home care, respite care recreation opportunities, or improving home/school/ provider communication).</td>
</tr>
</tbody>
</table>

**Instructions:**
A) Please select and circle one level from Levels 1, 2, 3, or 4 for each theme above (circle one).
B) Then indicate whether you place your practice at a PARTIAL or COMPLETE ranking within that level (circle one).
## Domain 5: Data Management: For CSHCN and Their Families

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<th>Level 4</th>
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<tbody>
<tr>
<td>#5.1 Electronic Data Support</td>
<td><em>Primary care providers (PCPs)</em> retrieve information/data by individual chart review; electronic data are available and retrievable from payer sources only.</td>
<td>Electronic recording of data is limited to billing &amp; scheduling; data are retrieved according to diagnostic code in relation to billing and scheduling; these data are used to identify specific patient groupings.</td>
<td>An electronic data system includes identifiers and utilization data about children with special health care needs CSHCN; these data are used for monitoring, tracking, and for indicating levels of care complexity.</td>
<td>In addition to Level 3, an electronic data system is used to support the documentation of need, monitoring of clinical care, care plan and related coordination and the determination of outcomes (e.g. clinical, functional, satisfaction and cost outcomes).</td>
</tr>
<tr>
<td>#5.2 Data Retrieval Capacity</td>
<td><em>PCP</em> retrieves patient data from paper records in response to outside agency requirements (e.g. quality standards, special projects, or practice improvements).</td>
<td>The <em>practice</em> retrieves data from paper records and electronic billing and scheduling for the support of significant office changes (e.g. staffing, or allocation of resources).</td>
<td>Data are retrieved from electronic records to identify and quantify populations and to track selected health indicators &amp; outcomes.</td>
<td>In addition to Level 3, electronic data are produced and used to drive practice improvements &amp; to measure quality against benchmarks; (those producing and using data practice confidentiality).</td>
</tr>
</tbody>
</table>
## Domain 6: Quality Improvement/Change: For CSHCN and Their Families

<table>
<thead>
<tr>
<th>THEME:</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>#6.1 Quality Standards (structures)</td>
<td>Quality standards for children with special health care needs (CSHCN) are imposed upon the practice by internal or external organizations.</td>
<td>In addition to Level 1, an individual staff member participates on a committee for improving processes of care at the practice for CSHCN. This person communicates and promotes improvement goals to the whole practice.</td>
<td>The practice has its own systematic quality improvement mechanism for CSHCN; regular provider and staff meetings are used for input and discussions on how to improve care and treatment for this population.</td>
<td>In addition to Level 3, the practice actively utilizes quality improvement (QI) processes; staff and parents of CSHCN are supported to participate in these QI activities; resulting quality standards are integrated into the operations of the practice.</td>
</tr>
<tr>
<td>#6.2 Quality Activities (processes)</td>
<td>Primary care providers (PCPs) have completed courses or have had an adequate orientation to continuous quality improvement methods.</td>
<td>Corporate owners, administrators or payers identify practice deficits and set goals for improvements; practice providers and staff are identified to fix problems with limited participation in the process.</td>
<td>Periodic formal, and informal quality improvement activities gather staff input about practice improvement ideas and opportunities for CSHCN; efforts are made toward related changes and improvements for this population.</td>
<td>In addition to Level 3, the practice systematically learns about CSHCN &amp; draws upon family input; together the practice and families design and implement office changes that address needs and gaps; they then study their outcomes and act accordingly.</td>
</tr>
</tbody>
</table>

Please make certain you have chosen a Level (1-4). Also indicate whether your practice performance within that level is "partial" (some activity within that level) or "complete" (all activity within the level). Thank You

**Instructions:**
A) Please select and circle one level from Levels 1, 2, 3, or 4 for each theme above (circle one).
B) Then indicate whether you place your practice at a PARTIAL or COMPLETE ranking within that level (circle one).
Definitions of Core Concepts. (Words in *italics* throughout the document are defined below.)

**Children with Special Health Care Needs (CSHCN):**
Children with special health care needs are defined by the US Maternal and Child Health Bureau as those who have, or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who require health and related services of a type or amount beyond that required by children generally (USDHHS, MCHB, 1997).

**Medical Home:**
A medical home is a community-based primary care setting which provides and coordinates high *quality*, planned, patient/family-centered: health promotion (acute, preventive) and *chronic condition management* © CMHI, 2006).

**Family-Centered Care (US Maternal and Child Health Bureau, 2004):**
Family-centered care assures the health and well-being of children and their families through a respectful family-professional partnership. It honors the strengths, cultures, traditions and expertise that everyone brings to this relationship. Family-centered care is the standard of practice which results in high quality services.
Glossary of Terms

Practice-Based Care Coordination
Care and services performed in partnership with the family and providers by health professionals to:

1) Establish family-centered community-based Medical Homes for CSHCN and their families.
   - Make assessments and monitor child and family needs
   - Participate in parent/professional practice improvement activities

2) Facilitate timely access to the Primary Care Provider (PCP), services and resources
   - Offer supportive services including counseling, education and listening
   - Facilitate communication among PCP, family and others

3) Build bridges among families and health, education and social services; promotes continuity of care
   - Develop, monitor, update and follow-up with care planning and care plans
   - Organize wrap around teams with families; support meeting recommendations and follow-up

4) Supply/provide access to referrals, information and education for families across systems.
   - Coordinate inter-organizationally
   - Advocate with and for the family (e.g. to school, day care, or health care settings)

5) Maximize effective, efficient, and innovative use of existing resources
   - Find, coordinate and promote effective and efficient use of current resources
   - Monitor outcomes for child, family and practice

Chronic Condition Management (CCM):
CCM acknowledges that children and their families may require more than the usual well child, preventive care, and acute illness interventions. CCM involves explicit changes in the roles of providers and office staff aimed at improving:

1) Access to needed services
2) Communication with specialists, schools, and other resources, and
3) Outcomes for patients, families, practices, employers and payers.
GLOSSARY OF TERMS *(continued)*

**Quality:**
Quality is best determined or judged by those who need or who use the services being offered. Quality in the medical home is best achieved when one learns what children with special health care needs and their families require for care and what they need for support. Health care teams in partnership with families then work together in ways which enhance the capacity of the family and the practice to meet these needs. Responsive care is designed in ways which incorporate family needs and suggestions. Those making practice improvements must hold a commitment to doing what needs to be done and agree to accomplish these goals in essential partnerships with families.

**Office Policies:**
Definite courses of action adopted for expediency; "the way we do things"; these are clearly articulated to and understood by all who work in the office environment.

**Practice:**
The place, providers, and staff where the PCP offers pediatric care

**Primary Care Provider - (PCP):**
Physician or pediatric nurse practitioner who is considered the main provider of health care for the child

**United States Maternal and Child Health Bureau - (USMCHB):**
A division of Health Resources Services Administration

Requires both MD and key non-MD staff person's perspective - you will see this declaration before select themes; CMHI has determined that these questions require the input of both MD and non MD staff to best capture practice activity.
Summary/Notes

Notes, comments and questions:

Comments:

Questions:

Confusing themes:

What do you want to be asked that this measurement tool does not address?

What would you like us to know about the quality of care that you provide?