Center for
Medical Home
Improvement

The Medical Home Index - Short Version:

Measuring the Organization and Delivery of Primary Care for Children with Special Health Care Needs

The Medical Home Index - Short Version (MHI-SV) represents ten indicators which have been derived from the Center for Medical Home Improvement's (CMHI) original Medical Home Index (MHI). This short version can be used as an interval measurement in conjunction with the original MHI ***or*** it can be used as a quick "report card" or snapshot of practice quality. CMHI recommends the use of the full MHI for practice improvement purposes but offers this short version for interval or periodic measurement and/or when it is not feasible to use the full MHI.

The Medical Home Index is a nationally validated self-assessment tool designed to quantify the "medical homeness" of a primary care practice. The MHI contains twenty-five indicators which detail excellent, pro-active, comprehensive pediatric primary care. It functions both as a quality improvement tool and as a self education medium relevant to the medical home.

The Medical Home Index: Short Version (MHI-SV) is a brief representation of the more complete measurement tool. It scores a practice on a continuum of care across three levels:

- Level 1 is good, responsive pediatric primary care.
- Level 2 is pro-active pediatric primary care (in addition to Level 1)
- Level 3 illustrates pediatric primary care at the most comprehensive levels (it is in addition to Levels 1 and 2).

As the reporter for your entire practice and in response to each of the ten indicators - please score your medical home at: Level 1, Level 2 "partial", Level 2 "complete", Level 3 "partial", or Level 3 "complete".

Both the full 25-item Medical Home Index and this 10-item Medical Home Index – Short Version can be downloaded from the CMHI website at www.medicalhomeimprovement.org.

Medical Home Index – Short Version (MHI-SV)

	Level 1	***Level 2*** (in addition to level 1)	***Level 3*** (in addition to level 2)
# 1 Family Feedback ***Requires both MD & key non-MD staff person's perspective.*** ***(# 1.5 MHI-Full Version)***	Pediatric primary care without the elements detailed in levels 2 and 3. ❒ **Level 1**	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. ❒ **PARTIAL** ❒ **COMPLETE**	An advisory process is in place with families of ***CSHCN*** which helps to identify needs and implement creative solutions; there are tangible supports to enable families to participate in these activities (e.g. childcare or parent stipends). ❒ **PARTIAL** ❒ **COMPLETE**
# 2 Cultural Competence ***(# 1.6 MHI-FV)***	Pediatric primary care without the elements detailed in levels 2 and 3. ❒ **Level 1**	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. ❒ **PARTIAL** ❒ **COMPLETE**	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 & community cultural needs. ❒ **PARTIAL** ❒ **COMPLETE**
#3 Identification of Children in the Practice with Special Health Care Needs ***(# 2.1 MHI-FV)***	Pediatric primary care without the elements detailed in levels 2 and 3. ❒ **Level 1**	A ***CSHCN*** list is generated by applying a definition (see pg. 6), 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). ❒ **PARTIAL** ❒ **COMPLETE**	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. ❒ **PARTIAL** ❒ **COMPLETE**

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#4 Care Continuity *(# 2.2 MHI-FV)*	Pediatric primary care without the elements detailed in levels 2 and 3. ❒ **Level 1**	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. ❒ **PARTIAL** ❒ **COMPLETE**	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. ❒ **PARTIAL** ❒ **COMPLETE**
#5 Cooperative Management Between Primary Care Provider (PCP) and Specialist *(# 2.4 MHI-FV)*	Pediatric primary care without the elements detailed in levels 2 and 3. ❒ **Level 1**	The ***PCP*** and family set goals for referrals and communicate these to specialists; together they clarify co-management roles among family, ***PCP*** and specialists and determine how specialty feedback to the family and ***PCP*** is expressed, used, and shared. ❒ **PARTIAL** ❒ **COMPLETE**	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). ❒ **PARTIAL** ❒ **COMPLETE**

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#6 Supporting the Transition to Adulthood *(# 2.5.1 MHI-FV)*	Pediatric primary care without the elements detailed in levels 2 and 3. ❒ **Level 1**	Pediatric and adolescent PCPs support youth & family to manage their health using a transition timeline & 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. ❒ **PARTIAL** ❒ **COMPLETE**	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). ❒ **PARTIAL** ❒ **COMPLETE**
#7 Care Coordination /Role Definition *(# 3.1 MHI-FV)*	Pediatric primary care without the elements detailed in levels 2 and 3. ❒ **Level 1**	Care coordination activities are based upon ongoing assessments of child and family needs; the ***practice*** partners with the family (and older child) to accomplish care coordination goals. ❒ **PARTIAL** ❒ **COMPLETE**	Practice staff offer a set of care coordination activities, 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. ❒ **PARTIAL** ❒ **COMPLETE**

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#8 Assessment of Needs/ Plans of Care *(# 3.4 MHI-FV)*	Pediatric primary care without the elements detailed in levels 2 and 3. ❒ **Level 1**	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. ❒ **PARTIAL** ❒ **COMPLETE**	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. ❒ **PARTIAL** ❒ **COMPLETE**
#9 Community Assessment of Needs for CSHCN *(# 4.1 MHI-FV)*	Pediatric primary care without the elements detailed in levels 2 and 3. ❒ **Level 1**	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. ❒ **PARTIAL** ❒ **COMPLETE**	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 & state agencies. ❒ **PARTIAL** ❒ **COMPLETE**
#10 Quality Standards (structures) *(# 6.1 MHI-FV)*	Pediatric primary care without the elements detailed in levels 2 and 3. ❒ **Level 1**	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. ❒ **PARTIAL** ❒ **COMPLETE**	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***. ❒ **PARTIAL** ❒ **COMPLETE**

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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, family-centered health promotion and chronic condition management. According to the American Academy of Pediatrics (AAP) "medical home" is accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally competent.

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.

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GLOSSARY OF TERMS (continued)

Care Coordination Activities:

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, daycare, 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 children and families.

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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; the project has found that these questions require the input of both MD and non MD staff to best capture practice activity.