

The Medical Home Index: Revised Short Form: 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. The medical home model 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.

The MHI-Revised Short Form (MHI-RSF) is a subset of 14 items from the MHI. The item numbers in black are the original item numbers from the MHI, and the numbers in red denote the 14 items on the MHI-RSF. 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 have received care from a practice for over a year. The MHFI provides the practice team with a valuable parent/consumer perspective on the overall experience of care.

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Clinic Contact Information

Date: _____

Clinic Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Email: _____

Who took the lead in completing this form? _____

Title/Position/Role: _____

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 Email: _____

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Describe your practice type/model: _____

Number of: 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

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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 1-4 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 conditions.
- Third:** When you have selected your Level, please indicate whether *practice* performance within that level is: "**PARTIAL**" (some activity within that 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**".

Italicized terms are included in the **glossary** beginning on page 11 of this document.

Domain 1: Organizational Capacity:					
THEME:	Level 1	Level 2	<u>EXAMPLE</u>	Level 3	Level 4
#1.1 The Mission of the Practice	<i>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.</i> <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE	<i>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).</i> <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE	The practice uses a family-centered approach to care, they assess CSHCN and the needs of their families in accordance with its mission; feedback is solicited from families and influences office policy (e.g. the way things are done). <input checked="" type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE	<i>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.</i> <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE	

Domain 1: Organizational Capacity: For CSHCN and Their Families				
THEME:	Level 1	Level 2	Level 3	Level 4
1 #1.2 Communication/ Access	Communication between the family and the <i>primary care provider (PCP)</i> occurs as a result of family inquiry; <i>PCP</i> contacts with the family are for test result delivery or planned medical follow-up. <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE	In addition to Level 1, standardized office communication methods are identified to the family by the <i>practice</i> (e.g. call-in hours, phone triage for questions, or provider call back hours). <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE	<i>Practice</i> and family communicate at agreed upon intervals and both agree on "best time and way to contact me"; individual needs prompt weekend or other special appointments. <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE	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 <i>practice</i> staff (e.g. fax, e-mail or web messages, home, school or residential care visits). <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE
2 #1.5 Family Feedback <i>CMHI has determined that item 1.5 requires the input of both physician and non-physician staff to best capture practice activity.</i>	Family feedback to the <i>practice</i> occurs through external mechanisms such as satisfaction surveys issued by a health plan; this information is not always shared with <i>practice</i> staff. <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE	Feedback from families of <i>children with special health care needs (CSHCN)</i> is elicited sporadically by individual <i>practice</i> providers or by a suggestion box; this feedback is shared informally with other providers and staff. <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE	Feedback from families of <i>CSHCN</i> 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. <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE	In addition to Level 3, an advisory process is in place with families of <i>CSHCN</i> 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). <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE
3 #1.6 Cultural Competence	The <i>PCP</i> attempts to overcome obstacles of language, literacy, or personal preferences on a case by case basis when confronted with barriers to care. <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE	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. <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE	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. <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE	In addition to Level 3, family assessments include pertinent cultural information, particularly about health beliefs; this information is incorporated into care plans; the <i>practice</i> uses these encounters to assess patient & community cultural needs. <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE

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).

Note: Any italicized words are defined in the glossary on page 11.

Domain 2: Chronic Condition Management (CCM): For CSHCN and Their Families				
THEME	Level 1	Level 2	Level 3	Level 4
4 #2.1 Identification of Children in the Practice with Special Health Care Needs	<i>CSHCN</i> be counted informally (e.g. by memory or from recent acute encounter); comprehensive identification can be done through individual chart review only. <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE	Lists of children with special health care needs are extracted electronically by diagnostic code. <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE	A <i>CSHCN</i> list is generated by applying a definition, the list is used to enhance care +/- or define <i>practice</i> activities (e.g. to flag charts and computer databases for special attention or identify the population and its subgroups) <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE	In addition to Level 3, diagnostic codes for <i>CSHCN</i> are documented, problem lists are current, and complexity levels are assigned to each child; this information creates an accessible <i>practice</i> database. <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE
5 #2.2 Care Continuity	Visits occur with the child's own <i>PCP</i> as a result of acute problems or well child schedules; the family determines follow up. <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE	Non-acute visits occur with families and their <i>PCP</i> to address chronic condition care; the <i>PCP</i> determines appropriate visit intervals; follow-up includes communication of tasks to staff and of lab and medical test results to the family. <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE	The team (including <i>PCP</i> , family, and staff) develops a plan of care for <i>CSHCN</i> which details visit schedules and communication strategies; home, school and community concerns are addressed in this plan. <i>Practice</i> back up/cross coverage providers are informed by these plans. <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE	In addition to Level 3, the <i>practice</i> /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. <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE
6 #2.4 Cooperative Management Between Primary Care Provider (PCP) and Specialists	Specialty referrals occur in response to specific diagnostic and therapeutic needs; families are the main initiators of communication between specialists and their <i>PCP</i> . <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE	In addition to Level 1, specialty referrals use phone, written and/or electronic communications; the <i>PCP</i> waits for or relies upon the specialists to communicate back their recommendations. <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE	The <i>PCP</i> and family set goals for referrals and communicate these to specialists; together they clarify co-management roles among family, <i>PCP</i> and specialists and determine how specialty feedback to the family and <i>PCP</i> is expressed, used, and shared. <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE	In addition to Level 3, the family has the option of using the <i>practice</i> in a strong coordinating role; parents as partners with the <i>practice</i> 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). <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE

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).

Note: Any italicized words are defined in the glossary on page 11.

Domain 2: Chronic Condition Management: For CSHCN and Their Families

THEME:	Level 1	Level 2	Level 3	Level 4
<div style="border: 1px solid black; padding: 2px; width: 20px; text-align: center; margin-left: -20px;">7</div> <p>#2.5 Supporting the Transition to Adulthood</p>	<p>Pediatric and adolescent <i>PCPs</i> adhere to defined health maintenance schedules for youth with special health care needs in their <i>practice</i>.</p> <p><input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE</p>	<p>Pediatric and adolescent <i>PCPs</i> offer age appropriate anticipatory guidance for specific youth & families related to their chronic condition, self-care, nutrition, fitness, sexuality, and other health behavior information.</p> <p><input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE</p>	<p>Pediatric and adolescent <i>PCPs</i> support youth & family to manage their health using a transition time line & developmental approach; they assess needs & offer culturally effective guidance related to:</p> <ul style="list-style-type: none"> • health & wellness • education & vocational planning • guardianship and legal & financial issues • community supports & recreation <p>When youth transition from pediatrician to adult provider: Pediatricians help to identify an adult <i>PCP</i> 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.</p> <p><input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE</p>	<p>In addition to level 3, progressively from age 12, youth, family and <i>PCP</i> 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).</p> <p><input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE</p>

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).

Note: Any italicized words are defined in the glossary on page 11.

Domain 3: Care Coordination: For CSHCN and Their Families				
THEME:	Level 1	Level 2	Level 3	Level 4
8 #3.1 Care Coordination/ Role Definition	The family coordinates care without specific support; they integrate office recommendations into their child's care. <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE	The <i>PCP</i> or a staff member engages in care support activities as needed; involvement with the family is variable. <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE	<i>Care coordination</i> activities are based upon ongoing assessments of child and family needs; the <i>practice</i> partners with the family (and older child) to accomplish <i>care coordination</i> goals. <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE	<i>Practice</i> staff offer a set of <i>care coordination</i> 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. <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE
9 #3.2 Family Involvement	The <i>PCP</i> makes medical recommendations and defines <i>care coordination</i> needs; the family carries these out. <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE	Families (and their older <i>CSHCN</i>) are regularly asked what care supports they need; treatment decisions are made jointly with the <i>PCP</i> . <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE	In addition to Level 2, families (and older <i>CSHCN</i>) are given the option of centralizing <i>care coordination</i> activities at and in partnership with the <i>practice</i> . <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE	In addition to Level 3, children & families contribute to a description of <i>care coordination</i> activities; a care coordinator specifically develops and implements this <i>practice</i> capacity which is evaluated by families and designated supervisors. <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE
10 #3.4 Assessment of Needs/ Plans of Care	Presentation of <i>CSHCN</i> with acute problems determines how needs are addressed. <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE	<i>PCPs</i> identify specific needs of <i>CSHCN</i> ; follow-up tasks are arranged for, or are assigned to families &/or available staff. <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE	The child with special needs, family, and <i>PCP</i> 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. <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE	In addition to Level 3, the <i>PCP</i> /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. <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE

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).

Note: Any italicized words are defined in the glossary on page 11.

Domain 4: Community Outreach: For CSHCN and Their Families

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THEME:	Level 1	Level 2	Level 3	Level 4
#4.1 Community Assessment of Needs for CSHCN	<p><i>PCP</i> awareness of the population of children with special health care needs <i>CSHCN</i> in their community is directly related to the number of children for whom the provider cares.</p> <p><input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE</p>	<p>The <i>practice</i> learns about issues and needs related to <i>CSHCNs</i> from key community informants; providers blend this input with their own personal observations to make an informal and personal assessment of the needs of <i>CSHCN</i> in their community.</p> <p><input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE</p>	<p>In addition to Level 2, providers raise their own questions regarding the population of <i>CSHCN</i> in their <i>practice</i> community; they seek pertinent data and information from families and local/state sources and use data to inform <i>practice</i> care activities.</p> <p><input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE</p>	<p>In addition to Level 3, at least one clinical <i>practice</i> provider participates in a community-based public health need assessment about <i>CSHCN</i>, integrates results into <i>practice</i> policies, and shares conclusions about population needs with community & state agencies.</p> <p><input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE</p>

Domain 5: Data Management: For CSHCN and Their Families

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THEME:	Level 1	Level 2	Level 3	Level 4
#5.1 Electronic Data Support	<p><i>PCPs</i> retrieve information/data by individual chart review; electronic data are available and retrievable from payer sources only.</p> <p><input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE</p>	<p>Electronic recording of data is limited to billing & scheduling; data are retrieved according to diagnostic code in relation to billing and scheduling; these data are used to identify specific patient groupings.</p> <p><input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE</p>	<p>An electronic data system includes identifiers and utilization data about children with special health care needs <i>CSHCN</i>; these data are used for monitoring, tracking, and for indicating levels of care complexity.</p> <p><input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE</p>	<p>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).</p> <p><input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE</p>

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).

Note: Any italicized words are defined in the glossary on page 11.

Domain 5: Data Management: For CSHCN and Their Families

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THEME:	Level 1	Level 2	Level 3	Level 4
#5.2 Data Retrieval Capacity	<p><i>PCP</i> retrieves patient data from paper records in response to outside agency requirements (e.g. <i>quality</i> standards, special projects, or <i>practice</i> improvements).</p> <p><input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE</p>	<p>The <i>practice</i> retrieves data from paper records and electronic billing and scheduling for the support of significant office changes (e.g. staffing, or allocation of resources).</p> <p><input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE</p>	<p>Data are retrieved from electronic records to identify and quantify populations and to track selected health indicators & outcomes.</p> <p><input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE</p>	<p>In addition to Level 3, electronic data are produced and used to drive <i>practice</i> improvements & to measure <i>quality</i> against benchmarks; (those producing and using data <i>practice</i> confidentiality)</p> <p><input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE</p>

Domain 6: Quality Improvement/Change: For CSHCN and Their Families

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THEME:	Level 1	Level 2	Level 3	Level 4
#6.1 Quality Standards (structures)	<p><i>Quality</i> standards for <i>CSHCN</i> are imposed upon the <i>practice</i> by internal or external organizations.</p> <p><input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE</p>	<p>In addition to Level 1, an individual staff member participates on a committee for improving processes of care at the <i>practice</i> for <i>CSHCN</i>. This person communicates and promotes improvement goals to the whole <i>practice</i>.</p> <p><input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE</p>	<p>The <i>practice</i> has its own systematic QI mechanism for <i>CSHCN</i>; regular provider and staff meetings are used for input and discussions on how to improve care and treatment for this population.</p> <p><input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE</p>	<p>In addition to Level 3, the <i>practice</i> actively utilizes QI processes; staff and parents of <i>CSHCN</i> are supported to participate in these QI activities; resulting <i>quality</i> standards are integrated into the operations of the <i>practice</i>.</p> <p><input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE</p>

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).

Note: Any italicized words are defined in the glossary on page 11.

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.

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Glossary of Terms (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.

Medical Home:

The Center for Medical Home Improvement defines the medical home as a community-based primary care setting which provides and coordinates high *quality*, planned, patient/family-centered: health promotion (acute, preventive) and *chronic condition management*.

Family-Centered Care:

Family-centered care, as defined by the US Maternal and Child Health Bureau, 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)

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.

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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.

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.

Maternal and Child Health Bureau (MCHB):

A division of Health Resources Services Administration.