Appendix B:
The Medical Home Index:
Adult (Long Version)

Form Approved
OMB No. XXXX-XXXX
Exp. Date MM/DD/YYYY

Practice-Level Assessments of Processes of Care

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 patients and families. All patients and families, and particularly those affected by chronic health conditions, benefit greatly from having a high quality medical home. Medical Home represents the standard of excellence for all primary care; this means the primary care practice is ready and willing to provide well, acute and chronic care for all of its patients including those affected by chronic health conditions, disabilities, 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: 1) organizational capacity, 2) chronic condition management,3) care coordination, 4) community outreach, 5) data management and 6) 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 patients 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.

Your responses to the MHI will help provide context for the responses patients provide on a patient-level assessment of care coordination.

CMHI
Center for Medical Home Improvement

The Medical Home Index: Adult

Measuring the Organization and Delivery of Primary Care for *All* Adults and Their Families

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:

CMHI
Center for Medical Home Improvement

The Medical Home Index: Adult

Measuring the Organization and Delivery of Primary Care for *All* Adults and Their Families

Describe your practice type/model: _____ Number of clinicians: MDs ____ ARNPs ____ PA's ____ Other ____

Is there a care coordinator working at your practice who supports patients/families? Yes ◯ No ◯

What is the estimated number of patients that your practice cares for? _____ What is your patient panel size? _____

Can you estimate the percentage (total should = 100%) of patents that 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 concepts of a medical home as defined by the American Academy of Pediatrics, American Academy of Family Physicians, American College of Physicians, and American Osteopathic Association (www.medicalhomeinfo.org; www.pcpcc.net)?

1) ☐ No knowledge of the concepts 2) ☐ Some knowledge/not applied

3) ☐ Knowledgeable/concepts sometimes applied in practice 4) ☐ Knowledgeable/concepts regularly applied in practice

How familiar/knowledgeable are you about the elements of patient-centered care?
(http://www.medicalhomeimprovement.org/pdf/National_Partnership_PCMH%20Principles_9_09.pdf)

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)

CMHI
Center for Medical Home Improvement

The Medical Home Index: Adult

Measuring the Organization and Delivery of Primary Care for *All* Adults and Their Families

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".**

Domain 1: Organizational Capacity: **EXAMPLE**				
THEME:	*Level 1*	*Level 2*	*Level 3*	*Level 4*
#1.1 The Mission of the *Practice*	Primary care providers *(PCPs)* at the *practice* have individual ways of delivering care to patients with chronic health conditions; their own education, experiences and interests drive care *quality*. ☐ PARTIAL ☐ COMPLETE	Approaches to the care of patients with chronic health conditions at the *practice* are more disease than *patient-centered*; office needs drive the implementation of care (e.g. carrying out processes of care). ☐ PARTIAL ☐ COMPLETE	**The *practice* uses a patient and family-centered approach to care, staff assess patients with chronic health conditions and the needs of their families in accordance with their practice mission; feedback is solicited from patients and families/ caregivers and influences *office policies* (e.g. the way things are done).** ☒ PARTIAL ☐ COMPLETE	In addition to Level 3, a patient/ consumer "advisory group" promotes *patient-centered* strategies, *practices*, and policies (e.g. enhanced communication methods or systematic inquiry of patient concerns/priorities); a written, visible mission statement reflects practice commitment to *quality* care for all patients and their families. ☐ PARTIAL ☐ COMPLETE

CMHI
Center for Medical Home Improvement

Domain 1: Organizational Capacity:				
THEME:	*Level 1*	*Level 2*	*Level 3*	*Level 4*
#1.1 The Mission of the Practice	Primary care providers *(PCPs)* at the *practice* have individual ways of delivering care to patients with chronic health conditions; their own education, experiences and interests drive care *quality*. ◯ PARTIAL ◯ COMPLETE	Approaches to the care of patients with chronic health conditions at the *practice* are more disease than *patient-centered*; office needs drive the implementation of care (e.g. carrying out processes of care). ◯ PARTIAL ◯ COMPLETE	The *practice* uses a patient and family-centered approach to care, staff assess patients with chronic health conditions and the needs of their families in accordance with their practice mission; feedback is solicited from patients and families/caregivers and influences *office policies* (e.g. the way things are done). ◯ PARTIAL ◯ COMPLETE	In addition to Level 3, a patient/consumer "advisory group" promotes *patient-centered* strategies, *practices*, and policies (e.g. enhanced communication methods or systematic inquiry of patient concerns/priorities); a written, visible mission statement reflects practice commitment to *quality* care for all patients and their families. ◯ PARTIAL ◯ COMPLETE
#1.2 Communication /Access	Communication between the patient and the *PCP* occurs as a result of patient inquiry; *PCP* contacts with the patient are for test result delivery or planned medical follow-up. ◯ PARTIAL ◯ COMPLETE	In addition to Level 1, standardized office communication methods are identified to the patient by the *practice* (e.g. call-in hours, phone triage for questions, or provider call back hours). ◯ PARTIAL ◯ COMPLETE	*Practice* and patient communicate at agreed upon intervals and both agree on "best time and way to contact me"; individual needs prompt week-end or other special appointments. ◯ PARTIAL ◯ 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 web messages, home, work or used by other *practice* staff (e.g. fax, e-mail or residential care visits). ◯ PARTIAL ◯ COMPLETE
#1.3 Access to the Medical Record Requires both *MD & key non-MD staff person's perspective.*	A policy of access to medical records is not routinely discussed with patients; records are provided only upon request. ◯ PARTIAL ◯ COMPLETE	In addition to Level 1, it is established among staff that patients can review their own record (but this fact is not explicitly shared with patients). ◯ PARTIAL ◯ COMPLETE	All patients are informed that they have access to their record; staff facilitates access within 24-48 hours. ◯ PARTIAL ◯ COMPLETE	In addition to Level 3, *practice* orientation materials include information on record access; staff locates space for patients to read their records and make themselves available to answer questions. ◯ PARTIAL ◯ 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).

Domain 1: Organizational Capacity (continued):				
THEME:	***Level 1***	***Level 2***	***Level 3***	***Level 4***
#1.4 Office Environment *Requires both MD & key non-MD staff person's perspective.*	Special needs concerning physical access and other visit accommodations are considered at the time of the appointment and are met if possible. ◯ PARTIAL ◯ COMPLETE	Assessments are made during the visit of patients with chronic health conditions; any physical access & other visit accommodation needs are addressed at the visit and are documented for future encounters. ◯ PARTIAL ◯ COMPLETE	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. ◯ PARTIAL ◯ COMPLETE	In addition to Level 3, key staff identify patients scheduled each day with chronic health conditions, 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. ◯ PARTIAL ◯ COMPLETE
#1.5 Patient/Family Feedback *Requires both MD & key non-MD staff person's perspective.*	Patient 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. ◯ PARTIAL ◯ COMPLETE	Feedback from patients with chronic health conditions is elicited sporadically by individual *practice* providers or by a suggestion box; this feedback is shared informally with other providers and staff. ◯ PARTIAL ◯ COMPLETE	Feedback from patients with chronic health conditions regarding their perception/experience 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	In addition to Level 3, an advisory process is in place for patients with chronic health conditions which helps to identify needs and implement creative solutions; there are tangible supports to enable patients and families/caregivers to participate in this process (e.g. after hours events, transportation, stipends, etc). ◯ PARTIAL ◯ COMPLETE
#1.6 Cultural Competence	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. ◯ PARTIAL ◯ COMPLETE	In addition to Level 1, resources and information are available for patients with chronic health conditions of the most common cultural backgrounds; others are assisted individually through efforts to obtain translators or to access information from outside sources. ◯ PARTIAL ◯ COMPLETE	In addition to Level 2, translation services and materials are available and appropriate for non-English speaking patients with chronic health conditions and/or those with limited literacy; these materials are appropriate to the reading level of the patient and their family or caregiver. ◯ PARTIAL ◯ COMPLETE	In addition to Level 3, patient assessments include pertinent cultural information, particularly about health beliefs; this information is incorporated into care plans; the *practice* uses these encounters to assess patient and community cultural needs. ◯ PARTIAL ◯ COMPLETE

Domain 1: Organizational Capacity (continued):				
THEME:	*Level 1*	*Level 2*	*Level 3*	*Level 4*
#1.7 Staff Education *Requires both MD & key non-MD staff person's perspective.*	For all staff, an orientation to internal office *practices*, procedures and policies is provided. ◯ PARTIAL ◯ COMPLETE	In addition to Level 1, the *practice* supports (paid time/tuition support) continuing education for all staff in *quality* care for patients with chronic health conditions. ◯ PARTIAL ◯ COMPLETE	In addition to Level 2, educational information on community-based resources for patients with chronic health conditions, including diagnosis specific resource information, is available for all staff. ◯ PARTIAL ◯ COMPLETE	In addition to Level 3, patients with chronic health conditions are integrated into office staff orientations and educational opportunities as teachers or "patient faculty"; tangible supports for patients and families and caregivers are provided to enable them to take on this role. ◯ PARTIAL ◯ COMPLETE
Domain 2: *Chronic Condition Management (CCM)* :				
THEME:	*Level 1*	*Level 2*	*Level 3*	*Level 4*
#2.1 Identification of Populations of Patients with Chronic Health Conditions	Patients with chronic health conditions can be counted informally (e.g. by memory or from recent acute encounter); comprehensive identification can be done through individual chart review only. ◯ PARTIAL ◯ COMPLETE	Lists of patients with chronic health conditions are extracted electronically by diagnostic code. ◯ PARTIAL ◯ COMPLETE	A population of patients with chronic health conditions is generated by using a set group of diagnoses; the list is used to enhance care and/or define *practice* activities (e.g. to flag charts and computer databases for special attention or identify a population and its subgroups) ◯ PARTIAL ◯ COMPLETE	In addition to Level 3, patients with chronic health conditions are identified and documented, problem lists are current, and complexity levels are assigned to each patient; this information creates an accessible *practice* database/patient registry. ◯ PARTIAL ◯ COMPLETE
#2.2 Care Continuity	Visits occur with the patients' own primary care provider (*PCP*) for annual preventive visits or as a result of acute problems; the patient determines when follow up occurs. ◯ PARTIAL ◯ COMPLETE	Non-acute visits occur with patients 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 patient. ◯ PARTIAL ◯ COMPLETE	The team (*PCP*, patient, and staff) develops a plan of care following evidence-based *practices* for patients with chronic health conditions, the plan details visit schedules and communication strategies; home, work and community concerns are addressed in this plan and cross coverage providers are so informed. ◯ PARTIAL ◯ COMPLETE	In addition to Level 3, the *practice* /teams use chronic condition protocols which include goals, services, interventions and referral contacts. A designated care coordinator uses these tools and other standardized office processes to support and engage patients and their families and/or caregivers. ◯ PARTIAL ◯ COMPLETE

Domain 2: *Chronic Condition Management* (continued):				
THEME:	*Level 1*	*Level 2*	*Level 3*	*Level 4*
#2.3 Continuity Across Settings	Communication among the *PCP*, specialists, therapists, and health care agencies happen as needs arise for patients with chronic health conditions. ◯ PARTIAL ◯ COMPLETE	A *PCP* makes requests and/or responds to requests from agencies or employers on behalf of patients with chronic health conditions (e.g. specific needs for accommodations, medical orders or approval of plans, or for a particular workplace support); all communication is documented. ◯ PARTIAL ◯ COMPLETE	Systematic *practice* activities foster communication among the *practice*, patient, and external providers such as specialists, therapists, and other community professionals supporting patients with chronic health conditions in their self-management; these methods are documented and may include e-mail, conference calls, information exchange forms, or ad hoc meetings with external providers. ◯ PARTIAL ◯ COMPLETE	In addition to Level 3, a method is used to convene the patient (and family/ caregiver as appropriate) and key professionals on behalf of patients with chronic health conditions; specific issues are brought to this group and they all share and use a written plan of care. ◯ PARTIAL ◯ COMPLETE
#2.4 Cooperative Management Between Primary Care Provider *(PCP)* and Specialists	Specialty referrals occur in response to specific diagnostic and therapeutic needs; patients are the main initiators of communication between specialists and their primary care provider *(PCP)*. ◯ PARTIAL ◯ COMPLETE	In addition to Level 1, specialty referrals use phone, written and/or electronic communications; the *PCP* waits for or relies upon the specialists to communicate back their recommendations. ◯ PARTIAL ◯ COMPLETE	The *PCP* and patient set goals for referrals and communicate these to specialists; together they clarify comanagement roles among patient, *PCP* and specialists and determine how specialty feedback to the patient and *PCP* supports self management and is explicitly shared. ◯ PARTIAL ◯ COMPLETE	In addition to Level 3, the patient has the option of using the practice in a strong coordinating role; patients as partners with the *practice* manage their care using specialists for consultations and information (unless they decide it is prudent for the specialist to manage the majority of their care). ◯ PARTIAL ◯ 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).

Domain 2: *Chronic Condition Management* (continued):				
THEME:	*Level 1*	*Level 2* (in addition to level 1)	*Level 3* (in addition to level 2)	*Level 4* (in addition to level 2)
#2.5 Transitions of care: (From home to hospital; hospital to hospital; hospital to home, nursing home, or rehab; from ER to primary care or home; from one primary care setting to another, etc).	The *practice* learns of any emergency room use, hospitalizations, rehabilitation care, or other access to and transition points along the health care continuum-after they occur through discharge summaries or directly from patients at subsequent office visits. ◯ PARTIAL ◯ COMPLETE	The *practice* provides patients who have chronic health conditions with explicit information and tools (e.g. fax back forms or information about the role of their primary care *medical home*); the patient is solely responsible for timely communications about transitions back to primary care. ◯ PARTIAL ◯ COMPLETE	Patients with chronic health conditions have a portable written plan of care which includes practice contact information and a request for timely updates about any care transitions. The *practice-based care coordinator* communicates with hospital and rehabilitation discharge planners and referring clinics prior to transitions to insure needed resources are in place and follow-up plans are clear. ◯ PARTIAL ◯ COMPLETE	In addition to Level 3: Electronic health information systems are in place to identify and receive real time information about patient access to the health care system and related transitions of care; the *practice team* receives timely transfer of patient information and integrates this knowledge into a full and continuous plan of care (in partnership with the patient and family or care giver). ◯ PARTIAL ◯ COMPLETE
#2.6 Patient/Family Support *Requires both MD & key non-MD staff person's perspective.*	Patients are responsible for carrying out recommendations made to them by their *PCP* when they specifically ask for support or help. ◯ PARTIAL ◯ COMPLETE	The *practice* responds to the clinical needs of the patient; broader social and family needs are addressed and referrals to support services facilitated. ◯ PARTIAL ◯ COMPLETE	The *practice* actively takes into account the overall impact when an individual has a chronic health condition by considering all family members in care; when patients make requests, staff will assist them to set up supportive connections. ◯ PARTIAL ◯ COMPLETE	In addition to Level 3, the *practice* sponsors patient support and self management activities (e.g. group appointments, condition related support groups, and patient education); staff have current knowledge of community or state support organizations and work with patients/families to make connections. ◯ PARTIAL ◯ COMPLETE

Domain 3: Care Coordination:				
THEME:	*Level 1*	*Level 2*	*Level 3*	*Level 4*
#3.1 Care Coordination /Role Definition	Patients coordinate their care without specific support; they integrate office recommendations into care. ◯ PARTIAL ◯ COMPLETE	The primary care provider *(PCP)* or a staff member engages in care support activities as needed; involvement with the patient is variable. ◯ PARTIAL ◯ COMPLETE	Care coordination activities are based upon ongoing assessments of patient/family needs; the *practice* partners with the patient to accomplish care coordination goals. ◯ PARTIAL ◯ COMPLETE	*Practice* staff offers a set of care coordination activities (*see page 16), their level of involvement fluctuates according to patient wishes. A designated care coordinator ensures the availability of these activities including written care plans with ongoing monitoring. ◯ PARTIAL ◯ COMPLETE
#3.2 Patient/Family Involvement	The *PCP* makes medical recommendations and defines care coordination needs, the patient carries these out. ◯ PARTIAL ◯ COMPLETE	Patients are regularly asked what care supports they need; treatment decisions are made jointly with their *PCP* . ◯ PARTIAL ◯ COMPLETE	In addition to Level 2, patients (and families/caregivers) are given the option of centralizing care coordination activities at and in partnership with the *practice*. ◯ PARTIAL ◯ COMPLETE	In addition to Level 3, patients/families contribute to a description of needed care coordination activities; a care coordinator specifically develops and implements this *practice* capacity which is evaluated by patients and families and designated supervisors. ◯ PARTIAL ◯ COMPLETE
#3.3 Patient Family/ Caregiver Education *Requires both MD & key non-MD staff person's perspective.*	Generic and specific reading materials and brochures are available from the *practice* upon request. ◯ PARTIAL ◯ COMPLETE	Basic information relevant to patients with chronic health conditions is offered in one on one interactions; these encounters use supportive written condition and resource information. ◯ PARTIAL ◯ COMPLETE	General information regarding managing one's chronic health condition and evidence-based diagnosis specific information is offered by the *practice* in a standardized manner; education anticipates potential issues and problems and refers patients to additional educational resources. ◯ PARTIAL ◯ COMPLETE	In addition to Level 3, diverse materials and teaching methods are used to address individual learning styles and needs; education is broad in scope and learning outcomes are measured. ◯ PARTIAL ◯ COMPLETE

Domain 3: Care Coordination (continued):				
THEME:	*Level 1*	*Level 2*	*Level 3*	*Level 4*
#3.4 Assessment of Needs/ Plans of Care	Presentation of patients with acute problems determines how needs are addressed. ◯ PARTIAL ◯ COMPLETE	*PCPs* identify specific needs of patients; follow-up tasks are arranged for or are assigned to available staff. ◯ PARTIAL ◯ COMPLETE	Patients with a chronic health condition, family, and *PCP* review current health status and anticipated problems or needs; they create/revise action plans and allocate shared responsibilities at least 2 times per year or at individualized intervals. ◯ PARTIAL ◯ COMPLETE	In addition to Level 3, the *PCP*/staff and patients create a written plan of care that is monitored at every visit; the office care coordinator is available to the patients and family to implement, update and evaluate the care plan. ◯ 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 patient visit intakes; the *practice addresses* immediate patient information and resource needs. ◯ PARTIAL ◯ COMPLETE	Using a listing of community, state, and national resources which cover physical, developmental, social and financial needs the *practice* responds to patient requests for information; the patient seeks out additional information & may share lessons learned with the *practice*. ◯ PARTIAL ◯ COMPLETE	Significant office knowledge about medical resources and insurance options is available; assessment of patient needs leads to supported use of resources and information to solve specific problems. ◯ PARTIAL ◯ COMPLETE	In addition to Level 3, *practice* staff work with patients helping to solve resource problems; a designated care coordinator provides follow up, researches additional information, seeks and provides feedback and assists the patient to integrate new information into their care plans. ◯ PARTIAL ◯ COMPLETE
#3.6 Advocacy	The *PCP* suggests that the patient find support services & resources outside of the *practice* when specific needs arise (e.g. diagnosis specific support groups, disability rights organizations, or patient support centers). ◯ PARTIAL ◯ COMPLETE	All patients/families/caregivers are routinely provided with basic information about patient and family support groups and advocacy resources during scheduled *practice* visits. ◯ PARTIAL ◯ COMPLETE	The *practice* team identifies resources to the patient for support and advocacy, facilitates the connections, and advocates on a patient's behalf to solve specific problems pertinent to their conditions and needs. ◯ PARTIAL ◯ COMPLETE	In addition to Level 3, the team advocates on behalf of all patients with chronic health conditions and their families as a population and helps to create opportunities for community forums, discussions or support groups which address specific health and wellness concerns. ◯ PARTIAL ◯ COMPLETE

Domain 4: Community Outreach:				
THEME:	*Level 1*	*Level 2*	*Level 3*	*Level 4*
#4.1 Community Assessment of Health Needs	Primary care provider *(PCP)* awareness of the population of patients with chronic health conditions in their community is directly related to the number of patients for whom the provider cares. ◯ PARTIAL ◯ COMPLETE	The *practice* learns about issues and needs related to patients with chronic health conditions from key community informants; providers blend this input with their own personal observations to make an informal and personal assessment of the needs of patients in their community. ◯ PARTIAL ◯ COMPLETE	In addition to Level 2, providers raise their own questions regarding the population of patients with chronic health condition in their practice communities; they seek pertinent data and information from patients and local/state sources and use data to inform *practice* care activities. ◯ PARTIAL ◯ COMPLETE	In addition to Level 3, at least one clinical *practice* provider participates in a community-based public health needs assessment about patients with chronic health conditions, integrates results into *practice* policies, and shares conclusions about population needs with community & state agencies. ◯ PARTIAL ◯ COMPLETE
#4.2 Outreach to Community Based Agencies	When the patient, family, employer or agency request interactions with the primary care provider *(PCP)* on behalf of a patient's community needs, the provider responds, thereby establishing the *practice* as a resource. ◯ PARTIAL ◯ COMPLETE	In addition to Level 1, when a community agency or employer requests technical assistance or education from the *practice* about patients with chronic health conditions, the *practice* communicates, collaborates, and educates based upon availability and interest. ◯ PARTIAL ◯ COMPLETE	The *practice* initiates outreach to community agencies and employers that directly serve patients with chronic health conditions (e.g. through representation on one or more advisory boards or committees); the *practice* advocates for preventive care and self management support with inter-organizational collaboration and communication. ◯ PARTIAL ◯ COMPLETE	In addition to Level 3, the practice identifies needs of patients and their families; they work with patients to sponsor activities that raise community awareness of resource and support needs (e.g. home care, respite, exercise/fitness and recreation opportunities, or improving home, provider, and employer communications). ◯ PARTIAL ◯ 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).

Domain 5: Data Management:				
THEME:	*Level 1*	*Level 2*	*Level 3*	*Level 4*
#5.1 Electronic Data Support	*Primary care providers (PCPs)* retrieve information/data by individual chart review; electronic data are available and retrievable from payer sources only. ◯ PARTIAL ◯ COMPLETE	Electronic recording of data is limited to billing & scheduling; data are retrieved according to diagnostic codes in relation to billing and scheduling; these data are used to identify specific patient groupings. ◯ PARTIAL ◯ COMPLETE	An electronic data system includes identifiers and utilization data about patients with chronic health conditions; these data are used for monitoring, tracking, and for indicating levels of care complexity. ◯ PARTIAL ◯ COMPLETE	In addition to Level 3, an electronic data system is used to support the documentation of need, monitoring of clinical care, following of evidence-based *practices*, care plan development and related coordination and the determination of outcomes (e.g. clinical, functional, satisfaction and cost outcomes). ◯ PARTIAL ◯ COMPLETE
#5.2 Data Retrieval Capacity	*PCP* retrieves patient data from paper records in response to outside agency requirements (e.g. *quality* standards, special projects, or *practice* improvements). ◯ PARTIAL ◯ COMPLETE	The *practice* retrieves data from paper records and electronic billing and scheduling for the support of significant office changes (e.g. staffing, or allocation of resources). ◯ PARTIAL ◯ COMPLETE	Data are retrieved from electronic records to identify and quantify populations and to track selected health indicators & outcomes. ◯ PARTIAL ◯ COMPLETE	In addition to Level 3, electronic reports are produced and used to drive *practice* improvements and to measure *quality* against benchmarks; (those producing and using data practice patient confidentiality). ◯ PARTIAL ◯ COMPLETE

CMHI
Center for Medical Home Improvement

Domain 6: Quality Improvement/Change:				
THEME:	*Level 1*	*Level 2*	*Level 3*	*Level 4*
#6.1 *Quality* Standards (structures)	*Quality* standards for patients with chronic health conditions are imposed upon the practice by internal or external organizations. ◯ PARTIAL ◯ COMPLETE	In addition to Level 1, an individual staff member participates on a *practice* committee for improving processes of care for patients with chronic health conditions. This person communicates and promotes improvement goals to the entire *practice*. ◯ PARTIAL ◯ COMPLETE	The *practice* has its own systematic *quality* improvement structures for patients with chronic health conditions; regular provider and staff meetings are used for input and discussions on how to improve care and treatment for these populations of patients. ◯ PARTIAL ◯ COMPLETE	In addition to Level 3, the practice actively utilizes *quality* improvement (QI) processes; staff and patients are supported to participate in these QI activities; resulting *quality* standards are integrated into the operations of the *practice*. ◯ PARTIAL ◯ COMPLETE
#6.2 *Quality* Activities (processes)	*Primary care providers (PCPs)* have completed courses or have had an adequate orientation to continuous *quality* improvement methods. ◯ PARTIAL ◯ COMPLETE	Corporate owners, administrators or payers identify *practice* deficits and set goals for improvements; *practice* providers and staff are identified to fix problems without having prior/or limited participation in the process. ◯ PARTIAL ◯ COMPLETE	Periodic formal and informal *quality* improvement activities gather staff input about *practice* improvement ideas and opportunities for patients with chronic health conditions; efforts are made toward related changes and improvements for this population. ◯ PARTIAL ◯ COMPLETE	In addition to Level 3, the *practice* systematically learns about patients with chronic health conditions and draws upon patient, family and caregiver input; together the *practice* and patient design and implement office changes that address needs and gaps; they then study outcomes and act accordingly. ◯ PARTIAL ◯ COMPLETE

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).

The Medical Home Index: Adult

Measuring the Organization and Delivery of Primary Care for *All* Adults and Their Families

Definitions and Concepts (Words in *italics* throughout the document are defined below).

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).

Achieving a high *quality* medical home requires:
a) macrosystem support for infrastructure (health systems policy level) and
b) microsystem support for (primary care) *practice* improvement

Joint Principles of the Patient Centered Primary Care Medical Home
Use this link (http://www.pcpcc.net/) to go to the Patient Centered Primary Care Collaborative website to download the consensus document: The Joint Principles of the Patient Centered Medical Home (click on patient centered medical home), endorsed by:

The American Academy of Family Physicians (AAFP)
The American Academy of Pediatrics (AAP)
The American College of Physicians (ACP), and
The American Osteopathic Association (AOA)

The Medical Home Index: Adult

Measuring the Organization and Delivery of Primary Care for *All* Adults and Their Families

Glossary of Terms

Practice-Based Care Coordination

Care and services performed in partnership with the patient, family, & caregiver by health professionals to:

1) Establish *patient-centered* community-based "Medical Homes" for patients with chronic health conditions and their families.
   - -Make assessments and monitor needs
   - -Participate in patient/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*, patients and others

3) Build bridges among patients and health, education, social services and employer; promotes continuity of care
   - -Develop, monitor, update and follow-up with care planning and care plans
   - -Organize team meetings; support meeting recommendations and follow-up

4) Supply/provide access to referrals, information and education for patients and caregivers across systems.
   - -Coordinate inter-organizationally
   - -Advocate with and for the patient and family (e.g. at work or with 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 patient and *practice*

The Medical Home Index: Adult

Measuring the Organization and Delivery of Primary Care for *All* Adults and Their Families

Glossary of Terms ⋆ (continued)

Chronic Condition Management (CCM):
CCM involves explicit changes in the roles of providers and office staff aimed at improving:
1) Access to needed services
2) Communication with specialists, employers, and other resource supports, and
3) Outcomes for patients, families, *practices*, employers and payers.

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 patients with chronic health conditions need and their families require for care and what they need for support. Health care teams in partnership with patients then work together in ways which enhance the capacity of the patient and the *practice* to meet these needs. Responsive care is designed in ways which incorporate patients 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 patients.

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.

Patient–centered care:
Patient-centered, defined by the Institute of Medicine, is providing care that is respectful of and responsive to individual patient preferences, needs and values and ensuring that patient values guide all clinical decisions.

Family-Centered care:
Recognizes that the family is essential to the patient/child's care and is constant in the patient/child's life.
The medical provider acknowledges who the key family members are
The medical provider asks families what they value
Decision-making is shared

The Medical Home Index: Adult

Measuring the Organization and Delivery of Primary Care for *All* Adults and Their Families

GLOSSARY OF TERMS * (continued)

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

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

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.

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?