



The Medical Home Index in Adult Primary Care Short Version: Measuring the Organization and Delivery of Primary Care

The Medical Home Index in Adult Primary Care Short Version (MHIAPC-SV) represents ten indicators which have been derived from the Center for Medical Home Improvement's (CMHI) original Medical Home Index in Adult Primary Care (MHIAPC). This short version can be used as an interval measurement in conjunction with the original MHIAPC or it can be used as a quick "report card" or snapshot of practice quality. CMHI recommends the use of the full MHIAPC 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 MHIAPC.

The MHIAPC 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 in Adult Primary Care Short Version (MHIAPC-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 primary care.
- Level 2 is pro-active primary care (in addition to Level 1)
- Level 3 illustrates 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".

Measuring the Medical Home in Adult Primary Care Short Version

THEME:	Level 1	Level 2 <small>(in addition to level 1)</small>	Level 3 <small>(in addition to level 2)</small>
<p>#1 Patient/Family Feedback <i>Requires both MD & key non-MD staff person's perspective.</i></p> <p>(#1.5 MHI-Full Adult Primary Care FV)</p>	<p>Adult Primary Care without the elements in levels 2 and 3.</p> <p><input type="checkbox"/> Level 1</p>	<p>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.</p> <p><input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE</p>	<p>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).</p> <p><input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE</p>
<p>#2 Cultural Competence</p> <p>(#1.6 MHI-Full Adult Primary Care FV)</p>	<p>Adult Primary Care without the elements in levels 2 and 3.</p> <p><input type="checkbox"/> Level 1</p>	<p>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.</p> <p><input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE</p>	<p>Patient 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 and community cultural needs.</p> <p><input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE</p>
<p># 3 Identification of Populations of Patients with Chronic Health Conditions</p> <p>(#2.1 MHI-Full Adult Primary Care FV)</p>	<p>Adult Primary Care without the elements in levels 2 and 3.</p> <p><input type="checkbox"/> Level 1</p>	<p>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 <i>practice</i> activities (e.g. to flag charts and computer databases for special attention or identify a population and its subgroups)</p> <p><input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE</p>	<p>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 <i>practice</i> database/patient registry.</p> <p><input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE</p>

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THEME:	Level 1	Level 2 <small>(in addition to level 1)</small>	Level 3 <small>(in addition to level 2)</small>
<p># 4 Care Continuity</p> <p>Adult Primary Care without the elements in levels 2 and 3.</p> <p><small>(#2.2 MHI-Full Adult Primary Care FV)</small></p>	<p><input type="checkbox"/> Level 1</p>	<p>The team (<i>PCP</i>, patient, and staff) develops a plan of care following evidence-based <i>practices</i> 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.</p> <p><input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE</p>	<p>The <i>practice</i>/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.</p> <p><input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE</p>
<p>#5 Cooperative Management Between Primary Care Provider (<i>PCP</i>) and Specialists</p> <p>Adult Primary Care without the elements in levels 2 and 3.</p> <p><small>(#2.4 MHI-Full Adult Primary Care FV)</small></p>	<p><input type="checkbox"/> Level 1</p>	<p>The <i>PCP</i> and patient set goals for referrals and communicate these to specialists; together they clarify co-management roles among patient, <i>PCP</i> and specialists and determine how specialty feedback to the patient and <i>PCP</i> supports self management and is explicitly shared.</p> <p><input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE</p>	<p>The patient has the option of using the <i>practice</i> in a strong coordinating role; patients as partners with the <i>practice</i> 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).</p> <p><input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE</p>

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THEME:	Level 2	Level 3	Level 4
<p>#6 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).</p> <p>(#2.5.1 MHI-Full Adult Primary Care FV)</p>	<p>Adult Primary Care without the elements in levels 2 and 3.</p> <p style="text-align: center;"><input type="checkbox"/> Level 1</p>	<p>Patients with chronic health conditions have a portable written plan of care which includes <i>practice</i> contact information and a request for timely updates about any care transitions. The <i>practice-based care coordinator</i> 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.</p> <p style="text-align: center;"><input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE</p>	<p>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 <i>practice</i> 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).</p> <p style="text-align: center;"><input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE</p>
<p>#7 Care Coordination /Role Definition</p> <p>(#3.1 MHI-Full Adult Primary Care FV)</p>	<p>Adult Primary Care without the elements in levels 2 and 3.</p> <p style="text-align: center;"><input type="checkbox"/> Level 1</p>	<p>Care coordination activities are based upon ongoing assessments of patient/ family needs; the <i>practice</i> partners with the patient to accomplish care coordination goals.</p> <p style="text-align: center;"><input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE</p>	<p><i>Practice</i> staff offers a set of care coordination activities (*see page 14), 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.</p> <p style="text-align: center;"><input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE</p>

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THEME:	Level 1	Level 2 <small>(in addition to level 1)</small>	Level 3 <small>(in addition to level 2)</small>
<p>#8 Assessment of Needs/ Plans of Care</p> <p><small>(#3.4 MHI-Full Adult Primary Care FV)</small></p>	<p>Adult Primary Care without the elements in levels 2 and 3.</p> <p style="text-align: center;"><input type="checkbox"/> Level 1</p>	<p>Patients with a chronic health condition, family, and <i>PCP</i> 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.</p> <p style="text-align: center;"><input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE</p>	<p>The <i>PCP</i>/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.</p> <p style="text-align: center;"><input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE</p>
<p>#9 Community Assessment of Health Needs</p> <p><small>(#4.1 MHI-Full Adult Primary Care FV)</small></p>	<p>Adult Primary Care without the elements in levels 2 and 3.</p> <p style="text-align: center;"><input type="checkbox"/> Level 1</p>	<p>Providers raise their own questions regarding the population of patients with chronic health condition in their <i>practice</i> communities; they seek pertinent data and information from patients and local/state sources and use data to inform <i>practice</i> care activities.</p> <p style="text-align: center;"><input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE</p>	<p>At least one clinical <i>practice</i> provider participates in a community-based public health needs assessment about patients with chronic health conditions, integrates results into <i>practice</i> policies, and shares conclusions about population needs with community & state agencies.</p> <p style="text-align: center;"><input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE</p>
<p>#10 Quality Standards (structures)</p> <p><small>(#6.1 MHI-Full Adult Primary Care FV)</small></p>	<p>Adult Primary Care without the elements in levels 2 and 3.</p> <p style="text-align: center;"><input type="checkbox"/> Level 1</p>	<p>The <i>practice</i> has its own systematic <i>quality</i> 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.</p> <p style="text-align: center;"><input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE</p>	<p>The <i>practice</i> actively utilizes <i>quality</i> improvement (QI) processes; staff and patients 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 style="text-align: center;"><input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE</p>

Measuring the *Medical Home* in Adult Primary Care 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)

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Definitions and Concepts

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

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*

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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 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.

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 care and is constant in the patient life.

The medical provider acknowledges who the key family members are

The medical provider asks families what they value

Decision-making is shared

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Practice:

The place, providers, and staff where the *PCP* offers primary 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?