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.

© Center for Medical Home Improvement, 2001. Used with permission. Transition to adulthood indicator #2.5 revised 2006; Medical Home Index revised to create MHI-RSF 2012.
# The Medical Home Index: Revised Short Form: Pediatric

Measuring the Organization and Delivery of Pediatric Primary Care for All Children, Youth, and Families

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

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

© Center for Medical Home Improvement, 2001. Used with permission. Transition to adulthood indicator #2.5 revised 2006; Medical Home Index revised to create MHI-RSF 2012.
The Medical Home Index: Revised Short Form: Pediatric
Measuring the Organization and Delivery of Pediatric Primary Care for All Children, Youth, and 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 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".

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

### Domain 1: Organizational Capacity:

<table>
<thead>
<tr>
<th>THEME</th>
<th>Level 1</th>
<th>Level 2</th>
<th>EXAMPLE</th>
<th>Level 3</th>
<th>Level 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1.1</td>
<td>Primary care providers (PCPs) at the practice have individual ways of delivering care to children with special health care needs (CSHCN); their own education, experience and interests drive care quality.</td>
<td>Approaches to the care of CSHCN at the practice are child rather than family-centered; office needs drive the implementation of care (e.g. the process of carrying out care).</td>
<td>The practice uses a family-centered approach to care, 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).</td>
<td>In addition to Level 3, a parent/practice &quot;advisory group&quot; promotes family-centered strategies, practices and policies (e.g. enhanced communication methods or systematic inquiry of family concerns/priorities); a written, visible mission statement reflects practice commitment to quality care for CSHCN and their families.</td>
<td></td>
</tr>
<tr>
<td>PARTIAL COMPLETE</td>
<td>PARTIAL COMPLETE</td>
<td>PARTIAL COMPLETE</td>
<td>COMPLETE</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

© Center for Medical Home Improvement, 2001. Used with permission. Transition to adulthood indicator #2.5 revised 2006; Medical Home Index revised to create MHI-RSF 2012.
# Domain 1: Organizational Capacity: For CSHCN and Their Families

<table>
<thead>
<tr>
<th>THEME:</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>#1.2 Communication/Access</strong></td>
<td>Communication between the family and the primary care provider (PCP) occurs as a result of family inquiry; PCP contacts with the family are for test result delivery or planned medical follow-up.</td>
<td>In addition to Level 1, standardized office communication methods are identified to the family by the practice (e.g. call-in hours, phone triage for questions, or provider call back hours).</td>
<td>Practice and family communicate at agreed upon intervals and both agree on &quot;best time and way to contact me&quot;; individual needs prompt weekend or other special appointments.</td>
<td>In addition to Level 3, office activities encourage individual requests for flexible access; access and communication preferences are documented in the care plan and used by other practice staff (e.g. fax, e-mail or web messages, home, school or residential care visits).</td>
</tr>
<tr>
<td></td>
<td>☐ PARTIAL ☐ COMPLETE</td>
<td>☐ PARTIAL ☐ COMPLETE</td>
<td>☐ PARTIAL ☐ COMPLETE</td>
<td>☐ PARTIAL ☐ COMPLETE</td>
</tr>
</tbody>
</table>

| **#1.5 Family Feedback** | Family feedback to the practice occurs through external mechanisms such as satisfaction surveys issued by a health plan; this information is not always shared with practice staff. | Feedback from families of children with special health care needs (CSHCN) is elicited sporadically by individual practice providers or by a suggestion box; this feedback is shared informally with other providers and staff. | 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. | In addition to Level 3, 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                                                                              | ☐ PARTIAL ☐ COMPLETE                                                                              | ☐ PARTIAL ☐ COMPLETE                                                                              | ☐ PARTIAL ☐ COMPLETE                                                                              |

| **#1.6 Cultural Competence** | The PCP attempts to overcome obstacles of language, literacy, or personal preferences on a case by case basis when confronted with barriers to care. | 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. | 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. | In addition to Level 3, family assessments include pertinent cultural information, particularly about health beliefs; this information is incorporated into care plans; the practice uses these encounters to assess patient & community cultural needs. |
|                | ☐ PARTIAL ☐ COMPLETE                                                                              | ☐ PARTIAL ☐ COMPLETE                                                                              | ☐ PARTIAL ☐ COMPLETE                                                                              | ☐ 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).

Note: Any italicized words are defined in the glossary on page 11.
## Domain 2: Chronic Condition Management (CCM): For CSHCN and Their Families

<table>
<thead>
<tr>
<th>THEME</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>#2.1 Identification of Children in the Practice with Special Health Care Needs</strong></td>
<td>CSHCN be counted informally (e.g. by memory or from recent acute encounter); comprehensive identification can be done through individual chart review only.</td>
<td>Lists of children with special health care needs are extracted electronically by diagnostic code.</td>
<td>A CSHCN list is generated by applying a definition, the list is used to enhance care +/or define practice activities (e.g. to flag charts and computer databases for special attention or identify the population and its subgroups)</td>
<td>In addition to Level 3, diagnostic codes for CSHCN are documented, problem lists are current, and complexity levels are assigned to each child; this information creates an accessible practice database.</td>
</tr>
<tr>
<td>PARTIAL</td>
<td>COMPLETE</td>
<td>PARTIAL</td>
<td>COMPLETE</td>
<td>PARTIAL</td>
</tr>
<tr>
<td><strong>#2.2 Care Continuity</strong></td>
<td>Visits occur with the child's own PCP as a result of acute problems or well child schedules; the family determines follow up.</td>
<td>Non-acute visits occur with families and their PCP to address chronic condition care; the PCP determines appropriate visit intervals; follow-up includes communication of tasks to staff and of lab and medical test results to the family.</td>
<td>The team (including PCP, family, and staff) develops a plan of care for CSHCN which details visit schedules and communication strategies; home, school and community concerns are addressed in this plan. Practice back up/cross coverage providers are informed by these plans.</td>
<td>In addition to Level 3, the practice/teams use condition protocols; they include goals, services, interventions and referral contacts. A designated care coordinator uses these tools and other standardized office processes which support children and families.</td>
</tr>
<tr>
<td>PARTIAL</td>
<td>COMPLETE</td>
<td>PARTIAL</td>
<td>COMPLETE</td>
<td>PARTIAL</td>
</tr>
<tr>
<td><strong>#2.4 Cooperative Management Between Primary Care Provider (PCP) and Specialists</strong></td>
<td>Specialty referrals occur in response to specific diagnostic and therapeutic needs; families are the main initiators of communication between specialists and their PCP.</td>
<td>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.</td>
<td>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.</td>
<td>In addition to Level 3, the family has the option of using the practice in a strong coordinating role; parents as partners with the practice manage their child's care using specialists for consultations and information (unless they decide it is prudent for the specialist to manage the majority of their child's care).</td>
</tr>
<tr>
<td>PARTIAL</td>
<td>COMPLETE</td>
<td>PARTIAL</td>
<td>COMPLETE</td>
<td>PARTIAL</td>
</tr>
</tbody>
</table>

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

Note: Any italicized words are defined in the glossary on page 11.
## Domain 2: Chronic Condition Management: For CSHCN and Their Families

<table>
<thead>
<tr>
<th>THEME: #2.5 Supporting the Transition to Adulthood</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pediatric and adolescent PCPs adhere to defined health maintenance schedules for youth with special health care needs in their practice.</td>
<td>☐ PARTIAL ☑ COMPLETE</td>
<td>☐ PARTIAL ☑ COMPLETE</td>
<td>☐ PARTIAL ☑ COMPLETE</td>
<td>☐ PARTIAL ☑ COMPLETE</td>
</tr>
<tr>
<td>Pediatric and adolescent PCPs offer age appropriate anticipatory guidance for specific youth &amp; families related to their chronic condition, self-care, nutrition, fitness, sexuality, and other health behavior information.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pediatric and adolescent PCPs support youth &amp; family to manage their health using a transition time line &amp; developmental approach; they assess needs &amp; offer culturally effective guidance related to: • health &amp; wellness • education &amp; vocational planning • guardianship and legal &amp; financial issues • community supports &amp; 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 &quot;welcome&quot; visit and a review of transition goals.</td>
<td></td>
<td></td>
<td></td>
<td>In addition to level 3, 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).</td>
</tr>
</tbody>
</table>

### Instructions:

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

B) Then indicate whether you place your practice at a PARTIAL or COMPLETE ranking within that level (circle one).

Note: Any italicized words are defined in the glossary on page 11.
## Domain 3: Care Coordination: For CSHCN and Their Families

<table>
<thead>
<tr>
<th>THEME:</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>#3.1 Care Coordination/Role Definition</td>
<td>The family coordinates care without specific support; they integrate office recommendations into their child’s care.</td>
<td>The PCP or a staff member engages in care support activities as needed; involvement with the family is variable.</td>
<td>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.</td>
<td>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.</td>
</tr>
<tr>
<td>#3.2 Family Involvement</td>
<td>The PCP makes medical recommendations and defines care coordination needs; the family carries these out.</td>
<td>Families (and their older CSHCN) are regularly asked what care supports they need; treatment decisions are made jointly with the PCP.</td>
<td>In addition to Level 2, families (and older CSHCN) are given the option of centralizing care coordination activities and in partnership with the practice.</td>
<td>In addition to Level 3, children &amp; families contribute to a description of care coordination activities; a care coordinator specifically develops and implements this practice capacity which is evaluated by families and designated supervisors.</td>
</tr>
<tr>
<td>#3.4 Assessment of Needs/Plans of Care</td>
<td>Presentation of CSHCN with acute problems determines how needs are addressed.</td>
<td>PCPs identify specific needs of CSHCN; follow-up tasks are arranged for, or are assigned to families &amp;/or available staff.</td>
<td>The child with special needs, family, and PCP review current child health status and anticipated problems or needs; they create/revise action plans and allocate responsibilities at least 2 times per year or at individualized intervals.</td>
<td>In addition to Level 3, the PCP/staff and families create a written plan of care that is monitored at every visit; the office care coordinator is available to the child and family to implement, update and evaluate the care plan.</td>
</tr>
</tbody>
</table>

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.

© Center for Medical Home Improvement, 2001. Used with permission. Transition to adulthood indicator #2.5 revised 2006; Medical Home Index revised to create MHI-RSF 2012.
### Domain 4: Community Outreach: For CSHCN and Their Families

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

- ☐ PARTIAL ☐ COMPLETE
- ☐ PARTIAL ☐ COMPLETE
- ☐ PARTIAL ☐ COMPLETE
- ☐ PARTIAL ☐ COMPLETE

### Domain 5: Data Management: For CSHCN and Their Families

<table>
<thead>
<tr>
<th>THEME:</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>#5.1 Electronic Data Support</td>
<td>PCPs retrieve information/data by individual chart review; electronic data are available and retrievable from payer sources only.</td>
<td>Electronic recording of data is limited to billing &amp; scheduling; data are retrieved according to diagnostic code in relation to billing and scheduling; these data are used to identify specific patient groupings.</td>
<td>An electronic data system includes identifiers and utilization data about children with special health care needs CSHCN; these data are used for monitoring, tracking, and for indicating levels of care complexity.</td>
<td>In addition to Level 3, an electronic data system is used to support the documentation of need, monitoring of clinical care, care plan and related coordination and the determination of outcomes (e.g. clinical, functional, satisfaction and cost outcomes).</td>
</tr>
</tbody>
</table>

- ☐ PARTIAL ☐ COMPLETE
- ☐ PARTIAL ☐ COMPLETE
- ☐ PARTIAL ☐ COMPLETE
- ☐ 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).

Note: Any italicized words are defined in the glossary on page 11.
# Domain 5: Data Management: For CSHCN and Their Families

## #5.2 Data Retrieval Capacity

<table>
<thead>
<tr>
<th>THEME:</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PCP retrieves patient data from paper records in response to outside agency requirements (e.g. quality standards, special projects, or practice improvements).</strong></td>
<td>PARTIAL</td>
<td>PARTIAL</td>
<td>PARTIAL</td>
<td>PARTIAL</td>
</tr>
<tr>
<td></td>
<td>COMPLETE</td>
<td>COMPLETE</td>
<td>COMPLETE</td>
<td>COMPLETE</td>
</tr>
</tbody>
</table>

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

## #6.1 Quality Standards (structures)

<table>
<thead>
<tr>
<th>THEME:</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quality standards for CSHCN are imposed upon the practice by internal or external organizations.</strong></td>
<td>PARTIAL</td>
<td>PARTIAL</td>
<td>PARTIAL</td>
<td>PARTIAL</td>
</tr>
<tr>
<td></td>
<td>COMPLETE</td>
<td>COMPLETE</td>
<td>COMPLETE</td>
<td>COMPLETE</td>
</tr>
</tbody>
</table>

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

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

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

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.