The following appendix item is a tool to help you assess your or your provider's practice. While this tool is a proficient way to initiate such an assessment, it serves as a basis for establishing quality improvements within the practice.

For more information on follow-up strategies from the Index results, please visit the Center for Medical Home Improvement Web site:
www.medicalhomeimprovement.org

THE MEDICAL HOME INDEX:

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

This tool defines, describes, and quantifies activities related to the organization and delivery of primary care for ***Children with Special Health Care Needs (CSHCN)***. You will be asked to rank the level 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 do represent care matched to the kinds of services and supports that families of ***CSHCN*** report that they need. A frank assessment of your current practice is desirable; this will best define practice and help to identify the supports needed by pediatric practices to better serve ***CSHCN*** in their communities. Families will complete a companion instrument commenting on their experiences with your practice.

Name: _____ Title/Position/Role: _____

Address/Phone/E-mail/Fax: _____

Describe Your Practice Type/Model: _____ Number of Providers: MDs____ ARNPs ____ PAs _____ OTHER _____

Is there a care coordinator working at your practice who supports *CSHCN*/families? ☐ Yes ☐ No {Use other side of sheet to explain.}

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/CHIP)** 2) _____% **Private & Medicaid**

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 concept 2) ☐ Some knowledge/not applied

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

How familiar/knowledgeable are you with the elements of family-centered care as defined by the Institute on Family-Centered Care?

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

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

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THE MEDICAL HOME INDEX:

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

DEFINITIONS OF CORE CONCEPTS*

Children with Special Health Care Needs (CSHCN):
Children with special health care needs are defined by the ***US Maternal and Child Health Bureau*** as those who have, or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who require health and related services of a type or amount beyond that required by children generally (USDHHS, MCHB, 1997).

Medical Home according to the American Academy of Pediatrics (AAP):
A community-based primary care "medical home" is accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally competent.

Elements of Family-Centered Care (Institute on Family-Centered Care, Bethesda, Maryland):

1) Recognizing that the family is the constant in a child's life, the service systems and personnel within those systems fluctuate.
2) Facilitating family-professional collaboration at all levels of health care.
3) Honoring the racial, ethnic, cultural and socioeconomic diversity of families.
4) Recognizing family strengths and individuality and respecting different methods of coping.
5) Sharing with parents, on a continuing basis and in a supportive manner, complete and unbiased information.
6) Encouraging and facilitating family-to-family support and networking.
7) Understanding and incorporating the developmental needs of infants, children, and adolescents and families into health systems.
8) Implementing comprehensive policies and programs that provide emotional and financial support to meet the needs of families.
9) Designing accessible health care systems that are flexible, culturally competent, and responsive to family-identified needs.

***Words referenced here will be in italics throughout the document.**

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THE MEDICAL HOME INDEX:

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

GLOSSARY OF TERMS*

Care Coordination Activities:

Care and services performed in partnership with the family and providers by health professionals to:

1) Establish family-centered community-based **"Medical Homes"** for *CSHCN* and their families.
   - Make assessments and monitor child and family needs.
   - Participate in parent/professional practice improvement activities.
2) Facilitate timely access to the ***Primary Care Provider (PCP)***, services and resources.
   - Offer supportive services including counseling, education and listening.
   - Facilitate communication among PCP, family and others.
3) Build bridges among families and health, education and social services; promotes continuity of care.
   - Develop, monitor, update and follow-up with care planning and care plans.
   - Organize wrap-around teams with families; support meeting recommendations and follow-up.
4) Supply/provide access to referrals, information and education for families across systems.
   - Coordinate inter-organizationally.
   - Advocate with and for the family (e.g., to school, daycare, or health care settings).
5) Maximize effective, efficient, and innovative use of existing resources.
   - Find, coordinate and promote effective and efficient use of current resources.
   - Monitor outcomes for child, family and practice.

Chronic Condition Management (CCM):

CCM acknowledges that children and their families may require more than the usual well child, preventive care, and acute illness interventions. CCM involves explicit changes in the roles of providers and office staff aimed at improving:

1) Access to needed services,
2) Communication with specialists, schools, and other resources, and
3) Outcomes for children and families.

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THE MEDICAL HOME INDEX:

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

GLOSSARY OF TERMS* (continued)

Quality:
Quality is best determined or judged by those who need or who use the services being offered. Quality in the medical home is best achieved when one learns what children with special health care needs and their families require for care and what they need for support. Health care teams in partnership with families then work together in ways which enhance the capacity of the family and the practice to meet these needs. Responsive care is designed in ways which incorporate family needs and suggestions. Those making practice improvements must hold a commitment to doing what needs to be done and agree to accomplish these goals in essential partnerships with families.

Office Policies:
Definite courses of action adopted for expediency; "the way we do things;" these are clearly articulated to and understood by all who work in the office environment.

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

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

United States Maternal and Child Health Bureau – (USMCHB):
A division of Health Resources Services Administration.

Requires both MD and key non-MD staff person's perspective – you will see this declaration before select themes; the project has found that these questions require the input of both MD and non-MD staff to best capture practice activity.

***Words referenced here will be in italics throughout the document**

Medical Home Index instructions begin on the next page ...

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Domain 1: Organizational Capacity: For CSHCN and Their Families

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 children with special health care needs ***CSHCN***; their own education, experience and interests drive care quality. ☐ Partial ☐ Complete	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). ☐ Partial ☐ Complete	The ***practice*** uses a ***family-centered*** approach to care (see page X), they assess *CSHCN* and the needs of their families in accordance with its mission; feedback is solicited from families and influences office policies (e.g. ,the way things are done). ☐ Partial ☐ Complete	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. ☐ Partial ☐ Complete
#1.2 Communication/ Access	Communication between the family and the ***PCP*** occurs as a result of family inquiry; ***PCP*** contacts with the family 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 family by the practice (e.g., call-in hours, phone triage for questions, or provider call back hours). ☐ Partial ☐ Complete	Practice 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. ☐ 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 used by other ***practice*** staff (e.g., fax, e-mail or web messages, home, school 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 families; records are provided only upon request. ☐ Partial ☐ Complete	In addition to Level 1, it is established among staff that families can review their child's record (but this fact is not explicitly shared with families). ☐ Partial ☐ Complete	All families are informed that they have access to their child's record; staff facilitates access within 24-48 hours. ☐ Partial ☐ Complete	In addition to Level 3, ***practice*** orientation materials include information on record access; staff locate space for families to read their child's record 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) Indicate whether you place your practice at a PARTIAL or COMPLETE ranking within that level (circle one).

Domain 1: Organizational Capacity (continued): For CSHCN and Their Families

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 children with special health care needs and the needs of their families; any physical access and 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 children scheduled each day with special health care needs, 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; she/he advocates for changes (office/environmental) as needed. ☐ Partial ☐ Complete
#1.5 Family Feedback **Requires both MD & key non-MD staff person's perspective**	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. ☐ Partial ☐ Complete	Feedback from families of ***CSHCN*** 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 families of ***CSHCN*** regarding their perception of care is gathered through systematic methods (e.g., surveys, focus groups, or interviews); there is a process for staff to review this feedback and to begin problem solving. ☐ Partial ☐ Complete	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
#1.6 Cultural Competence	The ***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 families of the most common diverse 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, materials are available and appropriate for non-English speaking families, those with limited literacy; these materials are appropriate to the developmental level of the child/young adult. ☐ Partial ☐ Complete	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 and community cultural needs. ☐ Partial ☐ Complete

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Domain 1: Organizational Capacity (continued): For CSHCN and Their Families				
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 the care of ***CSHCN*** (children with special health care needs). ☐ Partial ☐ Complete	In addition to Level 2, educational information on community-based resources for ***CSHCN***, including diagnosis specific resource information, is available for all staff. ☐ Partial ☐ Complete	In addition to Level 3, families of ***CSHCN*** are integrated into office staff orientations and educational opportunities as teachers or "family faculty"; support for families to take this role is provided. ☐ Partial ☐ Complete

Domain 2: Chronic Condition Management (CCM): For CSHCN and Their Families				
THEME:	*Level 1*	*Level 2*	*Level 3*	*Level 4*
#2.1 Identification of Children in the Practice with Special Health Care Needs	Children with special health care needs (***CSHCN***) 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 children with special health care needs are extracted electronically by diagnostic code. ☐ Partial ☐ Complete	A ***CSHCN*** list is generated by applying a definition (see pg. 3), the list is used to enhance care +/ or define practice activities (e.g., to flag charts and computer databases for special attention or identify the population and its subgroups). ☐ Partial ☐ Complete	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. ☐ Partial ☐ Complete
#2.2 Care Continuity	Visits occur with the child's own ***primary care provider (PCP)*** as a result of acute problems or well child schedules; the family determines follow-up. ☐ Partial ☐ Complete	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. ☐ Partial ☐ Complete	The team (including ***PCP***, family, and staff) develops a plan of care for ***CSHCN*** which details visit schedules and communication strategies; home, school and community concerns are addressed in this plan. Practice back up/cross coverage providers are informed by these plans. ☐ Partial ☐ Complete	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. ☐ Partial ☐ Complete

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Domain 2: Chronic Condition Management (Continued): For CSHCN and Their Families

THEME:	*Level 1*	*Level 2*	*Level 3*	*Level 4*
#2.3 Continuity Across Settings	Communication among the ***PCP***, specialists, therapists, and school happens as needs arise for ***CSHCN***. ☐ Partial ☐ Complete	A ***PCP*** makes requests and/or responds to requests from agencies or schools on behalf of ***CSHCN*** *(e.g., specific needs for accommodations, medical orders or approval of plans, or for a particular classroom placement);* all communication is documented. ☐ Partial ☐ Complete	Systematic ***practice*** activities foster communication among the ***practice***, family, and external providers such as specialists, schools, and other community professionals for ***CSHCN***; these methods are documented and may include information exchange forms or ad hoc meetings with external providers. ☐ Partial ☐ Complete	In addition to Level 3, a method is used to convene the family and key professionals on behalf of children with more complex health concerns; 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 Specialist	Specialty referrals occur in response to specific diagnostic and therapeutic needs; families 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 family set goals for referrals and communicate these to specialists; together they clarify co-management roles among family, ***PCP*** and specialists and determine how specialty feedback to the family and ***PCP*** is expressed, used, and shared. ☐ Partial ☐ Complete	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). ☐ Partial ☐ Complete

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

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Domain 3: Care Coordination: For CSHCN and Their Families

THEME:	*Level 1*	*Level 2*	*Level 3*	*Level 4*
#3.1 Care Coordination/ Role Definition	The family coordinates care without specific support; they integrate office recommendations into their child's care. ☐ Partial ☐ Complete	The ***primary care provider (PCP)*** or a staff member engages in care support activities as needed; involvement with the family is variable. ☐ Partial ☐ Complete	Care coordination activities are based upon ongoing assessments of child and family needs; the ***practice*** partners with the family (and older child) to accomplish care coordination goals. ☐ Partial ☐ Complete	Practice staff offer a set of care coordination activities (*see page X), their level of involvement fluctuates according to family needs/wishes. A designated care coordinator ensures the availability of these activities including written care plans with ongoing monitoring. ☐ Partial ☐ Complete
#3.2 Family Involvement	The ***PCP*** makes medical recommendations and defines care coordination needs, the family carries these out. ☐ Partial ☐ Complete	Families (and their older ***CSHCN)*** are regularly asked what care supports they need; treatment decisions are made jointly with the ***PCP***. ☐ Partial ☐ Complete	In addition to Level 2, families (and older ***CSHCN)*** are given the option of centralizing care coordination activities at and in partnership with the ***practice***. ☐ Partial ☐ Complete	In addition to Level 3, children and 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. ☐ Partial ☐ Complete
#3.3 Child and Family 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 ***CSHCN*** is offered in one-on-one interactions with children and families; these encounters use supportive written information with resource information. ☐ Partial ☐ Complete	General information regarding having a child with special needs, and diagnosis specific information, is offered by the ***practice*** in a standardized manner; education anticipates potential issues and problems and refers families to other 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 examined. ☐ Partial ☐ Complete

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Domain 3: Care Coordination (continued) - For CSHCN and Their Families

THEME:	*Level 1*	*Level 2*	*Level 3*	*Level 4*
#3.4 Assessment of Needs/Plans of Care	Presentation of ***CSHCN*** with acute problems determines how needs are addressed. ☐ Partial ☐ Complete	***PCPs*** identify specific needs of ***CSHCN***; follow-up tasks are arranged for, or are assigned to families and/or available staff. ☐ Partial ☐ Complete	The child with special needs, family, and ***PCP*** review current child health status and anticipated problems or needs; they create/revise action plans and allocate responsibilities at least 2 times per year or at individualized intervals. ☐ Partial ☐ Complete	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. ☐ 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 family visit intakes; the ***practice*** addresses immediate family 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 family requests for information; the family seeks out additional information and may share back lessons learned. ☐ Partial ☐ Complete	Significant office knowledge about family and medical resources and insurance options is available; assessment of family needs leads to supported use of resources and information to solve specific problems. ☐ Partial ☐ Complete	In addition to Level 3, ***practice*** staff work with families helping solve resource problems; a designated care coordinator provides follow-up, researches additional information, seeks and provides feedback and assists with the family to integrate new information into the care plan. ☐ Partial ☐ Complete
#3.6 Advocacy	The ***PCP*** suggests that the family find support services and resources outside of the ***practice*** when specific needs arise (e.g., diagnosis specific support groups, disability rights organizations, or Parent Support and Information Centers). ☐ Partial ☐ Complete	All families of ***CSHCN*** are routinely provided with basic information about Parent to Parent groups, family support, and advocacy resources during scheduled practice visits. ☐ Partial ☐ Complete	The ***practice*** team identifies resources to the family for support and advocacy, facilitates the connections, and advocates on a family's behalf to solve specific problems pertinent to ***CSHCN***s. ☐ Partial ☐ Complete	In addition to Level 3, this team advocates on behalf of all ***CSHCN*** and their families as a population and helps to create opportunities for community forums, discussions or support groups which address specific concerns. ☐ Partial ☐ Complete

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Domain 4: Community Outreach: For *CSHCN* and Their Families

THEME:	*Level 1*	*Level 2*	*Level 3*	*Level 4*
#4.1 Community Assessment of Needs for *CSHCN*	***Primary care provider (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. ☐ Partial ☐ Complete	The practice learns about issues and needs related to ***CSHCNs*** 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. ☐ Partial ☐ Complete	In addition to Level 2, providers raise their own questions regarding the population of ***CSHCN*** in their practice community/communities; they seek pertinent data and information from families 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 need assessment about ***CSHCN***, integrates results into practice policies, and shares conclusions about population needs with community and state agencies. ☐ Partial ☐ Complete
#4.2 Community Outreach to Agencies and Schools	When the family, school or agency request interactions with the ***primary care provider (PCP)*** on behalf of a child'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 school requests technical assistance or education from the practice about ***CSHCN***, the practice communicates, collaborates, and educates based upon availability and interest. ☐ Partial ☐ Complete	The practice initiates outreach to community agencies and schools that directly serve ***CSHCN*** (e.g., through representation on one or more advisory boards or committees); they advocate for improved community services and inter-organizational collaboration and communication. ☐ Partial ☐ Complete	In addition to Level 3, the ***practice*** identifies needs of ***CSHCN*** and their families; they work with families to sponsor activities that raise community awareness to resource and support needs (e.g., specialized home care, respite care recreation opportunities, or improving home/ school/provider communication). ☐ Partial ☐ Complete

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

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Domain 5: Data Management - For *CSHCN* and Their Families

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 and scheduling; data are retrieved according to diagnostic code 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 children with special health care needs ***CSHCN***; 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, care plan 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 and outcomes. ☐ Partial ☐ Complete	In addition to Level 3, electronic data are produced and used to drive ***practice*** improvements and to measure quality against benchmarks; (those producing and using data ***practice*** confidentiality). ☐ Partial ☐ Complete

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

THEME:	*Level 1*	*Level 2*	*Level 3*	*Level 4*
#6.1 Quality Standards (structures)	Quality standards for children with special health care needs (***CSHCN***) are imposed upon the ***practice*** by internal or external organizations. ☐ Partial ☐ Complete	In addition to Level 1, an individual staff member participates on a committee for improving processes of care at the ***practice*** for ***CSHCN***. This person communicates and promotes improvement goals to the whole ***practice***. ☐ Partial ☐ Complete	The ***practice*** has its own systematic quality improvement mechanism for ***CSHCN***; regular provider and staff meetings are used for input and discussions on how to improve care and treatment for this population. ☐ Partial ☐ Complete	In addition to Level 3, the ***practice*** actively utilizes quality improvement (QI) processes; staff and parents of ***CSHCN*** are supported to participate in these QI activities; resulting quality standards are integrated into the operations of the ***practice***. ☐ Partial ☐ Complete
#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 with limited participation in the process. ☐ Partial ☐ Complete	Periodic formal, and informal quality improvement activities gather staff input about ***practice*** improvement ideas and opportunities for ***CSHCN***; efforts are made toward related changes and improvements for this population. ☐ Partial ☐ Complete	In addition to Level 3, the ***practice*** systematically learns about ***CSHCN*** and draws upon family input; together the ***practice*** and families design and implement office changes that address needs and gaps; they then study their 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) Indicate whether you place your practice at a PARTIAL or COMPLETE ranking within that level (circle one).

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SUMMARY

Please summarize your comments here (e.g., likes, dislikes, what we left out, too much stress, etc.).

Please list any examples of forms, tools, charting or ways you "do things" that you particularly want us to know about.

Other remarks:

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