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| Supplement Digital: Table 1. Primary Care Quality-Related Constructs Explored in the Development of the Primary Care Quality-Homeless Instrument | | |
| Eight Constructs Identified from Two Institute of Medicine Reports (1, 2)\* | | |
|  |  | **Source** |
| Accountability | The health care should anticipate patient needs, rather than simply reacting to events. | 1 |
| Access | Accessible refers to the ease with which a patient can initiate an interaction for any health problem with a clinician (e.g., by phone or at a treatment location) and includes efforts to eliminate barriers such as those posted by geography, administrative hurdles, financing, culture, and language. | 1, 2 |
| Cooperation | Clinicians and institutions should actively collaborate and communicate to ensure an appropriate exchange of information and coordination of care. | 2 |
| Coordination | Coordination ensures the provision of a combination of health services and information that meets a patient's needs. It also refers to the connection between, or the rational ordering of those services, including the resources in the community. | 2 |
| Shared Knowledge | Patients should be given the necessary information and the opportunity to exercise the degree of control they choose over health care decisions that affect them. The health system should be able to accommodate differences in patient preferences and encouraged shared decision-making. | 1 |
| Continuity | Patients should receive care whenever they need it and in many forms, including providing access to care over the internet, by telephone, and by other means in addition to face-to-face visits. Care over time by a single individual/team of professionals and communication of health information. | 1, 2 |
| Control | Patients should be given the necessary information and opportunity to exercise the degree of control they choose over health decisions and the health system should accommodate differences in preferences. | 1 |
| Evidence-based decision making | Patients should receive care based on the best available scientific knowledge. Care should not vary illogically from clinician to clinician or from place to place. | 1 |
| Three Constructs Emergent from Interviews with Homeless Patients and Experts  in their Care (themes) | | |
| Trust-Respect | Reflects themes identified by interviewees: confidentiality, comfort in relationship to primary care physician, trust in the dependability of the provider, belief that provider will act as a good fiduciary, mutual trust between provider, institution and patient, respect, compassion and dignity. |  |
| Homeless-Specific Needs | Training/aptitudes of providers in relation to homelessness, special requirements to meet non-medical needs (food, clothing), service package designed to address non-medical needs, special reference to self-esteem/self-worth challenges faced by homeless. |  |
| Substance Abuse/Mental Illness | Awareness/knowledge of behavioral (substance abuse/mental illness) issues with patient, negative stigma toward substance abuse/mental illness, substance abuse effects on dynamics of health care, challenges to receipt of care related to substance abuse/mental illness. |  |
| *\*Constructs of a priori interest* in development of this patient-reported quality measure drew upon two Institute of Medicine reports and are paraphrased from the following two reports:  (1) Crossing the Quality Chasm: A New Health System for the 21st Century (2001); (2) Primary Care: America's Health in a New Era (1996). | | |