Joint Commission Primary Care Medical Home (PCMH) Certification for Accredited Ambulatory Health Care Organizations

Question & Answer Guide

A. SCORING/DECISION-RELATED

Question: We are already Joint Commission accredited under the Ambulatory Care manual. Do we need to wait until we have fully implemented the PCMH requirements in all our care delivery sites before we submit our application for PCMH certification?

Answer: No, you don’t need to wait; The Joint Commission doesn’t expect that organizations will be 100% compliant with all standards for those seeking PCMH certification for the first time. We do expect the following:

- a) implementation for at least one patient population in at least one care delivery site;
- b) written policy and procedures to support that implementation; and,
- c) written plans for organization-wide application by the time of your next triennial survey (in 18 to 36 months).

For example, If an organization has only implemented electronic prescribing at one of its sites at the time of their survey (MM.04.01.01/EP 21), but has written policies and procedures to support e-prescribing, and also has written plans to implement e-prescribing at all its sites within the next 18 months, this would be considered minimally acceptable compliance for this element of performance.

B. MEANINGFUL USE EXPECTATIONS

Question: Do Joint Commission PCMH requirements address Meaningful Use expectations?

Answer: Yes, a number of CMS “meaningful use” requirements that are intended to reduce medical errors, adverse drug events, and improve patient adherence are addressed in the PCMH standards. These include e-prescribing, recording patient demographics, maintaining an up-to-date problem list of current and active diagnoses, maintaining an active medication list and active medication allergy list, using at least one clinical decision support rule, exchanging key clinical information among providers, and protecting electronic health information.
C. HEALTH INFORMATION TECHNOLOGY
AND ELECTRONIC HEALTH RECORD REQUIREMENTS

Question: Does the Joint Commission require an organization to use electronic health records (EHR)? Are there other health information technology (HIT) requirements?

Answer: At this time there is not a requirement that an organization use an EHR. The Joint Commission does require organizations to use HIT to: support the continuity of care; document and track care; support disease management to include providing education; support preventive care; create reports for internal/external use; facilitate electronic exchange of information among providers; and, support performance improvement (PC.02.04.03/EP 5).

In addition, there are requirements to use HIT to support both electronic prescribing (MM.04.01.01/EP 21) and clinical decision support tools (PC.01.03.01/EP 45).

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D. ROLE OF THE FAMILY IN A PCMH

Question: What is the Joint Commission’s view of the family within its PCMH model?

Answer: Within the Joint Commission’s PCMH model, patient-centeredness includes “partnering with patients and their families …” and “recognizing that patients and families are core members of the care team…”

The Joint Commission defines family in its glossary as:

“a person or persons who play a significant role in an individual’s life. A family is a group of two or more persons united by blood or adoptive, marital, domestic partnership, or other legal ties. The family may also be a person or persons not legally related to the individual (such as a significant other, friend or caregiver) whom the individual personally considers to be family. A family member may be a surrogate decision-maker if authorized to make care decisions for the individual should he or she lose decision-making capacity or choose to delegate decision-making to another.”

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Question: What are the minimum requirements for my organization to provide 24 hours a day, 7 days a week access to: appointment availability/scheduling; requests for prescription renewal; test results; and clinical advice for urgent health needs? (PC.02.04.01/EP 1)

Answer: The intent of this requirement is to provide more accessible services by using alternatives to a face-to-face visit, such as around-the-clock telephone or electronic access to a member of the care team, and alternative methods of communication, such as e-mail and patient portals. The PCMH is responsive to patients’ preferences regarding access.

When the organization is closed, simply having an answering machine prompting patients to go to the nearest emergency department, or to ‘call back’ during normal business hours does not meet the intent of this requirement.

For 24/7 appointment availability/scheduling:

At a minimum, a PCMH needs to have systems in place that provide patients the opportunity to contact the organization 24 hours a day, seven days a week, and either make a same day appointment, or enable patients to come to the organization as a walk-in during normal business hours.

Compliance could also include an organization providing their patients access to a password protected patient portal, enabling them to verify an appointment that was already scheduled, check appointment availability, and to cancel or request an appointment.

For 24/7 prescription renewal requests:

At a minimum, the PCMH has a system that allows the patient to request a prescription renewal 24 hours a day, seven days a week. It does not require an organization to fill a prescription renewal 24/7. An organization could utilize an automated phone line, answering service, or patient portal that prompts the primary care clinician (or a member of the interdisciplinary team that has prescriptive authority) to complete the renewal.

At the time of a patient’s visit, the PCMH provides education to the patient about their process to renew prescriptions (and, if applicable, which medications may require additional care), as well as their timeframes for following up on prescription renewal requests.

For 24/7 test results:

The intent of this requirement is for the PCMH to have a process whereby patients have 24 hours a day, 7 days a week access to their test results (including diagnostic tests), thereby enabling the patient (and family as appropriate) to participate in timely decisions regarding their care or treatment.
Minimum compliance is that a patient can contact the organization (via phone, web portal, etc) to obtain test results from the patient’s clinical record. If the organization is closed, the primary care clinician (or a member of the team) may access the test results either from an electronic health record or from the reference lab, and communicate these results directly with the patient.

Examples include an organization that provides their patients access to a password protected portal, thereby enabling them to view their test results when they become available; or one that partners with their contracted lab/diagnostic center to allow a patient direct telephonic access to their results.

**For 24/7 clinical advice for urgent care needs:**

At a minimum, a PCMH has a system in place that provides patients with the opportunity to contact them 24 hours a day, seven days a week to obtain clinical advice for concerns the patient (or their family as appropriate) may have.

An organization may utilize an after-hours service (e.g., on-call clinician with competency in making clinical decisions, or triage service) to provide clinical advice that ranges from offering home care instructions, how to make a next day appointment, or directing them to go to an emergency department.

An example is an organization that provides the capability for patients to email or instant message their PCMH (or a designated member of their interdisciplinary team) with questions or concerns about their health care.

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**F. PATIENT CHOICE OF PRIMARY CARE CLINICIAN**

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<th>Question: Will my organization be out of compliance if one of my primary care clinicians is no longer accepting new patients into his/her panel? (PC.02.01.01/EP 17)</th>
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Answer: The intent of this requirement is to give patients the opportunity to select an available primary care clinician, and to provide patients with information to make an informed decision between available primary care clinicians.

If a patient does not select a primary care clinician during their initial contact with the organization, or if the patient’s health plan initially selects their primary care clinician, the PCMH needs to have processes in place to assist these patients with selecting a primary care clinician. PCMH processes may include providing information about primary care clinicians’ educational backgrounds, areas of expertise, and languages spoken.

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G. HEALTH LITERACY

Question: How should the interdisciplinary team identify the patient’s health literacy needs? (PC.02.02.01/EP 24) Are there specific ways the primary care clinician and the interdisciplinary team incorporate health literacy into the patient’s education? (PC.02.02.01/EP 25)

Answer: Health Literacy is defined in the glossary as: “The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.”

The intent of this requirement is to improve communication between health care professionals and patients by going beyond simply documenting the patient’s highest level of education. In addition to basic literacy skills, health literacy requires knowledge of health topics and numeracy skills. To assess health literacy, there are several well established tools that an interdisciplinary team can use (see the websites of the federal Agency for Healthcare Research and Quality, Institute of Medicine, Office of Disease Prevention and Health Promotion, and Centers for Disease Control and Prevention).

After identifying a patient’s learning needs, potential learning barriers (including basic reading literacy, numeracy skills, and any physical limitations affecting learning), and preferred learning methods and modalities (drawings, models, audio, and video), the interdisciplinary team can select their own approach to applying this information when educating the patient about their diagnosis, treatment, and/or self-management plan. One effective method to demonstrate understanding of the information provided is to ask the patient to repeat back the instructions in their own words, or by using the “teach-back” technique. Confirmation is then documented in the clinical record.

H. POPULATION-BASED CARE

Question: How does an organization provide population-based care? (PC.02.04.03/EP 4)

Answer: Population-based care is defined in the glossary as:

“the assessment, monitoring, and management of the health care needs and outcomes of identified groups of patients and communities, rather than individual patients. The goal of population-based care is to improve the health of the population, increase awareness of behavioral-related health risks, promote healthy lifestyle activities and patient self-management, and decrease health care inequities.”

In other words, a PCMH focuses on the assessment, monitoring, and proactive management of the health care needs of patient populations, rather than individual patients only.
Maintaining registries of their patients is a common approach organizations use to track and trend data that improves the health of their target population, increases awareness of health risks, and promotes healthy lifestyle choices and self-management activities.

The development of a population-based care program may also be based on an assessment of community needs.

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**I. DESIGNATED GROUP OF PATIENTS**

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<th>Question: How does “population-based care” (required in PC.02.04.03/EP 4), differ from providing care for a “designated group of patients” (PC.02.04.05/EP 4)?</th>
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**Answer:** The PCMH’s primary care clinician(s) and interdisciplinary team(s) work together to proactively manage a designated group of patients (which is frequently referred to as a “panel of patients”). In contrast to focusing on overall patient population characteristics (see “H” above), it is the individual needs of each patient in the group (or on the panel) that is the principal concern.

For example, a primary care clinician and their team may have responsibility for caring for a panel of 2200 patients; in addition, they have also identified several sub-populations of patients (e.g. diabetics, seniors, patients with high BMIs) that will be monitored to improve health outcomes.

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**J. COMPOSITION OF INTERDISCIPLINARY TEAM**

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<th>Question: How is the composition of the interdisciplinary team determined? (PC.02.04.05/EP 1).</th>
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**Answer:** The organization determines the composition of the interdisciplinary team(s) based on the patient’s needs. For example, a team for a diabetic patient may be different than the team for a pediatric asthmatic patient. The organization can use professional practice models, staffing models, or current evidence to identify the appropriate mix of individuals on the interdisciplinary team. However, the patient (and if preferred, their family) should always be considered a part of the team. This requirement does not imply that all members of the interdisciplinary team will be onsite; the use of virtual team members may be necessary in underserved areas or when geographic separation occurs.

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K. TRACKING CARE

Question: How would a surveyor determine whether or not an interdisciplinary team tracks the care provided by external providers? (PC.02.04.05/EP 6)

Answer: The intent of this requirement is more than simply providing the patient with the name of a consultant, telling them to make their own appointment, and then expecting the patient to provide feedback about the results of the consultation. The surveyor would validate this process by examining the policy/procedure used by the organization to track care provided by external providers, interviewing patients about how the organization works with the patient when referred to external providers, and/or observing the referral process in the care setting.

An example of a compliant organization is one that provides a patient with the contact information for the referral and asks if the patient requires any assistance. The primary care clinician or designated interdisciplinary team member then follows-up with the patient or referred organization to ensure compliance with the referral. Alternatively, an organization may utilize a referral center or designate a member of the interdisciplinary team to make the appointment, pro-actively ensure the patient makes the appointment, and follow-up if there is a ‘no-show’ to the referred organization.

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L. CONTINUITY OF CARE

Question: Why was a note added specifically for the PCMH that highlights internal and external providers, when the element of performance already requires the clinical record to contain information about the patient’s care that promotes continuity of care? (RC.01.01.01/EP 8)

Answer: Although the Record of Care, Treatment and Services chapter details the requirements for the clinical record, this note is intended to ensure that not only is patient information from internal and external providers in the clinical record, but that it is accessible to those internal and external providers of care as well. The organization defines the components of information in the clinical record to ensure continuity of care.

For example, if a patient is sent to an endocrinologist for evaluation regarding insulin management, it is important for the endocrinologist to have a base of information to make informed decisions regarding the patient’s care, and to limit the amount of duplicative care (i.e. lab work, radiological studies, etc.). It is just as important for the referring primary care clinician to receive information back from the endocrinologist in order to manage the patient’s on-going care.

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M. PRIMARY CARE CLINICIAN COMPETENCY

Question: What educational background, knowledge, and experience is needed to be designated a primary care clinician (PCC)? (HR.03.01.01/EP 1).

Answer: The Joint Commission’s definition of the primary care clinician is as follows:

“A clinician operating within the primary care medical home who works collaboratively with an interdisciplinary team and in partnership with the patient to address the patient’s primary health care needs.

Primary care clinicians have the educational background, broad based knowledge, and experience necessary to handle most medical and other health care needs of the patients who have selected them, including resolving conflicting recommendations for care.

The primary care clinician is selected by the patient and serves as the primary point of contact for the patient and family.

A primary care clinician operating within the primary care medical home is a doctor of medicine or doctor of osteopathy, advanced practice nurse or physician assistant.”

The intent of the PCC’s role is to be the “point person” for the patient and the interdisciplinary team, with the care provided as a collaborative effort.

The need for the PCC to be able to “resolve conflicting recommendations for care” can be illustrated by an example. A patient has just seen her dentist and requires multiple tooth extractions. The patient has been advised by the dentist to stop taking any ‘blood thinners’ prior to the appointment to avoid any bleeding issues; however, the patient has been taking Warfarin for a history of atrial fibrillation and remembers being told by her PCC to not adjust her regimen. In this situation, it is expected that the PCC has the knowledge and experience to formulate a care plan that both allows the patient to have her tooth extracted safely, and to continue her medication regimen when appropriate.

It is also possible for a sub-specialist to be a PCC if they have the ability to “handle most medical and other health care needs of the patient.” Some examples include an infectious disease specialist caring for an HIV/AIDS patient, an oncologist caring for a terminally ill patient, an endocrinologist caring for a diabetic patient, and a cardiologist caring for a patient with heart failure.
N. SCOPE OF PRACTICE

Question: I am confused with the Element of Performance that requires the Primary Care Clinician and interdisciplinary teams to function within their scope of practice and in accordance with privileges granted (PC.02.04.05/EP 3); isn’t this already covered by another requirement?

Answer: Although there are competency-based standards in the Human Resource chapter (e.g. HR.01.06.01, HR.02.01.03), the intent of this requirement is to encourage an organization to have all staff performing their functions and duties at “maximum capacity” or “at the top of their credentials,” i.e., to the fullest extent of their licensure, certification, or registration in order to optimize the continuity of care and the provision of comprehensive and coordinated care, treatment, or services. Organizations are still required to ensure compliance with all local licensing and privileging requirements.

An example of functioning within scope of practice could be ensuring that the nurse on a team is performing duties appropriate to his/her competency and licensure, and not performing duties more suitable for a medical assistant or administrative staff.

O. E-PRESCRIBING EXPECTATIONS

Question: What type of electronic prescribing process does The Joint Commission consider to be acceptable? (MM.04.01.01/EP 21)

Answer: The Joint Commission doesn’t require a specific software or process for compliance, based on the Joint Commission’s definition of electronic prescribing (“the use of an automated data entry system by an authorized prescriber to transmit a prescription directly to a participating pharmacy”). However, an organization that utilizes an Electronic Health Record to only provide a printed prescription for the patient to take to the pharmacy in order to fill their medication(s) would not be in compliance.
P. CLINICAL DECISION SUPPORT TOOL

Question: What constitutes a clinical decision support tool? (PC.01.03.01/EP 45)

Answer: The organization needs to use at least one clinical decision support tool. The Joint Commission defines clinical decision support as:

“Software designed to assist in clinical decision making. A clinical decision support system matches two or more characteristics of an individual patient to a computerized clinical knowledge base and provides patient-specific assessments or recommendations to the clinician. The clinician makes decisions based on clinical expertise, knowledge of the patient, and the information provided through the clinical decision support system. A clinical decision support system can be used at different points in the care process such as diagnosis, treatment, and post-treatment care, including the prediction of future events.”

Common examples of clinical decision support tools include: Allergy alert with e-prescribing, medication dosage calculators, disease registry tracking tools, wellness and disease reminders.

Other examples of more advanced clinical decision support tools include: Utilizing multiple clinical decision support tools, embedded in the EHR and available throughout the organization, that incorporate clinical practice guidelines, treatment algorithms, etc. E-prescribing functionality may include software containing a drug utilization program that cross checks the prescribed medication against current medications, patient’s weight, contraindications, and dosing recommendations to alert the licensed independent provider to any issues.

Q. DATA COLLECTION

Question: The accreditation standards already require multiple data to collect and use. What is different about the PCMH requirements? (PI.01.01.01/EPs 16, 40, 41; PI.03.01.01/EP 11).

Answer: A PCMH is required to collect the following additional data: disease management outcomes; patient access to care within timeframes established by the organization; patient experience and satisfaction related to access to care and communication; and, patient perception of the comprehensiveness, coordination, and continuity of care.

After collecting this data, the organization then uses the data as part of its performance improvement activities. These requirements focus on patients, and their perceptions of the care, treatment, and services provided.