Along with the current ambulatory care standards that must be maintained to achieve accreditation, the following are the additional requirements (arranged by 5 operational characteristics and 12 focus areas) that an accredited organization must be in compliance with to be designated as a Primary Care Medical Home.

I. OPERATIONAL CHARACTERISTIC: PATIENT-CENTEREDNESS

A. FOCUS AREA: INFORMATION TO PATIENTS ABOUT THE PCMH

1. **Provides information to the patient** about:
   
   ✓ The mission, vision, and goals of the primary care medical home. [RI.01.04.03/EP 1]
   
   *Note: This may include how it provides for patient-centered and team-based comprehensive care, a systems-based approach to quality and safety, and enhanced patient access.*
   
   ✓ The scope of care and types of services provided [RI.01.04.03/EP 2]
   
   ✓ How the primary care medical home functions, including the following: [RI.01.04.03/EP 3]
     
     o Processes supporting patient selection of a primary care clinician
     o Involving the patients in his or her treatment plan
     o Obtaining and tracking referrals
     o Coordinating care
     o Collaborating with patient-selected clinicians who provide specialty care or second opinions
   
   ✓ How to access the primary care medical home for care or information [RI.01.04.03/EP 4]
   
   ✓ Patient responsibilities, including providing health history and current medications, and participating in self-management activities [RI.01.04.03/EP 5]
   
   ✓ The patient’s right to obtain care from other clinicians within the primary care medical home, to seek a second opinion, and to seek specialty care [RI.01.04.03/EP 6].

B. FOCUS AREA: DESIGNATED PRIMARY CARE CLINICIAN

1. **Each patient has a designated primary care clinician.** [PC.02.01.01/EP 16]

2. The organization **allows the patient to select his or her primary care clinician.** [PC.02.01.01/EP 17]
C. FOCUS AREA: PATIENT INVOLVEMENT IN OWN CARE DECISIONS

1. The organization respects the patient’s right to make decisions about the management of his or her care. [RI.01.02.01/EP 31]

2. The interdisciplinary team involves the patient in the development of his or her treatment plan. [PC.02.04.05/EP 11]

3. The interdisciplinary team works in partnership with the patient to achieve planned outcomes. [PC.02.04.05/EP 9]

4. The organization respects the patient’s right and provides the patient opportunity to:
   ✓ Obtain care from other clinicians of the patient’s choosing within the primary care medical home
   ✓ Seek a second opinion from a clinician of the patient’s choosing
   ✓ Seek specialty care

   Note: This does not imply financial responsibility for any activities associated with these rights.

D. FOCUS AREA: PATIENT LANGUAGE & COMMUNICATION NEEDS

1. The primary care clinician and the interdisciplinary team identify the patient’s oral and written communication needs, including the patient's preferred language for discussing health care. [PC.02.01.21/E1]

   Note: Communication need examples include the need for personal devices such as hearing aids or glasses, language interpreters, communication boards, and translated or plain language materials.

2. The primary care clinician and the interdisciplinary team communicate with the patient in a manner that meets the patient's oral and written communication needs. [PC.02.01.21/EP2]

3. The clinical record contains the patient’s communication needs, including preferred language for discussing health care. [RC.02.01.01/EP1]

   Note: If the patient is a minor, is incapacitated, or has a designated advocate, the communication needs of the parent or legal guardian, surrogate decision-maker, or legally authorized representative is documented in the clinical record.

4. The organization provides language interpreting and translation services. [RI.01.01.03/EP2]

   Note: Language interpreting options may include trained bilingual staff, contract interpreting services, or employed language interpreters. These options may be provided in person or via telephone or video. The documents translated and languages into which they are translated are dependent on the organization’s patient population.

5. The clinical record contains the patient’s race and ethnicity. [RC.02.01.01/EP 28]
E. FOCUS AREA: PATIENT EDUCATION, HEALTH LITERACY, & SELF-MANAGEMENT

1. The interdisciplinary team identifies the patient’s health literacy needs. [PC.02.02.01/EP 24]

2. The primary care clinician and the interdisciplinary team incorporate the patient’s health literacy into the patient’s education. [PC.02.02.01/EP 25]

3. Patient self-management goals are identified and incorporated into the patient’s treatment plan. [PC.01.03.01/EP 44]

4. The primary care clinician and the interdisciplinary team educate the patient on self-management tools and techniques based on the patient’s individual needs. [PC.02.03.01/EP 1]

5. The clinical record includes the patient’s self-management goals and the patient’s progress toward achieving those goals. [RC.02.01.01/EP 29]
II. OPERATIONAL CHARACTERISTIC: COMPREHENSIVENESS

A. FOCUS AREA: EXPANDED SCOPE OF RESPONSIBILITY

1. The organization manages transitions in care and provides or facilitates patient access to:
   [PC.02.04.03/EP 1]
   - Acute care
   - Management of chronic care
   - Behavioral health needs
   - Preventive services that are age and gender-specific

   Note: Some of these services may be obtained through the use of community resources as available, or in collaboration with other organizations.

2. The organization provides:
   - Care that addresses various phases of a patient’s lifespan, including end-of-life care
   - Disease and chronic care management services [PC.02.04.03/EP3]
   - Population-based care [PC.02.04.03/EP 4]

B. FOCUS AREA: TEAM MEMBERSHIP & GENERAL RESPONSIBILITIES

1. The organization identifies the composition of the interdisciplinary team. [PC.02.04.05/EP1]

2. The members of the interdisciplinary team provide comprehensive and coordinated care, and maintain the continuity of care. [PC.02.04.05/EP2]
   Note: The provision of care may include making internal and external referrals.

3. The primary care clinician and team members provide care for a designated group of patients. [PC.02.04.05/EP 4]

4. The interdisciplinary team participates in the development of the patient’s treatment plan. [PC.02.04.05/EP8]

5. The interdisciplinary team assesses patients for health risk behaviors. [PC.02.04.05/EP12]

6. The interdisciplinary team monitors the patient’s progress towards achieving treatment goals. [PC.02.04.05/EP10]
III. OPERATIONAL CHARACTERISTIC: COORDINATION OF CARE

A. FOCUS AREA: CARE COORDINATION

1. The primary care clinician is responsible for making certain that the interdisciplinary team provides comprehensive and coordinated care, and maintains the continuity of care. [PC.02.04.05/EP5]

   Note: Coordination of care may include making internal and external referrals, developing and evaluating treatment plans, and resolving conflicts in providing care.

2. When a patient is referred to an external organization, the interdisciplinary team reviews and tracks the care provided to the patient. [PC.02.04.05/EP6]

3. The interdisciplinary team acts on recommendations from internal and external referrals for additional care, treatment, or services. [PC.02.04.05/EP7]

4. The clinical record contains information that promotes continuity of care among providers. [RC.01.01.01/EP 8]

   Note: This requirement refers to care provided by both internal and external providers.

IV. OPERATIONAL CHARACTERISTIC: SUPERB ACCESS TO CARE

A. FOCUS AREA: ENHANCED ACCESS TO SERVICES

1. The organization provides patients with 24/7 access to: [PC.02.04.01/EP1]
   - Appointment availability/scheduling
   - Requests for prescription renewal
   - Test results
   - Clinical advice for urgent health needs

   Note: Access may be provided through a number of methods, such as telephone, flexible hours, websites, and portals.

2. The organization offers flexible scheduling to accommodate patient care needs. [PC.02.04.01/EP 2]
   Note: This may include open scheduling, same day appointments, expanded hours, and arrangements with other organizations.

3. The organization has a process to address patient urgent care needs 24 hours a day, 7 days a week. [PC.02.04.01/EP 3]
V. OPERATIONAL CHARACTERISTIC: SYSTEMS FOR QUALITY/SAFETY

A. FOCUS AREA: HEALTH INFORMATION TECHNOLOGY (HIT) - RELATED

1. The organization uses health information technology to: [PC.02.04.03]
   - Support the continuity of care, and provision of comprehensive and coordinated care
   - Document and track care
   - Support disease management, including providing patient education
   - Support preventive care
   - Create reports for internal use and external reporting
   - Facilitate electronic exchange of information among providers
   - Support performance improvement

2. The organization uses an electronic prescribing process. [MM.04.01.01/EP 21]

3. The organization uses clinical decision support tools to guide decision making. [PC.01.03.01/EP 45]

B. FOCUS AREA: PERFORMANCE IMPROVEMENT-RELATED

1. The organization collects data on:
   - Disease management outcomes. [PI.01.01.01/EP 40]
   - Patient access to care within timeframes established by the organization [PC.01.01/EP 41]
   - Patient experience and satisfaction related to access to care and communication [PI.01.01.01/EP 16]
   - Patient perception of the comprehensiveness, coordination, and continuity of care [PI.01.01.01/EP 16]

2. The organization uses the data it collects on the patient’s experience and satisfaction related to access to care and communication, and the patient’s perception of the comprehensiveness, coordination, and continuity of care [PI.03.01.01/EP 11]

3. Leaders involve patients in performance improvement activities. [LD.04.01.01/EP 24]
   Note: Patient involvement may include activities such as participating on a quality committee or providing feedback on safety and quality issues.

4. The interdisciplinary team actively participates in performance improvement activities. [PC.02.04.05/EP13]

5. Ongoing performance improvement occurs organization-wide for the purpose of demonstrably improving the quality and safety of care. [LD.04.04.01/EP 4]

6. The organization evaluates how effectively the primary care clinician and the interdisciplinary team work in partnership with the patient to support the continuity of care and the provision of comprehensive and coordinated care. [LD.01.03.01/EP 20]

C. FOCUS AREA: COMPETENCY OF PRIMARY CARE CLINICIAN & TEAM

1. The primary care clinician has the educational background and broad-based knowledge and experience necessary to handle most medical needs of the patient and resolve conflicting recommendations for care. [HR.03.01.01/EP 1]

2. The primary care clinician and the interdisciplinary team members function within their scope of practice and in accordance with privileges granted. [PC.02.04.05/EP 3]

For further information on the Primary Care Medical Home designation from the Joint Commission, call 630.792.5286 or indicate your interest via web link: www.jointcommission.org/PCMH