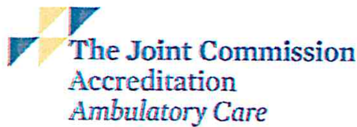

The Joint Commission Primary Care Medical Home (PCMH) Model

The Joint Commission's Primary Care Medical Home (PCMH) Model is based on the Agency for Healthcare Research and Quality's (AHRQ) definition of a medical home. This definition describes a medical home as a model of primary health care that has the following core functions and attributes:

- Patient-centered care
- Comprehensive care
- Coordinated care
- Superb access to care
- A systems-based approach to quality and safety

The operational characteristics below describe the components of The Joint Commission's PCMH Model. They address the roles and functions of the patient, organization, primary care clinician, and interdisciplinary team, which are interdependent and, therefore, key to the provision of patient-centered, comprehensive, and collaborative primary care.

These operational characteristics will serve as the basis for The Joint Commission's PCMH requirements. Since this option will be applicable only to accredited ambulatory care organizations, the characteristics noted below were based on the AHRQ definition and will be addressed through the applicability of both existing requirements and newly developed ambulatory care requirements for The Joint Commission's PCMH.

I. Patient-Centered Care

The primary care medical home provides primary health care that is relationship-based with an orientation toward the whole person. Partnering with patients and their families requires understanding and respecting each patient's unique needs, culture, values, and preferences. The medical home practice actively supports patients in learning to manage and organize their own care at the level the patient chooses. Recognizing that patients and families are core members of the care team, medical home practices ensure that they are fully informed partners in establishing care plans.

Concepts to be addressed in The Joint Commission PCMH elements of performance:

A. Patient-selected Primary Care Clinician (PCC)
B. PCC and interdisciplinary team work in partnership with the patient
C. Consideration of the patient's cultural, linguistic, language, and educational needs and preferences
D. Patient involvement in establishing the treatment plan
E. Support for patient self-management

II. Comprehensive Care

The primary care medical home is accountable for meeting the large majority of each patient's physical and mental health care needs, including prevention and wellness, acute care, and chronic care. Providing comprehensive care requires a team of care providers. This team might include physicians, advanced practice nurses, physician assistants, nurses, pharmacists, nutritionists, mental health workers, social workers, educators, and care coordinators. Although some medical home practices may bring together large and diverse teams of care providers to meet the needs of their patients, many others, including smaller practices, will build virtual teams linking themselves and their patients to providers and services in their communities.

Concepts to be addressed in The Joint Commission PCMH elements of performance:

A. The provision of acute, preventive, and chronic care
B. Provision of continuous and comprehensive care
C. Team-based approach and the use of a multidisciplinary team to provide care
D. Use of internal and external resources to meet patient needs
E. PCC 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
F. PCC works collaboratively with an interdisciplinary team
G. Care that addresses various phases of a patient's lifespan, including end-of-life care
H. Disease management

III. Coordinated Care

The primary care medical home coordinates care across all elements of the broader health care system, including specialty care, hospitals, home health care, and community services and supports. Such coordination is particularly critical during transitions between sites of care, such as when patients are being discharged from the hospital. Medical home practices also excel at building clear and open communication among patients and families, the medical home, and members of the broader care team.

Concepts to be addressed in The Joint Commission PCMH elements of performance:

A. Use of internal and external resources to meet patient needs
B. Responsibility for care coordination
C. Team-based approach

IV. Superb Access to Care

The primary care medical home delivers accessible services with shorter waiting times for urgent needs, enhanced in-person hours, around-the-clock telephone or electronic access to a member of the care team, and alternative methods of communication such as email and telephone. The medical home practice is responsive to patients' preferences regarding access.

Concepts to be addressed in The Joint Commission PCMH elements of performance:

A. Enhanced access- defined as responsiveness to patients' preferences regarding access, including: timely response to and shorter wait times for urgent needs; flexible appointment hours and days of service; telephonic or electronic access to a member of the care team; and alternative methods of communication such as email
B. Availability 24 hours a day, 7 days a week
C. Access for non-visit related patient needs
D. Access for patients with special communication needs

V. A Systems-Based Approach to Quality and Safety

The primary care medical home demonstrates a commitment to quality and quality improvement through ongoing engagement in activities such as using evidence-based medicine and clinical decision-support tools to guide shared decision making with patients and families, engaging in performance measurement and improvement, measuring and responding to patient experiences and patient satisfaction, and practicing population health management. Sharing robust quality and safety data and improvement activities publicly is also an important marker of a system-level commitment to quality.

Concepts to be addressed in The Joint Commission PCMH elements of performance:

A. Population-based care
B. Use of health information technology, including electronic prescribing
C. PCC and team members function within their scope of practice and in accordance with law and regulation and privileges granted
D. Use of evidence-based medicine and decision support tools
E. The provision of care to a panel of patients
F. Patient involvement in performance monitoring and improvement efforts