Joint Commission Primary Care Medical Home (PCMH) Certification for Accredited Ambulatory Health Care Organizations Question & Answer Guide

(Effective July 1, 2014)

A. ELIGIBILITY/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; for organizations seeking PCMH certification for the first time you can still apply even if your organization is not 100% compliant with all standards at all sites. We do expect the following:

a) Implementation of the PCMH requirements for at least one patient population in at least one eligible care delivery site*;

b) Written policy and procedures to support that implementation; and,

c) Written plans for organization-wide application of the PCMH requirements by the time of your next triennial survey (in 18 to 36 months).

For example, if an organization has only implemented the requirement that "the primary care clinician and team members provide care for a panel of patients" (PC.02.04.05/EP 4) at one of its sites at the time of their survey, but has written policies and procedures to support empanelment, and also has written plans to implement empanelment at all its sites within the next 18 months, this would be considered minimally acceptable compliance for this element of performance.

*An eligible care delivery site is defined as a location where on-going established relationships exist between a primary care clinician and a panel of patients. This site needs to provide on-going and continuous primary care to a majority of its patients, irrespective of the location of the site or the population of patients being served.

Examples of sites that are not eligible include: administrative offices, dental-only practices, lab/phlebotomy-only, physical therapy services-only, opioid treatment programs, podiatric services-only, mental health services-only, and sites that primarily provide episodic or urgent medical care rather than on-going and continuous primary care.

==========

B. 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."*

==========

C. SUPERB ACCESS TO CARE (24/7 - RELATED)

Question: What are the minimum requirements for my organization to provide 24 hours a day, 7 days a week, patients the ability to: schedule a same or next day appointment; request prescription renewal; and obtain 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 make either a same or next day appointment. For example, a patient could speak to the provider on-call, who based on their assessment, could advise the patient to either go to the ER or come into the office the next day to be seen.

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 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.

==========

D. PATIENT CHOICE OF PRIMARY CARE CLINICIAN

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)

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.

==========

E. HEALTH LITERACY NEEDS

Question: How should the interdisciplinary team identify the patient's health literacy needs? (PC.02.02.01/EP 24) How should an organization insure that patient education is consistent with the identified health literacy needs? (PC.02.02.01/EP 25)

Also, what is the relationship of health literacy to the other patient education accreditation requirements: to assess the patient's learning needs (PC.02.03.01/EP 1); to evaluate the patient's understanding of the education and training provided (PC.02.03.01/EP 25); and, to provide education regarding anticoagulation therapy (NPSG.03.05.01/EP 7)?

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*."

Also, the related note to this requirement states, *"Health Literacy is typically an interactive process, the goal of which is to ascertain the patients capacity to process and understand basic health information needed to make appropriate health decisions".*

The intent of this requirement is to improve communication between health care professionals and patients (and their families) by going beyond simply documenting the patient's highest level of education and preferred language. In addition to being affected by basic literacy skills (the ability to read/write) and English proficiency, health literacy is also impacted by a patient's knowledge of health topics, terminology, and numeracy skills.

The identification of a patient's health literacy needs builds on the assessment of a patient's learning needs *(PC.02.03.01/EP 1)*, which includes identifying both potential learning barriers (e.g. any physical limitations affecting learning), and preferred learning methods and modalities (e.g. drawings, models, audio, video).

To assess health literacy needs, 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). While neither the use of a specific assessment tool, nor the determination of a health literacy level is required, an interactive process or method must be evident in order to be minimally compliant.

Although one effective approach to evaluating a patient's understanding of the education/training provided *(PC.02.03.01/EP 25)* is to ask the patient to repeat back the instructions in their own words (the "teach-back" technique) and to document confirmation in the clinical record, using that approach alone is not sufficient for compliance.

Finally, as required in providing effective anticoagulation patient education *(NPSG .3.5.1/EP 7)*, there needs to be a "face-to-face interaction with a trained professional who works closely with patients to be sure that they understand the risks involved with anticoagulation therapy, the precautions they need to take, and the need for regular International Normalized Ratio (INR) monitoring". By identifying a patient's health literacy needs first, this will enable any subsequent patient education to be more efficient and effective.

==========

F. INFORMATION PATIENTS NEED ABOUT THE PCMH

Question: Is there a specific method of communication that should be used to provide patients with information about the specified functions and services of the PCMH? (RI.01.04.03/EPs 1-7)

Answer:

The intent of this patient-centered requirement is to help foster a partnership relationship between providers and patients (and their families when appropriate) to enable patients to be actively involved in their own care. There are a variety of methods that a PCMH might choose to communicate the required information, with the selected ones taking into consideration the needs and preferences of their patients. Information might be: posted on the organization's website; included in a patient orientation brochure or other handout; displayed on posters in the waiting or exam room; or, verbally described during a patient visit.

The PCMH must include in their communications the following information about how they function:

- Their mission, vision, and goals; scope of care; and types of services;
- How they manage: selection of a primary care clinician; involvement of patients in their own treatment plan; referrals and coordination of care; collaboration with patient-selected clinicians who provide specialty care or second opinions; and communication about a patient's health care concerns;
- Patient responsibilities, including providing health history and current medications and participating in self-management activities;
- 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; and,
- The credentials and educational background information of individuals serving in the role of primary care clinician.

==========

G. 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. Population-based care includes data collection and analysis in order to assess, monitor, and manage the needs of a specific population. Types of data that may be used include: clinical data (e.g. biometric, lab, health risk assessment); utilization data; adherence data; operational data; and satisfaction data.

==========

H. PANEL OF PATIENTS

Question: How does "population-based care" (required in PC.02.04.03/EP 4), differ from providing care for a "panel of patients" (PC.02.04.05/EP 4)?

Answer: The PCMH's primary care clinician(s) and interdisciplinary team(s) work together to proactively manage a designated panel or group of patients. In contrast to focusing on overall patient population characteristics (see "H" above), it is the individual needs of each patient on the panel that is the principle focus.

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.

==========

I. 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.

==========

J. 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.

==========

K. PRIMARY CARE CLINICIAN COMPETENCY

Question: What educational background, knowledge, and experience are required to serve in the role of primary care clinician (PCC) within the PCMH? (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, or an advanced practice nurse or physician assistant practicing in collaboration with a doctor of medicine or doctor of osteopathy. The term "collaboration" in this context means that health care providers work together to meet the needs of the patient. It is not the intent of this requirement to impose additional restrictions on the scope of practice of an advanced practice nurse, nor is it meant to preempt applicable state law.*

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 cooperative 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 regiment. 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 teeth 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 educational background, broad-based knowledge, and experience outlined in the definition of a PCC, and have the ability to "handle most medical and other health care needs of the patient." Some examples include an infectious disease specialist managing primary care for an HIV/AIDS patient, an oncologist managing primary care for a cancer patient, an endocrinologist managing primary care for a diabetic patient, and a cardiologist managing primary care for a patient with heart failure.

==========

L. COMPOSITION OF INTERDISCIPLINARY TEAM

Question: The requirement that the organization identifies the composition of the interdisciplinary team specifies that the team must include a physician. Are organizations required to have formal collaborative agreements with physicians that are included on interdisciplinary teams? (PC.02.04.05/EP 1).

Answer: No, organizations are not required to have formal collaborative agreements in place with physicians, beyond those required by state law. If a collaborative agreement or physician supervision is required by state law, surveyors will verify that they are in place.

Also, while there is an expectation that a physician is always available to be part of the interdisciplinary team, his or her involvement in a patient's care would be determined by the needs of the patient.

During the survey, surveyors will explore how non-physicians serving as primary care clinicians collaborate with physicians and how physicians are included in a patient's interdisciplinary team when a physician's involvement is required to meet the needs of individual patients.

Organizations and practices may choose when and how to document these collaborative discussions, however, documentation will not be required.

==========

M. 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.

N. 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.

==========

O. 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.

==========

P. MEANINGFUL USE – COMPUTERIZED ORDER ENTRY

Question: How will compliance be evaluated for the requirements that address the use of a computerized order entry system (for medication, radiology, and lab orders), and e-prescribing for varying percentages and types of orders? (MM.04.01.01/EP 22; PC.02.01.01/EPs 18 and 19)

Answer: Compliance with these requirements will be explored during patient tracer discussions (with staff and providers) and during the data management sessions. The organization should have established processes in place to monitor their level of compliance with these requirements.

Compliance would be assessed by reviewing reports and data collected to show the percentage of the specified orders that were entered using the computerized order entry system.

==========

Q. MEANINGFUL USE – PATIENT PORTAL

Question: Is my organization required to have a patient portal? Also, what about the exceptions, such as bandwidth limitations, that CMS accepts? (PC.02.04.01/EP 4)

Answer: Organizations are required to provide their patients with online access to their health information (including diagnostic test results, lab results, summary lists, and medication lists) within four business days after the information is available to the PCC or interdisciplinary team. An effective and efficient way of doing this is through the use of a patient portal.

At a minimum, however, compliance might occur using a combination of processes, such as a secure messaging system and a process that connects patients directly with the lab provider for telephonic access to their lab results. Exceptions allowed by CMS will be accepted by surveyors.

==========

R. MEANINGFUL USE – APPOINTMENT REMINDERS

Question: We use our certified EHR to generate a list of patients (with two or more visits in the last two years) that are then contacted by phone to provide appointment reminders. Is this compliant with the requirement? (PC.02.04.01 /EP 5)

Answer: Yes. Although organizations may use their certified electronic health record to drive automated appointment reminder calls, using the EHR to identify those patients who need to be contacted and then using any method the organization determines appropriate, will at minimum be compliant for this requirement.