

**American Academy of Family Physicians (AAFP)  
American Academy of Pediatrics (AAP)  
American College of Physicians (ACP)  
American Osteopathic Association (AOA)**

**Guidelines for Patient-Centered Medical Home (PCMH) Recognition and  
Accreditation Programs**

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In 2007, the Joint Principles of the Patient-Centered Medical Home were released by the four primary care physician societies—the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the American College of Physicians (ACP), and the American Osteopathic Association (AOA)—and have since been endorsed by 19 additional physician organizations, including the American Medical Association, as well as the Patient-Centered Primary Care Collaborative (PCPCC), a multi-stakeholder coalition with a mission to develop and advance the patient-centered medical home. Following the release of these Joint Principles, the PCMH concept has become a fast-growing model of primary care redesign across the country, with many demonstration and pilot projects underway or in development.

As a result of the proliferation of test\* projects and the overall growing interest in the PCMH concept, there are now multiple entities developing or offering medical home recognition or accreditation programs. The primary care physician societies have long supported the need for robust recognition and/or accreditation programs to help assess whether a given practice is delivering care based on the PCMH model. Therefore, to assist with the development and use of these programs, the AAFP, AAP, ACP, and AOA offer these “Guidelines for Patient-Centered Medical Home Recognition and Accreditation Programs.”

All Patient-Centered Medical Home Recognition or Accreditation Programs should:

**1. Incorporate the Joint Principles of the Patient-Centered Medical Home**

The Joint Principles of the Patient-Centered Medical Home are intended to describe the characteristics of a PCMH, including: a personal physician in a physician-directed, team-based medical practice; whole person orientation; coordinated and/or integrated care; quality and safety; enhanced access; and payment.

**2. Address the Complete Scope of Primary Care Services**

The Institute of Medicine (IOM) has developed a commonly accepted definition of primary care which is as follows: “Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community” (IOM, 1996). The term “integrated” in the IOM definition encompasses “the provision of comprehensive, coordinated, and continuous services that provide a seamless process of care.”

\* The term “test” projects is intended to encompass both pilot and demonstration projects, which may have different meanings, as well as other PCMH research and quality improvement projects and initiatives that may chose to utilize a recognition or accreditation program.

The patient-centered medical home model facilitates ideal primary care and therefore recognition and accreditation programs should attempt to assess all of the primary care domains outlined by the IOM—comprehensiveness, coordination, continuity, accessibility, and patient engagement and experience. This will further ensure that every recognized or accredited entity provides care consistent with the Joint Principles, including, but not limited to, having a whole person orientation which means taking responsibility for coordinating each patient’s full array of health care services using a team-based approach—i.e., delivering care for all stages and ages of life, acute care, chronic care, behavioral and mental health care, preventive services, and end of life care—and coordinating and/or integrating care for services not provided by the PCMH across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient’s community (e.g., family, public and private community-based services).

### **3. Ensure the Incorporation of Patient and Family-Centered Care Emphasizing Engagement of Patients, their Families, and their Caregivers**

A commonly accepted definition of “patient-centered care” also is provided by the IOM: Patient-centered care is “healthcare that establishes a partnership among practitioners, patients, and their families (when appropriate) to ensure that decisions respect patients’ wants, needs, and preferences and that patients have the education and support they need to make decisions and participate in their own care” (IOM, 2001). Therefore, recognition and accreditation programs for the patient-centered medical home should attempt to incorporate elements that assess a practice’s or organization’s ability to implement patient- and family-centered care based on the needs and preferences of their patients, family, and caregivers; incorporate shared-decision making; encourage and support self-management and self-care techniques; facilitate complete and accurate information sharing and effective communication; encourage active collaboration of patients/families in the design and implementation of delivery of care; ensure cultural and linguistic competency among its clinicians and staff; and collect and act upon patient, family, and caregiver experience and satisfaction data. There should also be special considerations to align program standards, elements, characteristics, and/or measures with populations that have specific needs such as the pediatric and geriatric populations.

### **4. Engage Multiple Stakeholders in the Development and Implementation of the Program**

The development, implementation, and evaluation of a patient-centered medical home recognition or accreditation program should be a transparent process, open to input (e.g., through a public comment period) from all relevant stakeholders, such as clinicians, practice staff, patients and families, professional societies, private and public payers, employers/purchasers, health care-oriented community organizations including patient and family advocacy groups, and representatives from quality improvement programs.

## **5. Align Standards, Elements, Characteristics, and/or Measures with Meaningful Use Requirements**

Recognition and accreditation programs related to the patient-centered medical home should actively work to align their standards, elements, characteristics, and/or measures with the meaningful use criteria outlined by the Centers for Medicare and Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC). In the short term, these programs should clearly identify which of their standards, elements, characteristics, and/or measures are related to the meaningful use criteria. Then, over time, those items should evolve to align sufficiently with the meaningful use criteria such that CMS and ONC might allow recognized or accredited entities to receive “credit” based on achievement of PCMH status.

## **6. Identify Essential Standards, Elements, and Characteristics**

Recognition and accreditation programs for the patient-centered medical home should clearly identify a set of standards, elements, and/or characteristics that are considered essential (i.e., core to being a medical home practice). These should include but not be limited to: (1) Advanced Access Principles (e.g., same day appointments, extended hours, group and e-visits, and patient portals); (2) Comprehensive Practice-based Services (e.g., acute and chronic care, prevention screening and ancillary therapeutic, support, or diagnostic service); (3) Effective Care Management (e.g., demonstrated capacity to execute population management); (4) Care Coordination (e.g., between providers and other practices, subspecialty care, hospitals, home health agencies, nursing homes, and/or community-based care resources); (5) Practice-based Team Care; and (6) Guarantees of Quality and Safety (e.g., incorporation of evidence-based best practices, clinical outcomes analysis, regulatory compliance, risk management, and medication management).

These items should be based on the best available evidence, which can be determined via literature review; ongoing evaluation of the individual standards, elements, and/or characteristics and the program as a whole; evaluation of implementation tools and resources; evaluations of projects, organizations, and practices that are utilizing the program; and expert stakeholder, patient, and family input. Flexibility for practices in satisfying these essential elements should be a feature of all recognition and accreditation programs. These standards should be applicable to different sizes of practices from a small solo practice to a large multispecialty group and also be implementable in different geographic settings from rural areas to large metropolitan cities.

## **7. Address the Core Concept of Continuous Improvement that is Central to the PCMH Model**

Transforming to a patient-centered medical home is a process requiring a culture of continuous quality improvement that will be different for each practice. Therefore, patient-centered medical home recognition and accreditation programs should foster practice transformation and acknowledge progress towards the medical home ideal by providing increasingly complex goals for practices to meet. These progressive goals

could be reflected through different levels of recognition or accreditation, as well as through the use of practice-level outcomes measurement and time-limited recognition or accreditation that would require the need to periodically reapply.

Additionally, recognition and accreditation programs should include goals that are more advanced or aspirational in nature for practices to pursue. For example, calling for the practice to seek feedback from its patients and families on key aspects of its operations and to document practice changes in response to that information. These goals could be presented as potential future standards, elements, policy changes, or characteristics that some practices or organizations might want to achieve sooner. Inclusion of these objectives would provide an opportunity for recognized or accredited medical homes to consider steps beyond the essential standards, elements, characteristics, and existing levels of the recognition or accreditation process. This approach also would allow recognizing and accrediting bodies to learn about the challenges, relevance, and implications of these more advanced elements.

## **8. Allow for Innovative Ideas**

Patient-centered medical home recognition and accreditation programs should encourage applicants to submit innovative approaches (e.g., best practices) for providing patient/family-centered care, particularly in a team-based environment. This approach can also provide a data set from which the certifying, recognizing, or accrediting body, and possibly others, can learn about innovative ideas (e.g., best practices).

## **9. Care Coordination within the Medical Neighborhood**

According to the Joint Principles, a medical home is characterized by every patient/family having a personal physician who provides first contact care, understands the health care needs of the patient/family, facilitates planned co-management across the lifespan, and has the resources and capacity to meet the patient/family needs. Recognition and accreditation programs for the patient-centered medical home should acknowledge the care coordination role of the PCMH practice or organization within the larger medical neighborhood and community that shares the care for its patients and families, including transitions across practices and settings (e.g., pediatric/adolescent care transitioning to adult care), interactions with the specialist and subspecialist practices, hospitalists, and care facilities such as hospitals and nursing homes and their connections to home and community based support services.

## **10. Clearly Identify PCMH Recognition or Accreditation Requirements for Training Programs**

Recognition and accreditation programs for the patient-centered medical home should address the unique nature of health professional training programs (e.g., residency programs) by providing clarifications and/or additional explanations where necessary to permit such training site practices to be considered by recognition and accreditation programs.

Additionally, patient-centered medical home recognition and accreditation programs should consider the “Joint Principles for the Medical Education of Physicians as Preparation for Practice in the Patient Centered Medical Home,” released by AAFP, AAP, ACP, and AOA, when developing and/or revising their programs (AAFP, AAP, ACP, and AOA, 2010).

## **11. Ensure Transparency in Program Structure and Scoring**

Programs for the recognition or accreditation of patient-centered medical homes should clearly identify which standards, elements, and/or characteristics relate to each other so that practices and organizations can tackle the prerequisite items first before moving on to others that rely on the responses and documentation for the previous items. Provision of a “roadmap” such as this will result in the recognition or accreditation process being more user friendly in terms of how the applicants can approach the requirements and move along the continuum toward medical home transformation, while still allowing for variation.

Similarly, those programs that involve scoring, rating, or ranking of practices and organizations against their established standards, elements, and/or characteristics should ensure that their scoring processes are informed by evidence, and are as transparent, consistent, and objective as possible. The scoring processes for these programs should include the provision of specific feedback to applicants regarding the calculation of their scores, highlight areas of strengths and weaknesses relative to the program’s requirements, and acknowledge incremental improvements that have been or can be achieved.

## **12. Apply Reasonable Documentation/Data Collection Requirements**

It may be necessary for a patient-centered medical home recognition or accreditation program to require provision of documentation by practices and organizations in order to verify that they are indeed implementing the standards, elements, and/or characteristics of the program. This documentation may be prospective “proof” of processes and structures that indicate the submitting practice or organization is capable of providing preventive, acute, and chronic care consistent with the patient-centered medical home model and/or process and outcome measure data that meet certain performance or improvement thresholds (e.g., chronic care management, provision of preventive services, patient experience). For any documentation approach that is taken, the requirements should be transparent, consistent, and regularly reviewed for their relevance and reliability. Documentation requirements found not to be relevant or reliable should be removed from the requirements when identified. Further, programs should be prepared to provide comprehensive and accessible technical assistance to applicants that supplement clear application and documentation instructions.

Additionally, recognizing and accrediting bodies should consider collaborating with health information technology (health IT) vendors, such as registry and EHR companies, to ensure that the vendors incorporate structured data elements that will enable collection of the necessary data, according to patient population (e.g., pediatrics, geriatrics, adult), to meet the documentation requirements for each of the standards, elements, and/or

characteristics. This could eventually allow applicants to submit the required documentation directly from their health IT solutions. Recognizing and accrediting bodies should also consider consulting with public health agencies to ascertain those data elements that could effectively measure and enhance knowledge of health and healthcare disparities in a community.

### **13. Conduct Evaluations of the Program’s Effectiveness and Implement Improvements Over Time**

Entities involved in the development and implementation of patient-centered medical home recognition or accreditation programs should exhibit a commitment to comprehensively evaluate and improve their programs over time, informed by evidence, field testing, the experience of the stakeholders utilizing their programs including patients and families, public comment, and the changing health care environment. The evaluation should include qualitative measures that address quality of care (preventive, acute, and chronic) across all ages and cultural backgrounds; patient, family, and health care professional satisfaction; and the effectiveness of the recognition/accreditation program’s technical assistance and guidance to applicants; as well as quantitative measures that address health outcomes, utilization and program costs, and the changing health care environment. Results of these evaluations should be published in the professional literature.

Additionally, in order to ensure that the participating practices are fulfilling the program requirements, recognizing and accrediting entities should conduct random site visits and/or audits of a percentage of those practices. The participating practices should in turn have a transparent and easy-to-use mechanism for providing direct feedback to the recognizing or accrediting entities, and receive assurance of a timely response when a response is appropriate or requested.

#### **References:**

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