Facts about Primary Care Medical Home Certification

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The Joint Commission's Primary Care Medical Home (PCMH) Certification focuses on care coordination, access to care, and how effectively a primary care clinician and interdisciplinary team work in partnership with the patient (and when applicable, their family). The Joint Commission introduced PCMH Certification for accredited ambulatory care organizations in 2011, for accredited hospitals and critical access hospitals in 2013, and in 2014 a Behavioral Health Home (BHH) Certification option for organizations accredited under the behavioral health care program.

The PCMH Certification option is consistent with the federal health care reform efforts to improve patient outcomes and the continuity, quality and efficiency of health care services.

The Joint Commission's PCMH certification option focuses on educating the patient and encouraging them to self-manage their condition or disease. Patients benefit from this model of care because they have increased access to their primary care clinician and interdisciplinary health care team; their care is tracked and coordinated; and increased use of health information technology supports their care.

The Joint Commission's PCMH certification option is based on the Agency for Healthcare Research and Quality's (AHRQ) definition of a medical home, which includes these core functions and attributes:

- Patient-centered care – Relationship-based care focuses on the whole person and understanding and respecting each patient's needs, culture, values and preferences.
- Comprehensive care – A team of providers (may include physicians, advanced practice nurses, physician assistants, nurses, pharmacists, nutritionists, mental health workers, social workers and others) work to meet each patient's physical and mental health care needs, including prevention and wellness, acute care and chronic care.
- Coordinated care – Care is coordinated across the broader health care system, including specialty care, hospitals, home care and the provision of community and support services. This is particularly critical during transitions between sites of care, such as when patients are discharged from the hospital.

- Superb access to care – Patients have access to services with shorter waiting times for urgent needs, enhanced in-person hours, around the clock telephone or electronic access to members of the care team, and alternative methods of communication.

- Systems-based approach to quality and safety – The organization uses evidence-based medicine and clinical decision support tools, engages in performance measurement and improvement, measures and responds to patient experiences and satisfaction, practices population health management, and publicly shares robust quality and safety data and improvement activities.