American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

Response from the AAP Board of Directors to the Top Ten 2014 Resolutions

Responses are given in rank order for the ten high priority resolutions.

1) Resolution # LR6SA Ban on Marijuana Advertising that Could be Perceived as Directed to Children

Submitted by: District IX

RESOLVED, *that the Academy advocate for a ban on marijuana and synthetic cannabinoid product advertising within all media, events and venues, including the internet.*

Response from the Board of Directors

The Academy strongly supports the intent of the resolution and is actively engaged on multiple levels to pursue a ban on marijuana and synthetic cannabinoid product advertising within all media, events and venues, including the internet. These activities include:

Policy

- The AAP Council on Communications and Media (COCM) continues to include advertising to children among its top priorities. Through policy and education, the council advocates for the protection of children from unhealthy media exposure, including advertising. Several of AAP policies from COCM contain recommendations related to drug and tobacco advertising and advocacy. Specific recommendations included:

  Children, Adolescents, and the Media (2013)

  - Pediatricians should work with the AAP and local chapters to challenge manufacturers of products with public health implications (tobacco, alcohol, food) to do the following:
    - Make socially responsible decisions on marketing products to youth; betterment of children's health is the ultimate goal.

Children, Adolescents, and Advertising (2006, Reaffirmed 2010)

Ask Congress to:

- Implement a ban on cigarette and tobacco advertising in all media, including banners and logos in sports arenas;
- To work with the Federal Communications Commission to prohibit interactive advertising to children on digital TV; and
- Convene a national task force on advertising under the auspices of the Institute of Medicine, the National Institutes of Health, or the Federal Trade Commission (FTC). This task force would discuss the nature of the current problem and the current research and would propose solutions toward limiting children's exposure to unhealthy advertising, including the funding of future research.

Children, Adolescents, Substance Abuse & the Media (2010)

- Legislative Advocacy by Pediatricians: Pediatricians should encourage Congress to pass new strict laws regulating digital advertising that targets children and adolescents.

The above noted policies have been discussed by the COCM and it was agreed the AAP advertising policy will be revised to specifically include marijuana advertising. It was also agreed that the media and substance abuse policy will be incorporated into a new policy on high risk behaviors and the influence of the media and will include information relative to marijuana advertising. The policy updates are anticipated by 2016.

The COCM and the AAP Committee on Substance Abuse will work together to include recommendations regarding advertising into the proposed statement, *The Impact of Marijuana Policies on Youth: Clinical, Research, and Legal Update.* The policy is anticipated late 2014.

The AAP Children, Adolescents, and Media Leadership Work Group (CAMLWG) will be planning a media research conference in 2015 and will work closely with the COCM to implement the AAP strategic priorities related to media. The agenda for the research conference is being developed and may include presentations of research related to marijuana advertising.

Advocacy Activities

Marijuana is currently legal for recreational use under state law in Colorado and Washington. In absence of AAP policy that addresses how to protect children in states in which recreational marijuana is legal, the AAP is working to provide guidance to the AAP Colorado and Washington chapters that recreational marijuana regulations should be at least as strong as the provisions that currently protect children from advertising of alcohol and tobacco products. A potential model for protecting children from advertising and marketing efforts can be found within language from the 1998 Master Settlement Agreement (MSA), an accord reached between 46 states attorneys general and the 5 major tobacco companies. The MSA forbids targeted marketing of tobacco products directly or indirectly towards youth and bans and restricts transit advertising, most forms of outdoor advertising, including billboards, product placement in media, branded merchandise, free product samples (except in adult-only facilities), and most sponsorships. Subsequent Congressional action codified these requirements in the Family Smoking Prevention and Tobacco

Control Act of 2009. In the absence of similar federal action on marijuana, states are acting to protect children from harm.

The need for guidance to prevent marijuana advertising to children is needed for other states and chapters. In November 2014, voters will be considering ballot initiatives to legalize marijuana for recreational use in Alaska and Oregon. In 2014, 17 states introduced bills that would legalize marijuana for recreational use. Though none of these bills have passed, it remains likely that states will continue to consider legalizing marijuana for recreational use in future legislative sessions.

The AAP will continue to provide guidance to chapters on emerging issues related to the legalization of marijuana including prohibiting advertising of marijuana to children, preventing child and adolescent access to marijuana, and preventing the unintentional ingestion of marijuana products by children. The AAP will ensure that future policy development addresses the issue of marketing marijuana to children in states where marijuana is legalized.

2) Resolution # 34.35SB **Human Trafficking Education as a Component of Medical Education and Pediatric Training**

Submitted by: District III
District VIII

RESOLVED, *that the Academy become an active partner in addressing child trafficking in the United States, and be it further*

RESOLVED, *that the Academy advocate that the subject of human trafficking should be a component of medical education and pediatric training for medical students, residents, fellows and all who provide healthcare for children and adolescents, to include information about recognition, management and linkages to community resources.*

Response from the Board of Directors

The Academy strongly supports the intent of the resolution and supports advocacy efforts with regard to the subject of human trafficking as a component of medical education and pediatric training.

The Accreditation Council for Graduate Medical Education (ACGME), an independent regulatory body, has authority over the content of pediatric residency and fellowship training. The ACGME periodically accepts external comments from organizations like the American Academy of Pediatrics regarding the content of required residency training. During such times when comments regarding content are being accepted, the AAP invites the participation in the process from all AAP Committees, Councils, and Sections.

The ACGME is currently not accepting comments regarding content as the pediatric requirements were just updated in 2013. However, the ACGME, with the implementation of its Next Accreditation

System (NAS) (which includes general pediatrics training) does allow for more robust innovation in what is being taught to trainees and leaves many of those decisions to the individual training program. A core requirement does include "ambulatory experiences to include elements of community pediatrics and child advocacy".

Also, 99% of programs and pediatric residents are enrolled in PediaLink and can purchase or enroll in free educational modules that could include a series of modules on human trafficking. The AAP also recommends that MOC modules be developed for ongoing education in this area.

3) Resolution #1	**Ratification on the United Nations Convention on the Rights of the Child (CRC)**

Submitted by: District VIII

RESOLVED, *that the Academy work with a coalition to encourage the President of the United States and the United States Senate to ratify the Convention on the Rights of the Child.*

Response from the Board of Directors

The AAP Board of Directors understands the need to work with a coalition to encourage the President of the United States and the United States Senate to ratify the United Nations Convention on the Rights of the Child.

The AAP is urging the federal government to ratify the Convention on the Rights of the Child (CRC). In June 2014, the AAP signed a letter asking President Obama to send the treaty package to the Senate, in recognition that 2014 marks the CRC's 25th anniversary. The letter was authored by the Campaign for US Ratification of the CRC and to date has 73 signatories from a coalition of diverse constituencies; it is scheduled to be submitted to the White House in fall 2014.

The CRC was adopted by the United Nations General Assembly on November 20, 1989, entered into force in 1990, and to date has 193 States Parties. Secretary of State Madeleine Albright signed the CRC on behalf of President Clinton in February 1995, but the Administration did not believe it could get the two thirds majority required for ratification, and as a result the treaty was never sent to the Senate. The Obama Administration has said that this term it will submit the CRC to the Senate for the first time, but has not provided a timeframe.

Opposition to the CRC, such as the Senate resolution (S. Res. 519) introduced in 2010 with 31 cosponsors calling on the President not to submit the treaty for ratification, includes claims that the CRC undermines parents' rights and states' rights; detractors are also concerned that ratification would subordinate American laws to the United Nations.

The AAP is currently in consultation with the Campaign about potential paths forward. Before the treaty can be sent to the Senate the State Department has to review it for compliance with US law, normally a two-year process, which State Department lawyers have been reluctant to do without an indication that the treaty is likely to move forward. The Campaign is also planning to host events

and mobilize social media around Universal Children's Day, November 20, 2014 with AAP participation.

AAP co-hosted an ACTIVATE webinar with UNICEF and NCD child in September, 2014, on youth and non communicable diseases which advocated forms human rights perspective regarding prevention of NCDs and access to treatment and care. ACTIVATE talks are incorporated into UNICEF's Annual State of the World's Children report, and are promoted globally to country stakeholders in the convention on the rights of the child.

The AAP has been working to support advocacy efforts with an analysis of how ratification would affect American children and pediatric practice, along with anecdotes about why pediatricians support the treaty.

4) Resolution # 33SB The Risk of Non-Standard Vaccine Schedules

Submitted by: District VII

RESOLVED, *that the Academy clearly discourage the use of non-standard vaccine schedules because they enhance risk from vaccine-preventable diseases, and be it further*

RESOLVED, *that the Academy issue a statement that physicians and other health care professionals member fellows of the Academy who advocate or promulgate the use of non-standard vaccine schedules which substantially deviate from the Advisory Committee on Immunization Practices recommended vaccine schedule are enhancing risk from vaccine-preventable diseases to their patients and the public at large.*

Response from the Board of Directors

The Academy supports the intent of this resolution and is already actively engaged in activities to implement it.

The AAP is currently working on a technical report entitled, "Vaccine Hesitancy – Impact on Practice." It is anticipated the technical report will be available in 2015. The AAP will determine the appropriate language to be included in the technical report which notes children should be immunized on schedule and that not following the schedule may place children and communities at risk for vaccine preventable diseases. This technical report will address the following: 1) increasing rate of parents choosing to delay or refuse one or more of the recommended childhood vaccines, 2) the evidence that supports the current vaccine schedule and the harms for using alternative schedules.

The policy will provide pediatric healthcare providers and the public with: 1) accurate information regarding the current knowledge about the problem, scale, and determinants of vaccine-hesitancy, 2) accurate information regarding the safety of the current immunization schedule, including detailed antigen and adjuvant components, and the Institute of Medicine (IOM) review,

3) availability of some flexibility within the current recommended schedule, with caution about deviation from recommended immunization schedules, and 4) current evidence for science-based decision making and the need for future work in this area. The technical report will provide the background information on the use and benefits of the Centers for Disease Control and Prevention (CDC), AAP, and American Academy of Family Physicians (AAFP) Immunization Schedule.

5) Resolution # 13SA Expanding Regulations on Electronic Cigarettes

Submitted by: District IX

RESOLVED, *that the Academy encourage state and federal regulation to prevent the sale of electronic cigarettes and other tobacco products to youth under the legal age for cigarette purchase in that state, and be it further*

RESOLVED, *that the Academy advocate for including electronic cigarettes and all vaporized nicotine products in clean air legislation that ban tobacco use in public spaces.*

Response from the Board of Directors

The Academy is strongly in support of this resolution and continues to be very concerned with the rise in popularity of electronic cigarettes, and their attractiveness and marketing to children and youth.

Advocacy

The AAP submitted comments (August 2014) on a proposed rule published in April 2014 by the Food and Drug Administration that would extend the FDA's authority over tobacco products to include electronic cigarettes. By extending FDA's authorities to include electronic cigarettes, the federal prohibition on the purchase of tobacco products by individuals under the age of 18 (which currently applies to cigarettes, smokeless tobacco, and roll-your-own tobacco) would also apply to electronic cigarettes.

The FDA, however, is prohibited from raising the tobacco purchase age above the age of 18. That authority is left to the states. The AAP continues to support the work of AAP chapters on state efforts to prohibit sales of electronic cigarettes to minors and to restrict their indoor use. We are working with chapters to identify advocacy opportunities at the local and municipal levels where earlier success may be replicated.

While a majority of states have already restricted electronic cigarette sales to minors, states are also demonstrating novel approaches to these issues, most notably in Illinois, where a bill to require childproof packaging for electronic cigarette liquid (which is extremely toxic and poses a potentially lethal ingestion risk to children) was signed by the governor and goes into effect January 1, 2015.

For additional information on state regulation of electronic cigarettes, see the State AdvocacyFOCUS on electronic cigarettes available at: www.aap.org/stateadvocacy.

6) Resolution # LR1SB The AAP Medical Home Standard and Certification

Submitted by: District II

RESOLVED, that the Academy produce and test a set of standards, based on the precepts of Quality Improvement (QI), for the Pediatric Medical Home, and create a certification for those practices that meet these standards, which shall be promoted to the public, government and insurers as verification that these practices truly deliver pediatric care in a real Pediatric Medical Home, and be it further

RESOLVED, that the Academy design standards for Pediatric Patient Centered Medical Home (PPCMH) as well as a certification process to interact with and flow from the Model Pediatric Ambulatory Electronic Health Record, originally designed to be used by the Pediatric Medical Home, thus ensuring that certification will occur via Continuous Quality Improvement (CQI), and be accomplished in the natural flow of care.

Response from the Board of Directors

The Executive Committee fully supports the concept put forth by the resolution – the need to make medical home recognition or certification programs much more relevant to pediatric care and to ensure that these programs promote a process that fosters high quality pediatric care based on measures that include pediatric-specific issues. The NCQA approach has challenges for pediatric practices, primarily the administrative burden it places on practices, its heavy focus on practice structure rather than outcomes, and the lack of items that seem particularly relevant to the pediatric medical home.

The Executive Committee has concerns about the difficulties and potential conflicts that arise from the Academy's development of its own recognition program or certification process.

The Academy has made progress with NCQA to make the standards more reflective of how care is, and should be, delivered in the pediatric medical home. We believe we need to 1) recognize where we have had success in NCQA discussions, 2) learn from those successes, and 3) strengthen our advocacy with NCQA and other accrediting bodies to address the concerns of the pediatric community.

The resolution asks the AAP to undertake its own certification program on behalf of its members. As with any new program idea, an assessment of the potential success of the program and the existing marketplace must be considered. The Board considered multiple factors, and significant concerns have been identified regarding development and acceptance difficulties and potential conflicts. More specifically these include:

1. Substantial Investment in New Research
   For the Academy to take on pediatric medical home accreditation directly, it will need to invest substantially in new research capabilities in standard development and testing and gain acceptance of new standards from several collaborators in the health care industry.

2. Crowded Marketplace and No Guarantee of Health Plan Acceptance
   Given the presence of NCQA and others including Accreditation Association for Ambulatory Health Care, the Joint Commission, and URAC (formerly known as the Utilization Review Accreditation Commission) in the standard setting arena, the Academy is likely to face difficulty in acceptance of its processes and standards. (See Attachment A: A Comparison of the National Patient-Centered Accreditation and Recognition Programs) Many states and health plans have already adopted established PCMH standards and have made significant financial investments into these efforts. Health plans may not accept AAP accreditation based on AAP standards where the AAP has some vested interest in those standards, perceiving it to be a conflict of interest. Without acceptance of AAP accreditation by health plans, AAP members will receive little financial benefit.

We recognize this is a problem area for the membership and the AAP is actively engaged in initiatives to help member practices receive recognition and appropriate payment for being a patient/family centered medical home. AAP leadership and staff meet regularly with the major national payors to advocate for payment for the quality, value-based care provided within pediatric medical homes. Furthermore, pediatric councils in many states advocate for enhanced payments for medical home accredited practices.

To facilitate NCQA recognition and ease some of the administrative burden, the Academy has developed the Digital Navigator tool. The Digital Navigator is a web-based software application designed to support pediatric and other primary care practices in managing patient care and the administrative functions to ensure successful implementation of the PCMH model of care based on NCQA standards. Although it does not serve as a stand-alone compendium of pediatric medical home measures, it also helps practices in achieving meaningful use requirements that coincide with NCQA recognition elements. The Digital Navigator has tailored the NCQA standards to more accurately reflect the dynamics of pediatric patient care and office management. A number of practices have experienced success in accreditation, and the AAP will work to disseminate their lessons learned.

As noted above, there are now multiple entities developing or offering medical home recognition or accreditation programs.

Therefore to assist with the development and use of these programs, in 2011 the primary care organizations AAFP, AAP, ACP and AOA developed and approved the "Guidelines for Patient-Centered Medical Home Recognition and Accreditation Programs" (See attachment B) The Academy will actively disseminate these guidelines and will specifically identify appropriate additional pediatric issues.

In addition, the Executive Committee, AAP leadership and AAP staff will continue to aggressively and strategically engage leadership from the NCQA and other PCMH standard setting organizations, to assure their future standards are more relevant and meaningful to pediatric care and practices.

7) Resolution # 4SA Universal Paid Parental Leave

Submitted by: District V

RESOLVED, *that the Academy recommend that all parents be given at least 12 weeks of paid parental leave within a year after the birth or adoption of a child, funded by a payroll tax such as included in the proposed FAMILY Act.*

Response from the Board of Directors

The AAP agrees with the importance of paid parental leave and its impact on parent-infant attachment.

By offering paid time off for parents after the birth or adoption of a child, the nation is assuring that all new parents have the opportunity to be with, and care for, their child, because we, as a nation, believe that parental involvement in child rearing is crucial for the best development of children and our society. It makes sense that there should be time for both parents to develop relationships with their children. And it makes sense that parents in salaried training programs would be offered the same leave. If a specific length of time is made available overall, that time could be divided between both parents as desired (i.e., one parent could use all of the time, or, they could split the available time in half). The evidence in support of parental leave is strong and strongly supports the importance of GME programs making necessary accommodations. These include immediate schedule adjustments to accommodate leave at the time of birth, which may be unpredictable. It also includes long-term schedule adjustments and extensions needed for residents to fulfill the time and content requirements to be eligible to take the boards.

In May 2014, the AAP signed on as a supporting organization of S. 1810/H.R. 3712, the Family and Medical Insurance Leave (FAMILY) Act, which would create a national family and medical leave insurance program to provide workers with a portion of their wages for a limited period of time (up to 60 workdays, or 12 weeks in a year) to address their own serious health condition, including pregnancy or childbirth; to deal with the serious health condition of a parent, spouse, domestic partner or child; to care for a new child; and/or for specific military caregiving and leave purposes. On May 7, 2014, AAP Board Member from District III, David Bromberg, MD, FAAP, spoke on behalf of the AAP at a briefing for congressional staff hosted by Zero To Three on the importance of passing the FAMILY Act. Senator Kirsten Gillibrand and Representative Rosa DeLauro, the lead authors of the FAMILY Act, also spoke at the event. The AAP will continue to look for opportunities to promote the FAMILY Act and the importance of paid parental leave.

8) Resolution # 16 AAP Policy and Education Regarding Electronic Cigarettes

Submitted by: District VIII

RESOLVED, *that the Academy develop policy regarding the marketing of electronic cigarettes toward children/adolescents, and be it further*

RESOLVED, *that the Academy educate pediatricians about electronic cigarettes and their potential risks.*

Response from the Board of Directors

The Academy is strongly in support of this resolution and continues to be very concerned with the rise in popularity of electronic cigarettes, and their attractiveness and marketing to children and youth.

Policy

The AAP is in the final stages of drafting a revision to the current tobacco policy statement ("Tobacco Use: A Pediatric Disease", 2009) and will be including electronic cigarette information and recommendations in the statement. Additionally, understanding the more immediate need for a policy from the AAP on this topic in order to assist in policy and advocacy efforts at the federal, state, and local levels, the AAP is currently in the process of developing a separate policy statement on electronic cigarettes and will "fast track" review and approval.

The AAP is concertedly working on all levels of tobacco policy, including electronic cigarettes to assure that children and youth are protected and they are part of comprehensive smoke-free indoor air laws. National AAP staff have worked with state chapters to offer testimony to or assist with testimony in local jurisdictions such as New York City, Chicago, and Los Angeles about youth restrictions to electronic cigarettes and including them as part of smoke-free indoor air laws. Several AAP principal investigators and trained tobacco advocates have served as spokespeople at national, state, and local events and hearings about the need for regulation of electronic cigarettes as tobacco products.

Education

The AAP has developed an electronic cigarette fact sheet for pediatricians and child health providers available at: http://www2.aap.org/richmondcenter/pdfs/ECigarette_handout.pdf and has a section on the AAP Julius B. Richmond Center Web site about electronic cigarettes on the Emerging and Alternative Products Web page available at: http://www2.aap.org/richmondcenter/EmergingAltProducts.html. This website is updated regularly.

The Julius B. Richmond Center has sponsored three webinars featuring information about emerging and alternative tobacco products in 2011, 2012, and 2014 that featured information about electronic cigarettes. The slides from these webinars are available publicly on the AAP Julius B. Richmond Center Web site at: http://www2.aap.org/richmondcenter/EmergingAltProducts.html.

The 2013 National Conference & Exhibition program, Tobacco and Kids: Promotion and Emerging Products, presented by Julius B. Richmond Center Principal Investigator Susanne Tanski, MD, MPH, FAAP, featured a section about what pediatricians need to know about electronic cigarettes.

At the 2014 National Conference and Exhibition, the AAP Julius B. Richmond Center will hold a series of focus groups to solicit information from practicing pediatricians about what they are hearing in practice and the tools and information they need to accurately and appropriately discuss electronic cigarettes with patients and families. This will be followed up by an online survey to pediatricians and child health providers about this same topic in early 2015. The information from the focus groups and online survey will be used to develop education for pediatricians and

resources for practice. Additionally, a planned speaker on this topic for the Section on Tobacco Control progress was elevated to a late-breaking plenary session at the 2014 NCE.

9) Resolution # 49 Medical Student Membership

Submitted by: District VI

RESOLVED, *that the Academy acknowledge medical students as national members with a student membership package (to be determined by the Board of Directors), while retaining the current Section on Medical Students, Residents, and Fellowship Trainees (SOMSRFT) financial medical student dues structure.*

Response from the Board of Directors

The Academy supports the strategic direction of bringing medical students interested in pediatrics into the AAP as a national category of membership. This would permit the AAP to embrace medical students early in their careers with leadership development and engagement opportunities, and provide access to critical information that will enable medical students to be a capable workforce for child health advocacy and the profession of pediatrics.

The AAP has also been working the past several years at consolidating and simplifying the AAP's membership categories and structure. To address this resolution the AAP agrees that it is time to consolidate what would potentially yield 3 separate member categories: Residents, Fellows in training, and medical students, into a single "In Training" membership category. The AAP Board of Directors formally approved the consolidation of member categories and voted approval to add this consolidated category as a bylaws referendum in the 2014 election process.

If the bylaw referendum is passed, implementation will begin immediately.

10) Resolution # 43SC Staying Politically Neutral for Universal Support of Children

Submitted by: District VIII

RESOLVED, *that the Academy request that all statements/presentations (written or spoken) done in association with the Academy be non-partisan and focus on child-centered health issues.*

Response from the Board of Directors

The Academy is strongly in support of this resolution and is committed to its full implementation. The AAP believes that all national AAP officers and leaders should be aware of the requirement for the AAP to remain nonpartisan while also advocating strongly for the needs of children.

In response to the resolution, the AAP will ensure that the information is 1) incorporated into the orientation and training of all national AAP officers, 2) included in the media training given to national AAP leaders and others speaking on behalf of the Academy, 3) added to the curriculum of AAP leadership training. The Executive Committee will be closely monitoring the implementation of this resolution.

Attachment A

A Comparison of the National Patient-Centered Medical Home Accreditation and Recognition Programs

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January 30, 2014

MGMA®
Medical Group Management Association

Introduction

In recent years, government and private-sector insurers have evaluated different care-delivery models that can simultaneously improve the health of a population, improve the patient experience of care and reduce the per capita cost of healthcare. While there are different approaches to meeting the "Triple Aim," there is consensus that the patient-centered medical home (PCMH) changes primary care delivery to be consistent with the Triple Aim's goals.

The PCMH concept was first developed almost 20 years ago by the American Academy of Pediatrics (AAP) and has been expanded and modified significantly since. In February 2011, the AAP, along with the American Academy of Family Physicians (AAFP), the American College of Physicians (ACP) and the American Osteopathic Association (AOA), released an updated version of its 2007 white paper, *Guidelines for Patient-Centered Medical Home Recognition and Accreditation Programs*, which described the conditions that comprise a PCMH and established the standards that a formal PCMH recognition or accreditation program should incorporate.

MGMA examined the multiple organizations that created standards that designate a medical practice as a PCMH and determined that four national organizations stood out among the multitude of PCMH-recognizing programs. Only the Accreditation Association for Ambulatory Health Care (AAAHC), the Joint Commission, the National Committee for Quality Assurance (NCQA) and URAC (formerly the Utilization Review Accreditation Commission) had PCMH programs that were truly national in scope, were PCMH specific, had been formalized in a published set of standards and had evidence of being used by a large number of medical organizations as the model for their PCMH.

This review compares the standards employed by each of the national organizations to the agreed-upon definition of what comprises a PCMH, the *2011 PCMH Guidelines for the Patient-Centered Medical Home*. The report notes whether, in MGMA's judgment, the program is in full or partial compliance with the intention of each guideline. The report uses as its basis the:

- AAAHC *2011 Medical Home Standards*
- Joint Commission Primary Care Medical Home 2011 *and 2014 Standards and Elements of Performance*
- NCQA *Patient-Centered Medical Home 2011 and Proposed 2014 Standards*
- URAC *Patient-Centered Medical Home Practice (PCMH) Certification Standard V1.1*

Report Summary

While the AAAHC, Joint Commission, NCQA and URAC define their standards differently, each shares a similar focus: to identify medical practices that exemplify the patient-centered medical home principals and practices while setting a standard for other practices to achieve. Each organization's PCMH program is based on the Joint Principles of the PCMH developed by the four medical associations that developed the PCMH concept:

1. Having a personal physician/provider in a team-based practice;
2. Having a whole-person orientation;
3. Providing coordinated and/or integrated care;
4. Focusing on quality and safety; and
5. Providing enhanced access.

Although none of these programs address the sixth Joint Principal, payment, they realize that their standards are the basis for many healthcare organizations to receive an enhanced payment.

The AAP, AAFP, ACP and AOA first published *The Guidelines for the Patient-Centered Medical Home* in 2007, which predates every PCMH accreditation/recognition program. The earliest organization to formally recognize a PCMH practice was the NCQA, which modified an existing program to create the Physician Practice Connections – Patient-Centered Medical Home (PCPC-PCMH) assessment tool to fit within *The Guidelines for the Patient-Centered Medical Home*. The AAAHC, Joint Commission and URAC created their programs subsequent to the publication of the guidelines, which explains why the four programs are in substantial compliance with the guidelines.

The organizations differ in how they determine whether a practice is qualified to be a PCMH in their programs. The AAAHC, Joint Commission and URAC utilize an on-site surveyor to assess practice performance and compliance with their PCMH standards. An on-site surveyor can better evaluate the patient experience and how well the practice meets a specific standard. An on-site survey also provides immediate feedback, allowing for corrective actions, and can educate staff on how to improve patient services. However, an on-site survey may significantly increase the cost of PCMH accreditation/recognition. The NCQA utilizes a process of self attestation and submitted documentation to indicate that a practice meets its standards. This provides a less costly program, but runs the risk of a practice not fully complying with a standard. To minimize this problem, the NCQA has developed an extensive review program and audits 5 percent of submissions to validate compliance.

How this report will help you

The comparison focuses on how the four national programs meet the guidelines and can assist an organization in better understanding the elements of the various programs while focusing on their most important elements. In developing this report, MGMA contacted the four organizations to confirm the accuracy of the information and ensure that users can better understand the strengths and weakness (if any) of each program and make an informed choice as to which program can best benefit their organizations.

Comparison of the AAAHC, Joint Commission, NCQA and URAC Patient-Centered Medical Home Programs to The *Guidelines for Patient-Centered Medical Home Recognition and Accreditation Programs*

Updated: Jan. 30, 2014

American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP) and American Osteopathic Association (AOA): *2011 Guidelines for Patient-Centered Medical Home (PCMH) Recognition and Accreditation Programs*	The Accreditation Association for Ambulatory Health Care (AAAHC): *2013 Medical Home Accreditation Standards and 2013 Medical Home Certification Standards*	The Joint Commission: *Primary Care Medical Home 2013 and 2014 Standards and Elements of Performance*	The National Committee for Quality Assurance (NCQA): *Standards for Patient-Centered Medical Home (PCMH) 2011 and 2014 Standards*	URAC: *2013 Patient-Centered Medical Home Practice (PCMH) Certification Standard V1.1*
Overall program compliance with the *Guidelines for Patient-Centered Medical Home Recognition and Accreditation Programs*				
	Standards meet the *Guidelines for Patient-Centered Medical Home Recognition and Accreditation Programs*, February 2011, developed by American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP) and American Osteopathic Association (AOA), *except* as noted for guideline 5.	The combined operating characteristics in the 2013 and 2014 Joint Commission Primary Care Medical Home designation meet the *Guidelines for Patient-Centered Medical Home Recognition and Accreditation Programs*, February 2011, developed by American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP) and American Osteopathic Association (AOA) *except* as noted for guideline 5.	The standards in the NCQA's PCMH 2011 and 2014 recognition programs meet the *Guidelines for Patient-Centered Medical Home Recognition and Accreditation Programs*, February 2011, developed by American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP) and American Osteopathic Association (AOA).	URAC's PCMH 2011 Patient Centered Health Care Home (PCMH) recognition program complies with the *Guidelines for Patient-Centered Medical Home Recognition and Accreditation Programs,* February 2011, developed by American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP) and American Osteopathic Association (AOA).
Evaluation method				
	The AAAHC utilizes an on-site surveyor to assess practice performance. Once an organization decides to seek AAAHC accreditation or on-site certification, an advisor/consultant is made available at no cost to assist in the organization's preparation before the survey. The organization is notified in advance to have specific documents and supporting information available for the surveyor to review during the mutually agreed-upon on-site visit date(s). In addition to the document review, the surveyors conduct interviews with members of the organization and patients.	The Joint Commission utilizes an on-site surveyor to assess practice performance and compliance with the Primary Care Medical Home standards. The on-site surveyor team provides feedback to practices on corrective actions, process improvement recommendations and education. Additionally, on an annual basis between surveys, practices are required to assess their compliance with standards through an electronic process called "Periodic Performance Review" and submit this documentation to The Joint Commission.	Practices submit information using a web-based survey tool addressing the NCQA 2011 and 2014 *Standards for Patient-Centered Medical Home* and attest to the accuracy of their information. Each survey and its documentation is reviewed for internal consistency and accuracy for a final decision on recognition by the NCQA staff. The NCQA routinely audits 5 percent of submissions and surveys all practices after they receive their recognition decision to assess satisfaction with the NCQA's recognition staff and processes. Practices may request reconsideration of their assessment by NCQA.	For practices to earn the PCMH designation, they must be evaluated on site by a URAC reviewer or URAC PCMH-certified auditor. Practices can earn one of four designations: 1) achievement; 2) achievement with electronic health record; 3) certification; or 4) certification with electronic health record. Practices must submit URAC's PCMH designation application and required preliminary documents. The web-based platform allows practices to communicate with their reviewer during the desktop review as well as before and after the on-site review process.

PCMH GUIDELINES	AAAHC 2013 STANDARD	JOINT COMMISSION 2013 AND 2014 STANDARD	NCQA 2011 AND 2014 STANDARD	URAC 2013 STANDARD
	At the conclusion of the on-site survey, surveyors present their findings for discussion and clarification. The AAAHC Accreditation Committee reviews all the information supplied by the organization, obtained during the survey, and any other relevant information before making a final award decision. The organization is then notified in writing of the decision and receives a comprehensive, written report of the survey findings. After the survey, the AAAHC staff continues to assist the organization during and after its conversion to deliver care as a medical home. To support AAAHC's ongoing quality assurance initiatives, an organization may be selected for an unannounced, random survey during its certification term. These unannounced surveys, conducted by one surveyor and lasting up to one full day, are a means by which AAAHC can evaluate the consistency and quality of its program while also demonstrating to the public and others that AAAHC-surveyed medical home organizations remain committed to AAAHC standards throughout the certification term. Additionally, discretionary surveys are conducted "for cause," when concerns have been raised about an organization's continued compliance with AAAHC standards. An organization may undergo a discretionary survey at any time, without advance notice, and at the discretion of AAAHC. If AAAHC determines that the organization is not in substantial compliance with the standards, its term may be reduced or revoked.	This process helps ensure that the organization remains compliant with program standards. The organization has access to an advisor/consultant who can help guide the organization as it continues its path to delivered patient-centered care.		The practice also receives a summary report that identifies compliance with mandatory standards, overall score, designation category (achievement or certification) and individual standard scoring compliance. If a practice is unsuccessful in achieving a designation the practice is given the opportunity to appeal the decision. The summary report is posted on URAC's website directory.

PCMH GUIDELINES	AAAHC 2013 STANDARD	JOINT COMMISSION 2013 AND 2014 STANDARD	NCQA 2011 AND 2014 STANDARD	URAC 2013 STANDARD
Program cost				
	The AAAHC application fee is $775. Survey fees are determined utilizing a scoring methodology and takes several factors into consideration. These factors include type and range of services provided, patient volume, number of providers, and number of sites seeking accreditation or certification. A statistical sampling is calculated for the survey. There are no additional fees through the term of accreditation or certification with the exception of organizations requiring an interim survey. The average fee for accreditation with medical home ranges from $4,500 to $26,000, with medical home certification ranging from $3,700 to $15,000.	The Joint Commission provides the Primary Care Medical Home certification survey at no additional cost to organizations that receive its ambulatory accreditation survey. The Joint Commission website has 2014 pricing information describing the fee for an ambulatory care accreditation survey. The fee has two components: the cost of the onsite evaluation based on the volume of patients (ranging from $3,500 to $13,400) and the number of sites (ranging from $1,335 to $6,625) and an annual fee based on patient volume (ranging from $2,130 to $4,810). Based on the size of the practice, total three-year fees can range from $9,000 to $27,000 billed over the three-year period.	NCQA charges an initial fee of $80 for the practice to obtain a survey tool license. Additionally, the application fees for the NCQA review of the survey tool and recognition processes are assessed based on the number of clinicians per practice. This fee is $550 per clinician through 12 providers in the practice. From 12 to 50 clinicians the fee is $6,600, and with more than 50 clinicians the fee is $6,600 plus $10 per provider over 50. NCQA offers a 20 percent discount from the full survey fee to applicants sponsored by health plans, employers and other programs. A detailed description of the current NCQA PCMH Recognition Program pricing is available at: https://recognitionportal.ncqa.org/rponlineapp/documents/NEWPCMH2011PricingSchedule5.13.pdf.	The price for the PCMH achievement or certification programs varies depending on the size of the practice and the number of sites. The average price range for awarding PCMH designation is $3,500 to $14,000. The price is determined by the number of reviewers and the number of on-site review days to examine the PCMH sites. URAC considers each PCMH's business structure in determining a final program and price. A PCMH that is successful in its review process by URAC will receive either a certification or achievement designation. The URAC price is not based upon the review outcome.

PCMH GUIDELINES	AAAHC 2013 STANDARD	JOINT COMMISSION 2013 AND 2014 STANDARD	NCQA 2011 AND 2014 STANDARD	URAC 2013 STANDARD
1. Incorporate the Joint Principles of the PCMH.				
The principles 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.	Consistent with guideline. AAAHC has two programs for medical home recognition: Accreditation that includes medical home, and Medical Home Certification. The standards in each of the AAAHC programs incorporate the *Joint Principles of the Patient-Centered Medical Home*. Both the AAAHC 2013 Medical Home Accreditation Program and the Certification Program have five main PCMH standards: 1) relationship, communication, understanding and collaboration, 2) accessibility; 3) comprehensiveness of care; 4) continuity of care; and 5) quality. Practices seeking AAAHC medical home accreditation must meet the five medical home standards – 1) relationship; 2) accessibility; 3) comprehensiveness of care; 4) continuity of care; 5) quality – and additionally meets the eight core AAAHC standards: 1) patient rights and responsibilities; 2) governance; 3) administration; 4) quality of care provided; 5) quality management and improvement; 6) clinical records and health information; 7) infection prevention, control and safety; and 8) facilities and environment. Practices seeking AAAHC medical home certification must meet eight core AAAHC certification standards: 1) patient rights, responsibility and empowerment; 2) governance and administration; 3) relationship; 4) accessibility; 5) comprehensiveness of care; 6) continuity of care; 7) clinical records and health information; and 8) quality.	Consistent with guideline. The 2013 and 2014 Joint Commission Primary Care Medical Home designation incorporates the *Joint Principles of the Patient-Centered Medical Home*. The Joint Commission Primary Care Medical Home designation evaluates five operational characteristics: 1) patient-centered care; 2) comprehensive care; 3) coordinated care; 4) superb access to care; and 5) systems-based approach to quality and safety. These areas parallel the Joint Principles. The Primary Care Medical Home Program requires the organization to also be accredited by The Joint Commission in ambulatory care. The five operational characteristics are used in conjunction with the accreditation standards set for ambulatory care as the basis for the Primary Care Medical Home certification. The 2013 comprehensive care standard specifies that the primary care clinician must have the educational background and broad-based knowledge and experience necessary to handle most of the patient's medical needs and resolve conflicting recommendations for care, but does not specify that the primary care clinician must be a doctor of medicine or doctor of osteopathy. This was changed in the 2014 Joint Commission Primary Care Medical Home update, which modifies the provision of care, treatment and services standards to specify that the interdisciplinary team must include a doctor of medicine or doctor of osteopathy.	Consistent with guideline. The NCQA's PCMH 2011 and 2014 recognition programs incorporate the *Joint Principles of the Patient-Centered Medical Home*. The NCQA 2011 PCMH Recognition Program comprises six standards: 1) enhance access and continuity; 2) identify and manage patient populations; 3) plan and manage care; 4) provide self-care support and community resources; 5) track and coordinate care; and 6) measure and improve performance. The NCQA 2014 PCMH Recognition Program builds on the 2011 standards by similar performance requirements, with increased requirements to implement clinical decision support systems for patients with selected conditions that follow evidence-based guidelines, and how the practice identifies patients requiring care management. The standard requires the practice to provide culturally and linguistically appropriate routine and urgent team-based care that meets the needs of patients and family. During office hours the practice has a written process and defined standards, and demonstrates that it monitors performance against the standards for providing same-day appointments, timely clinical advice by telephone and secure electronic messages during office hours.	Consistent with guideline. The URAC PCMH standard incorporates the *Joint Principles of the Patient-Centered Medical Home*. URAC defines a PCMH as a quality-driven, interdisciplinary, clinician- led team approach to delivering and coordinating care that puts patients, family members and personal caregivers at the center of all decisions concerning the patient's health and wellness. A PCMH provides comprehensive and individualized access to physical health, behavioral health, and supportive community and social services, ensuring that patients receive the right care in the right setting at the right time. The URAC PCMH standard includes 39 standards in seven modules: 1) core quality care management; 2) patient-centered operations management; 3) access and communications; 4) testing and referrals; 5) care management and coordination; 6) electronic capabilities; and 7) quality performance reporting and improvement. The 39 standards align to the *Joint Principles of the Patient-Centered Medical Home* and directly address key requirements for all meaningful use requirements for electronic medical records, e-prescribing and quality data submission. Seven of these standards are mandatory and are critical elements of the PCMH practice designation program. Practices are evaluated on their level of success in meeting these standards.

PCMH GUIDELINES	AAAHC 2013 STANDARD	JOINT COMMISSION 2013 AND 2014 STANDARD	NCQA 2011 AND 2014 STANDARD	URAC 2013 STANDARD
	Both programs address the patient focus of the program and how the medical home is defined. The services provided by a medical home are patient centered; physician, nurse practitioner or physician assistant directed; comprehensive, accessible and continuous; and organized to meet the needs of the individual patients served. The foundation of a medical home is the relationship between the patient, his/her family (as appropriate) and the medical home. Within the patient-centered medical home, patients are empowered to be responsible for their own healthcare. As used in these standards, a medical home is the patient's primary point of care.		After-hours access is provided and the practice has a written process and defined standards, and demonstrates that it provides access to routine and urgent-care appointments outside regular business hours and provides continuity of medical record information for care and advice when the office is not open. Continuity of care for patients/families is provided by a trained team of a selected primary clinician and associated clinical and support staff who have clearly defined patient care roles. Access to the designated clinician is monitored. The practice systematically records patient information and uses it for population management to support patient care using an electronic system that records structured (searchable) data. The practice systematically tracks, tests and coordinates care across specialty care, facility-based care and community resources, and uses performance data to identify opportunities for improvement and acts to improve clinical quality, efficiency and patient experience. The 2014 standard expands on the 2011 standard of having a non-scored element of using a certified EHR system, by adding elements regarding access to a health information exchange and has bidirectional transmittal of information through the exchanges.	The 2013 standards establish basic organizational, cultural training systems and operational requirements that support a successful medical home model of patient engagement, care delivery and follow up. The healthcare team is defined as the attending physician and other healthcare providers/clinicians with primary responsibility for the care provided to a consumer/patient. The healthcare team may include but is not limited to physicians, pharmacists, nurses, behavioral health professionals, social workers, case managers, specialists, therapists and medical assistants, including other paraprofessionals and non-clinicians within the healthcare system.

PCMH GUIDELINES	AAAHC 2013 STANDARD	JOINT COMMISSION 2013 AND 2014 STANDARD	NCQA 2011 AND 2014 STANDARD	URAC 2013 STANDARD
2. Address the complete scope of primary care services.				
Recognition and accreditation programs should attempt to assess all of the primary care domains outlined by the Institute of Medicine: comprehensiveness, coordination, continuity, accessibility, and patient engagement and experience. Integrated care is delivered to the whole person for all stages and ages of life, acute care, chronic care, behavioral and mental healthcare, preventive services and end-of-life care, along with coordinating and/or integrating care for services not provided in house but elsewhere in the community.	Consistent with guideline. The Accreditation Association for Ambulatory Health Care (AAAHC): 2013 Medical Home Accreditation and 2013 Medical Home Certification Standards require the delivery of acute care, chronic care, behavioral and mental health, and preventive services. The 2013 AAAHC medical home comprehensiveness of care standard addresses the requirement to provide the primary care scope of care, including acute, chronic and end of life. The services include but are not limited to preventive screening, behavioral health, oral healthcare guidance, healthy lifestyle and wellness care. The primary care domains outlined by the Institute of Medicine — comprehensiveness, coordination, continuity, accessibility, and patient engagement and experience — are each addressed in the AAAHC PCMH accreditation and certification programs.	Consistent with guideline. The 2013 and 2014 Joint Commission Primary Care Medical Home standard addresses acute care, chronic care, age- and gender-specific preventive services, behavioral health needs, oral healthcare, urgent and emergent care, and substance abuse treatment. The Primary Care Medical Home standard holds the organization accountable for meeting the large majority of each patient's physical and mental healthcare needs, including prevention and wellness, acute care and chronic care. Providing comprehensive care requires a team of care providers, which can include internal staff or virtual teams linking practice and outside providers to patients and services in their communities.	Consistent with guideline. NCQA's PCMH 2011 and 2014 standards require the delivery of acute care, chronic care, behavioral and mental health, and preventive services. The primary care domains outlined by the Institute of Medicine — comprehensiveness, coordination, continuity, accessibility, and patient engagement and experience — are addressed in this program. Coordination of care is addressed through tracking of care not provided in house, providing summary-of-care records to referral specialists and facilities. The NCQA 2014 PCMH Recognition Program builds on the 2011 standards by maintaining similar performance requirements with the additional requirement that the health assessments be periodically updated and that health literacy be evaluated. The standards emphasize the importance of identifying and managing patients needing additional care management.	Consistent with guideline. URAC's PCMH standards comply with this principal of the patient-centered medical home. Within URAC'S PCMH standards for ongoing care management protocols, all patients and coordination of care activities address the requirement to provide the primary care scope of care. The program addresses the primary care domains outlined by the Institute of Medicine: comprehensiveness, coordination, continuity, accessibility, and patient engagement and experience. The 2013 standards include a description of using a comprehensive patient registry to optimally manage a population of patients, improve health status and ultimately lower healthcare costs. The registry allows the practice to identify care gaps and needed preventive, wellness and follow-up services. All patients should have comprehensive and timely access to patient-centered, culturally sensitive and efficiently delivered services in the most appropriate settings and at convenient times. The medical home will connect patients with needed community services and resources by implementing processes that coordinate care between the medical home, community services agencies, family, caregivers and the patient. A method must be in place for tracking all the similar elements for referrals to requested specialist practices, including electronic transfer of required patient information.

PCMH GUIDELINES	AAAHC 2013 STANDARD	JOINT COMMISSION 2013 AND 2014 STANDARD	NCQA 2011 AND 2014 STANDARD	URAC 2013 STANDARD
3. Ensure the incorporation of patient- and family-centered care emphasizing engagement of patients, their families and their caregivers.				
Recognition and accreditation programs should attempt to incorporate elements that assess a practice's or an organization's ability to implement patient- and family-centered care based on respect for the needs and preferences of their patients, family and caregivers; ensure cultural and linguistic competency among its clinicians and staff; and collect and act upon patient, family and caregiver experience and satisfaction data among other opportunities to provide patient- and family-centered care from pediatrics to geriatrics.	Consistent with guideline. The Accreditation Association for Ambulatory Health Care (AAAHC): 2013 Medical Home Accreditation and 2013 Medical Home Certification Standards require the delivery of acute care, chronic care, behavioral and mental healthcare, and preventive services. The definition of a medical home includes the statement, "Within the patient-centered medical home, patients are empowered to be responsible for their own healthcare." The 2013 AAAHC Medical Home Standards address patient centeredness and patient engagement. The standards are evaluated during the on-site survey from the patient's perspective. The relationship standard heavily focuses on the need for the provider and/or provider-directed care team to develop relationships with patients. The patient is fully empowered to participate in decisions involving his or her healthcare. The provider is as thorough as the patient feels is needed. The needs of the patient's personal caregiver, when known, are assessed and addressed to the extent that they impact the patient's care. The organization is required to treat all patients with cultural sensitivity. Additionally, the continuity of care and comprehensiveness standards support this guideline.	Consistent with guideline. The 2013 and 2014 Joint Commission Primary Care Medical Home standards require patient-centered care emphasizing patient engagement, including performance improvement activities. The patient is involved in the development of treatment plans. Specific standards also address the patient's health literacy needs and the patient's preferred language for discussing healthcare. The primary care medical home provides primary healthcare 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 primary care 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, primary care medical home practices ensure that patients are fully informed partners in establishing care plans.	Consistent with guideline. NCQA's PCMH 2011 and 2014 standards require the practice to support patient self-care and community resources. The patient is encouraged to select a personal clinician and to collaborate in the development and management of individual care plans to include treatment goals. Care teams are expected to be trained on effective patient communication, particularly with vulnerable populations, to assess the cultural and linguistic needs of patients and families and to provide interpretation or bilingual services and materials in the languages of its population. The practice must develop and document self-management plans in collaboration with patients, their families and/or caregivers and provide resources to support patient/family self management. The practice is also expected to request feedback from patients on their experiences with the practice and the way care was delivered and to obtain performance and patient experience data for vulnerable patient groups, including a requirement to establish a goal and act to improve on at least one patient experience measure.	Consistent with guideline. URAC's PCMH standards comply with this principal of the PCMH. URAC establishes standards of enhancing patient access to services, informed decision-making with patients, coordination of care, care transitions and self-management standards to support this guideline. The intent of the standard is to empower patients and their families/caregivers to be active participants in their care through patient-friendly education and informed, shared decision making that is based on cooperation, trust and respect for each individual's healthcare. The patient's knowledge, health literacy, beliefs and cultural background are considered. A health risk assessment and the family medical history form the baseline for the patient's relationship with the medical home team. In addition, the patient will receive all appropriate wellness and preventive services using immunizations, screenings, active counseling and outreach efforts to communicate the need for preventive care to the patient along with self-management resources. An individualized care plan is developed in congress with the patient and family. The goals are reviewed regularly to assess progress as recorded in the clinical assessments that are recorded in the electronic record. Medication and allergy variation or changes are reviewed regularly. Systems are required to automate prescribing and medication reconciliation, which alert medication interactions and allergy conflicts, provide therapeutic equivalent and generic substitution information, streamline prescription fills and renewals, as well as provide clinicians with patient-specific coverage and insurance formulary information, all of which is documented and shared as appropriate with patient/family in a timely manner.

PCMH GUIDELINES	AAAHC 2013 STANDARD	JOINT COMMISSION 2013 AND 2014 STANDARD	NCQA 2011 AND 2014 STANDARD	URAC 2013 STANDARD
4. Engage multiple stakeholders in the development and implementation of the program.				
Create a transparent process that includes providers, patients, families, payers, employers, public health organizations, professional societies and advocacy groups.	Consistent with guideline. The AAAHC involved multiple external parties in the development of the standards and programs addressed in the overview provided for the 2013 *AAAHC Accreditation Handbook for Ambulatory Health Care and the Medical Home On-Site Certification Handbook*. AAAHC standards are continuously peer reviewed and annually placed out for public comment, which is actively solicited from accredited organizations and interested others prior to AAAHC Board approval. The AAAHC Medical Home Advisory Committee is comprised of a cross section of physicians, nurses and administrators who have reviewed the standards and provided their recommendations for content.	Consistent with guideline. The Joint Commission developed its standards in consultation with healthcare experts, providers and researchers, as well as insurers and patients. An expert panel assisted in the development of the original 2011 Joint Commission Primary Care Medical Home designation and the standards were posted for public comment. The 2013 standards went through a similar development process, including formal review and approval by The Joint Commission Ambulatory Care Professional and Technical Advisory Committee (PTAC), comprised of representatives from associations and professional societies involved in providing ambulatory care services.	Consistent with guideline. The NCQA conducted an extensive review of the 2011 standards by current practices and an extensive group of industry experts and advisors in developing the 2014 performance standard. NCQA solicited comment through multiple channels, including social media and a national press release. Current customers and subscribers to NCQA's *Recognition Notes* newsletter received a set of email notifications, sent prior to, during and a day before the close of the comment period. Additionally, all of NCQA's multi-stakeholder standing committees were directly notified by their dedicated point of contact (internal staff). One hundred fifty-three organizations participated in the open public comment period, held from June 19 to July 22, 2013, during which 1,663 comments were received from a broad range of stakeholders. The response was overwhelmingly positive; 89 percent offered support or support with modification to the proposed standards. NCQA seriously considers all feedback that it receives in public comment. Though the standard process allows respondents to self-identify their stakeholder group and code individual responses (support, support with modifications, do not support) submitted, NCQA staff read, re-read and further code responses during analysis. As follow up, further research and informal interviews were conducted to form the rationale for changes.	Consistent with guideline. URAC's PCMH is designed as part of a broader Provider Care Integration and Coordination Accreditation suite of programs, which offers a flexible, educational approach to assist provider organizations as they move from coordinated to integrated care. The standards for the URAC PCMH were developed by URAC's multi-stakeholder advisory committee. More than 200 responses were received from numerous stakeholders, healthcare providers, health plans, purchasers, employers and consumers during the public comment period and were reviewed and considered in the final development of the program.

PCMH GUIDELINES	AAAHC 2013 STANDARD	JOINT COMMISSION 2013 AND 2014 STANDARD	NCQA 2011 AND 2014 STANDARD	URAC 2013 STANDARD
5. Align standards, elements, characteristics and/or measures with meaningful use requirements.				
Meet the requirements of CMS and the Office of the National Coordinator (ONC) for Health Information Technology.	Partially consistent with guideline. While the 2013 AAAHC Medical Home Standards do not specifically measure meaningful use requirements outlined by the CMS and the ONC for Health Information Technology, the meaningful use requirements are aligned with the AAAHC requirements but are not specified for accreditation or certification. The AAAHC Medical Home accreditation and on-site certification both require continuous assessment of an organization's readiness and ability to make use of electronic medical records while not making the lack of electronic records a barrier to adopting a medical home practice model. The accessibility standard requires that health information technology is continually assessed as a means to enhance electronic and telephone communications with patients such as secure messaging, scheduling and patient education. It is also considered and evaluated as a means to enhance clinical record keeping. The AAAHC reports that a standard on meaningful use is in development and will be in place by January 2015. The AAAHC requires that all accredited organizations maintain operations in compliance with the most current AAAHC standards and policies throughout their accreditation term, which will mandate that all AAAHC-accredited PCMH programs comply with meaningful use.	Consistent with guideline. While the 2013 Joint Commission Primary Care Medical Home standards do not specifically measure meaningful use requirements outlined by the CMS and the ONC for Health Information Technology, they do align with many of the requirements. The 2014 Joint Commission Primary Care Medical Home standards update modifies the provision of care, treatment and services and medication management standards to more closely describe the use of information technologies consistent with the meaningful use requirements outlined by the CMS and the ONC for Health Information Technology. The revised provision of care, treatment and services standard requires a primary care medical home to provide patients with online access to their information within four business days after the information is available to the primary care clinician or interdisciplinary team. This information includes diagnostic test results, lab summary lists and medication lists. It also requires use of a certified electronic health record to provide appointment reminders to patients with two or more office visits in the last two years.	Consistent with guideline. NCQA's PCMH 2011 standards include compliance with HITECH Act meaningful use requirements. There is a non-scored standard that evaluates whether the practice has a certified EHR and the original Stage 1 15 core and 10 menu meaningful use requirements are embedded in the language of the standards. Practices seeking this PCMH recognition will be prepared to qualify for meaningful use if they meet the requirements of the following elements of performance: 1C) electronic access; 2A) patient information; 2B) clinical data; 2D) use data for population management; 3A) implement evidence-based guidelines; 3D) medication management; 3E) use electronic prescribing; 4A) support self-care process; 5A) test tracking and follow up; 5B) referral tracking and follow-up; 5C) coordinate with facilities and care transitions; and 6F) report data externally. Additionally, practices are required to provide the name and number of the software they use in their PCMH 2011 application and attest to the required security analysis. The standards in NCQA's PCMH 2014 Recognition Program are similar to those of the 2011 standard, with additional requirements to bring it into full alignment with the Meaningful Use Stage 2 requirements, including the practice demonstrate access to a health information exchange and the bidirectional transmittal of information through the exchanges. Additionally, the practice is required to identify patients' preferred method of communications and proactively reminds patients of needed preventive and follow-up care.	Consistent with guideline. URAC's PCMH standard includes compliance with HITECH Act meaningful use requirements. The handbook provides a crosswalk of the program standards and the meaningful use requirements. The following program elements include the meaningful use requirements: MH7) patient access to services; MH17) patient reminders; MH18) ongoing care management protocols; MH20) medication review and reconciliation; MH22) coordinating care transition and written plans; MH23) appropriate use of clinical guidelines; MH30) electronic prescribing utilized; MH31) basic electronic health record; MH32) advanced electronic health record; MH33) electronic communications portal; MH34) electronic communications portal review and evaluation; and MH39) performance reporting. The standards include a goal to implement electronic health record systems that fully integrate patient information from all sources within and outside of the practice. These systems must support measurement of practice performance as well as allow online interaction with patient/family/caregiver and must address confidentiality, privacy and security.

PCMH GUIDELINES	AAAHC 2013 STANDARD	JOINT COMMISSION 2013 AND 2014 STANDARD	NCQA 2011 AND 2014 STANDARD	URAC 2013 STANDARD
		This revised standard also specifies that the organization must use a certified electronic health record system to: • Support the continuity of care, and the provision of comprehensive and coordinated care, treatment or services • Document and track care, treatment or services • Support disease management, including providing patient education • Support preventive care, treatment or services • Create reports for internal use • Create and submit reports to external providers and organizations, including public health agencies, disease-specific registries, immunization registries and other specialized registries • Facilitate electronic exchange of information among providers • Support performance improvement • Identify and provide patient-specific education resources The medication management standard now specifies use of electronic prescribing for at least 50 percent of allowable prescriptions and that the primary care medical home uses a computerized order entry system for at least 60 percent of medication orders, 30 percent of laboratory orders and 30 percent of radiology orders.		

PCMH GUIDELINES	AAAHC 2013 STANDARD	JOINT COMMISSION 2013 AND 2014 STANDARD	NCQA 2011 AND 2014 STANDARD	URAC 2013 STANDARD
6. Identify essential (core to being a medical home practice) standards, elements and characteristics.				
Recognition and accreditation programs should include but not be limited to advanced access principles; comprehensive, practice-based services; effective care management; care coordination; practice-based team care; and guarantees of quality and safety in practices whether small or large, urban or rural.	Consistent with guideline. The 2013 AAAHC medical home standards — 1) relationship, communication, understanding and collaboration; 2) continuity of care; 3) comprehensiveness of care; 4) accessibility; and 5) quality — meet the intent of this guideline.	Consistent with guideline. The operational characteristics in the 2013 and 2014 Joint Commission Primary Care Medical Home designation — 1) patient-centered care; 2) comprehensive care; 3) coordinated care; 4) superb access to care; and 5) systems-based approach to quality and safety — meet the intent of this guideline.	Consistent with guideline. NCQA's PCMH 2011 standards — 1) enhance access and continuity; 2) identify and manage patient populations; 3) plan and manage care; 4) provide self-care support and community resources; 5) track and coordinate care; and 6) measure and improve performance — meet the intent of this guideline. There are "must pass" elements in each standard that are described as the basic building blocks of a PCMH. All six must-pass elements are required for recognition. The PCMH 2014 Recognition Program includes additional requirements to document the methods used to analyze patient access, manage patient populations and coordinate care across providers and settings.	Consistent with guideline. URAC's PCMH standards include requirements consistent with the PCMH guidelines, including the seven core modules: quality care management; patient-centered operations management; access and communications; testing and referrals; care management and coordination; advanced electronic capability and patient registry; and quality performance reporting and improvement.

PCMH GUIDELINES	AAAHC 2013 STANDARD	JOINT COMMISSION 2013 AND 2014 STANDARD	NCQA 2011 AND 2014 STANDARD	URAC 2013 STANDARD
7. Address the core concept of continuous improvement that is central to the PCMH model.				
Recognition and accreditation programs should foster practice transformation and acknowledge progress toward the medical home ideal by providing increasingly complex goals for practices to meet. Progressive goals can include different levels of recognition or accreditation, practice-level outcomes measurement, and time-limited recognition or accreditation for periodic evaluation.	Consistent with guideline. The quality standard for the AAAHC Medical Home Accreditation and the On-Site Certification programs include several key continuous improvement requirements that meet the criteria for this guideline. There is a requirement of active participation from the professional staff for ongoing, comprehensive self assessment of the quality of care provided, including medical necessity of care or procedures performed and appropriateness of care, and to use findings when appropriate in the revision of the organization's policies and consideration of clinical privileges. Additionally, organizations are required to perform quality activities to improve outcomes related to the core principles of the PCMH: 1) patient/provider relationship; 2) continuity of care; 3) comprehensiveness of care; 4) accessibility to care; and 5) clinical study. To support ongoing quality improvement initiatives, an accredited or certified organization may be selected for an unannounced random survey from nine to 30 months after the initial survey.	Consistent with guideline. The 2013 and 2014 Joint Commission Primary Care Medical Home program requires leaders to involve practice leaders, clinicians and patients in performance improvement activities. The performance improvement standard requires the organization to collect data that monitors performance in areas designated by practice leaders as well as disease management outcomes, patient access to care, and patient experience and satisfaction. The Joint Commission describes a system-based approach to performance improvement, including comparing performance to external sources and to identify improvements. It also requires patient involvement in attaining established goals. Organizations accredited by The Joint Commission are eligible for resurvey on an unannounced basis within an 18- to 36-month window from the initial survey.	Consistent with guideline. The 2011 and 2014 standards are based on prior versions of medical practice standards and incorporate more challenging criteria. In addition, progressive goals are reflected with the three recognition levels that allow practices of varying capabilities to be recognized. Further, within the three-year recognition, practices may apply for a higher level. NCQA Standard 6, Measure and Improve Performance, requires practices to set and measure goals and improve performance over time. Standard 6 further requires practices to request feedback from patients and families as well as to actively participate in the practice's improvement programs. Finally, practices are required to identify at least one performance measure and one patient experience measure for continuous quality improvement. The NCQA PCMH 2014 Recognition Program retains the three recognition levels based on an overall score on the assessment with similar key "must pass" requirements as the 2011 standard. NCQA Standard 6, Measure and Improve Performance, is expanded by requiring an annual quantitative measurement of care coordination and utilization measures affecting healthcare costs. The section on evaluating patient experience is unchanged, and the section on measuring continuous quality improvement is expanded to require practices to address measures from separate domains — preventive care, including immunizations and screenings, chronic and acute care — identified as priorities based on practice population, and at least one measure concerning vulnerable populations to address disparities in care.	Consistent with guideline. URAC's PCMH standard MH39, Performance Improvement, utilizes data analyses to identify and implement strategies to improve clinical practice performance at the individual and group levels as a part of the practice's continuous quality improvement efforts. The standard requires a documented quality improvement plan and a report on the status of its implementation.

PCMH GUIDELINES	AAAHC 2013 STANDARD	JOINT COMMISSION 2013 AND 2014 STANDARD	NCQA 2011 AND 2014 STANDARD	URAC 2013 STANDARD
8. Allow for innovative ideas.				
Recognition and accreditation programs should encourage applicants to submit innovative approaches for providing patient- and family-centered care, particularly in a team-based environment. Programs should also encourage and promote the use of proven, best-practice ideas.	Consistent with guideline. The quality standard for the AAAHC Medical Home Accreditation and the On-Site Certification programs includes quality improvement requirements. The quality standard requires the medical home to maintain an active, integrated, organized and peer-based quality improvement program and to evaluate its overall effectiveness at least annually. The AAAHC handbooks provide checklists to help organizations analyze quality improvement programs and to create meaningful studies along with sample topics.	Consistent with guideline. The operational characteristics of a systems-based approach to quality and safety in the 2013 and 2014 Joint Commission Primary Care Medical Home program meet this guideline. The systems-based approach to quality and safety standards requires an ongoing, organization-wide program that demonstrably improves the quality and safety of care, treatment or services. A companion organization to The Joint Commission, the Center for Transforming Healthcare, was created to provide additional innovative resources that can improve patient safety or practice performance. Current "Targeted Solutions Tool" programs offered include hand hygiene and improving handoffs and transitions.	Consistent with guideline. NCQA's PCMH 2011 and 2014 standards for measuring and improving performance address this guideline. Practices are encouraged to develop systems, processes and tools that fit their practice and patient population needs. Practices can obtain examples of innovative and effective approaches through NCQA's educational workshops. NCQA requires practices to measure performance on preventive and chronic care measures and from patient/family experience surveys. NCQA expects practices to implement a quality improvement process tailored to the needs and performance opportunities based on monitoring activities. NCQA's PCMH program strongly encourages practices to use the standards to support their continuous quality improvement efforts. Access standards include innovative means for patients to receive care with provision of "alternative types of clinical encounters." Information is provided to orient patient to medical home responsibilities and patient expectations, including how behavioral health needs are addressed. Practices are also encouraged to engage patients/families in quality improvement activities. As always, the program is highly flexible, allowing practices to address the basic functional requirements in innovative ways based on the needs and capabilities present in their practice.	Consistent with guideline. URAC's PCMH standard includes requirements to promote care quality and continuous quality improvement that reflects the commitment to provide high-quality care for patients and to measure and track care outcomes to drive continuous quality improvement. The introduction section in the standards handbook provides guidance on how healthcare professionals must identify and implement a quality improvement methodology that works for their business model and setting. The standards offer flexibility and innovation for meeting the requirements. Additionally, URAC's Best Practice Awards recognize organizations and individual practitioners who demonstrate best practices and innovations in delivering quality care.

PCMH GUIDELINES	AAAHC 2013 STANDARD	JOINT COMMISSION 2013 AND 2014 STANDARD	NCQA 2011 AND 2014 STANDARD	URAC 2013 STANDARD
9. Care coordination within the medical neighborhood.				
Recognition and accreditation programs 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, interactions with specialist and subspecialist practices, hospitalists, and care facilities such as hospitals and nursing homes and their connections to home- and community-based support services.	Consistent with guideline. The AAAHC PCMH standards of continuity of care and comprehensiveness of care meet the intent of this guideline. Additionally, the continuity of care standard specifies that the medical home coordinates care with available community and alternate healthcare resources; coordinates consultations, referrals and transfers of care; and has a timely exchange of information between the medical home and other providers and organizations relative to the patient's condition.	Consistent with guideline. The comprehensive and coordinated care standards in the 2013 and 2014 Joint Commission Primary Care Medical Home program meet the intent of this guideline. These standards require the primary care medical home to coordinate care across all elements of the broader healthcare system, including specialty care, hospitals, home healthcare, and community services and support. Standards require care coordination during transitions between sites of care, and having clear and open communication among patients and families, the medical home and members of the broader care team.	Consistent with guideline. NCQA's PCMH 2011 and 2014 standards for tracking and coordinating care meet the intent of this guideline. Additionally, the standard requires the practice to support patients/families who need access to community resources, including mental health and substance abuse resources and to offer health education programs (such as group classes and peer support). The 2014 program standards ask practices to demonstrate the process for obtaining proper consent for release of information (or protocols for doing so), as well as secure/timely information exchange and care coordination with community partners. These could include transitional care, long-term care, other adult care facilities (developmental disability, mental health), foster care, school-based care and more. The standards mirror the requirements for specialty practices set forth in NCQA's Patient-Centered Specialty Practice (PCSP) standards. These requirements support the coordination of patient care between primary care practices and specialty practices. This may include maintaining formal and informal agreements with a subset of specialists based on established criteria.	Consistent with guideline. URAC's PCMH standard includes the Coordination Of Care module, with four standards: MH21) coordination of care; MH22) coordinating care transition and written plans; MH23) appropriate use of clinical guidelines; and MH24) health record information exchange and alerts. These standards define requirements for care coordination and meet the intent of this guideline and related meaningful use requirements.

PCMH GUIDELINES	AAAHC 2013 STANDARD	JOINT COMMISSION 2013 AND 2014 STANDARD	NCQA 2011 AND 2014 STANDARD	URAC 2013 STANDARD
10. Clearly identify PCMH recognition or accreditation requirements for training programs.				
Recognition and accreditation programs should address the unique nature of health professional training programs by providing clarifications and/or additional explanations where necessary to permit such training site practices to be considered by recognition and accreditation programs.	Consistent with guideline. The AAAHC provides extensive training to its surveyors. Specific didactic and on-site mentoring trains them to support organizations to include the unique nature of health professional training programs. The AAAHC has accredited/certified organizations that sponsor physician training programs. The surveyors provide the organization this knowledge both verbally and through the survey reports that document the consultative process.	Consistent with guideline. The Joint Commission considers the need of special programs to include but not limited to training/residency programs; Joint Commission surveyors are trained to assess the unique needs and settings of these programs.	Consistent with guideline. The NCQA continues to recognize residency training program sites in their PCMH program. The residents who rotate in those practices are not recognized; however, the practice and attending physicians are and are expected to support continuity of care.	Consistent with guideline. URAC provides training for its reviewer staff and medical home-certified auditors. Along with training courses, webinars are offered to interested practices and others. URAC's onsite practice reviews also address educational program needs and opportunities.
11. Ensure transparency in program structure and scoring.				
Recognition and accreditation 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. Scoring processes should include the provision of specific feedback to applicants regarding the calculation of their scores, and highlight areas of strength and weakness relative to the program's requirements.	Consistent with guideline. The policies and procedures in the *AAAHC Accreditation Handbook for Ambulatory Health Care* and the *AAAHC Medical Home On-Site Certification Handbook* provide an explanation of the accreditation and on-site certification processes. Additionally, the accreditation handbook chapter on medical homes provides the characteristics and their criteria. At the conclusion of the on-site survey, surveyors conduct a formal summation conference to present their findings and consultative comments. Compliance, as stated in the policies and procedures, is assessed by the Accreditation Committee using documentation from the surveyor report and the organization's supporting documents, answers to implementation questions, on-site observations and on-site interviews. A comprehensive written survey report is provided to the surveyed organization and is a tool for organizations to create and implement a plan for continued improvement to its medical home services.	Consistent with guideline. The 2013 and 2014 Joint Commission Primary Care Medical Home standards are published in *Standards for Medical Care, Including Primary Care Medical Homes*, 2013. The publication covers the scoring and accreditation decision process, the standards for accreditation and PCMH certification. The individual elements of performance are defined for each of the five operating characteristics. The delivery of the preliminary accreditation report after the onsite survey identifies areas of noncompliance and includes the surveyors' assessment of program strengths and weaknesses.	Consistent with guideline. The NCQA published the PCMH 2011 standards with detailed information about the program structure and scoring methodology. Additionally, the policies and procedures highlight the eligibility and the application process. Once the review is complete, practices receive the results and access to comments from the reviewers. The NCQA will publish its 2014 standards in late March 2014. During 2014, practices will have the option of qualifying under either the 2011 or the 2014 standard.	Consistent with guideline. URAC's PCMH standard handbook provides information about eligibility criteria, program structure, designation levels, mandatory standards, scoring methodology and reports. The introduction message from the standards handbook explains how practices are evaluated by URAC-certified auditors or a URAC reviewer and rated on fully meeting, partially meeting or not meeting the standards. Reviewers discuss findings and provide feedback to the practices during the onsite review. At the conclusion of the survey an exit interview is conducted with practice representatives to discuss onsite findings, scoring implications and action plan recommendations. Also discussed are best practice observations and recommendations. The practice receives a summary report that identifies scoring, site locations included in the designation, level of designation and individual standard compliance.

PCMH GUIDELINES	AAAHC 2013 STANDARD	JOINT COMMISSION 2013 AND 2014 STANDARD	NCQA 2011 AND 2014 STANDARD	URAC 2013 STANDARD
12. Apply reasonable documentation/data collection requirements.				
Develop collaborative, transparent evaluation systems to verify/prove compliance with standards at all levels of the continuum of care, i.e., preventive, acute and chronic care.	Consistent with guideline. The AAAHC Medical Home Accreditation or Medical Home Certification survey is conducted on site. The organization submits required supporting documentation along with its application for a survey not sooner than six months prior to the desired on-site survey date. The organization is not only assessed on the medical home standards but must also meet standards in eight core areas: 1) rights of patients; 2) governance; 3) administration; 4) quality of care provided; 5) quality management and improvement; 6) clinical records and health information; 7) infection prevention, control and safety; and 8) facilities and environment. Consultation occurs throughout the survey, providing the opportunity for immediate improvement. Surveyors selected by the AAAHC are trained and specifically privileged to conduct medical home surveys. The final report to the organization provides detailed feedback identifying the program strengths, weaknesses and consultative comments for continued transformation to a higher-quality medical home.	Consistent with guideline. The Joint Commission Primary Care Medical Home designation evaluation is conducted on site as an optional add-on to its ambulatory care accreditation program. Surveyors have the opportunity to request all documents needed to verify/review compliance with the respective standards. During their on-site assessment, surveyors provide education and share best practices with the organization.	Consistent with guideline. NCQA requires a practice applying for PCMH recognition to submit electronic documentation for all elements to make sure the practice meets the given standards. Additionally, the NCQA recognition process provides for potential requests for additional documentation and site visits should the NCQA deem it necessary to validate the information provided by the practice. NCQA offers a streamlined set of documentation requirements for practices currently recognized and seeking to renew their recognition.	Consistent with guideline. In order for practices to earn the URAC PCMH designation they must submit documents for review and evaluation prior to the onsite visit. After evaluation, if opportunities for improvement are found, the practice is provided with identified issues and recommendations for compliance. Following the practice's assurance that the recommended changes are made, an on-site visit by a URAC reviewer or URAC PCMH-certified auditor is conducted. Practices must obtain an overall 65 percent score for achievement with or without electronic health records and an 85 percent score for certification with or without electronic health records. Seven of the 39 standards are mandatory.

PCMH GUIDELINES	AAAHC 2013 STANDARD	JOINT COMMISSION 2013 AND 2014 STANDARD	NCQA 2011 AND 2014 STANDARD	URAC 2013 STANDARD
13. Conduct comprehensive evaluation of the program's effectiveness and implement improvements over time. Implement field-tested improvements for all populations and markets over time.				
	Consistent with guideline. All proposed revisions, deletions or additions to the *AAAHC Accreditation Handbook for Ambulatory Health Care* and the *AAAHC Medical Home On-Site Certification Handbook* are posted for public comment on an annual basis by the AAAHC Standards and Survey Procedures Committee. The AAAHC boards of directors review and provide final approval of both documents. To evaluate the program's effectiveness, the surveyed organization is asked to complete an evaluation at the conclusion of the survey in order to evaluate the reasonableness of the standards and the value of the consultation provided to the organization's staff. This evaluation also enables the organization to evaluate the survey process in terms of its effect on improving the quality of care provided. To verify that organizations are fulfilling the medical home program requirements and to help the AAAHC evaluate the consistency and quality of its medical home program, the AAAHC selects organizations for random surveys. These random surveys are unannounced, conducted by one surveyor and may last one full day. At the conclusion of the on-site survey, the surveyors hold a summation conference at which they present their findings to representatives of the organization for discussion and clarification. Members of the organization's governing body, medical staff and administration are encouraged to take this opportunity to comment on or rebut the findings, as well as to express their perceptions of the survey.	Consistent with guideline. The Joint Commission has an ongoing process for developing its standards in consultation with healthcare experts, providers and researchers, as well as purchasers and consumers. All public comments are presented to the Ambulatory Care Professional and Technical Advisory Committee (PTAC) for review and then submitted to the Board of Commissioners for final implementation approval. The Joint Commission has continued to evaluate its Primary Care Medical Home Program to improve its standards. The 2013 standards were formally reviewed by the Ambulatory Care PTAC in June 2013 for a revision, which was approved for implementation in July 2014.	Consistent with guideline. NCQA provides an overview in the *Standards for Patient-Centered Medical Home 2011* of its PCMH 2011 standards, the revisions, improvements and the process used to develop PCMH 2011, including the results of data from PPC-PCMH, an Advisory Committee, and public comment. To verify that practices are fulfilling the program requirements, NCQA routinely audits 5 percent of submissions and surveys all practices after they receive their recognition decision to assess satisfaction with the NCQA's recognition staff and processes.	Consistent with guideline. URAC's PCMH standards were developed in consultation with experts representing providers, practitioners, consumers, purchasers and health plans on URAC's Advisory Committee. URAC's standards development process includes a continual monitoring of best practices, industry trends and regulations, which guides further revisions and program development. Practices have an opportunity to provide feedback throughout the review process by completing a series of satisfaction surveys that are available in the URAC accreditation portal. URAC also maintains a complaint investigation process to address any identified issues. Additionally, URAC's continuous quality improvement process receives feedback from its stakeholder's advisory group, healthcare experts, purchasers, employers and consumers, along with public comment. A compliance program is in place that requires an annual attestation of compliance from the practice. In addition, the practice may be chosen for an unscheduled and off-cycle site visit to validate ongoing compliance with the program requirements.

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

February 2011

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.

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