

# Primary Care Home Crosswalk

## Primary Care Home Characteristics Crosswalked to 2011 Joint Commission Ambulatory Care Standards & EPs

Primary Care Home Characteristics	Joint Commission Equivalent Number	Joint Commission Standards
<b>Operational Characteristic 1</b>  Patient-centered care	<b>LD.03.04.01</b>	<b>The organization communicates information related to safety and quality to those who need it, including staff, licensed independent practitioners, patients, families, and external interested parties.</b>
	<b>EP 1</b>	Communication processes foster the safety of the patient and the quality of care.
	<b>EP 3</b>	Communication is designed to meet the needs of internal and external users.
	<b>EP 4</b>	Leaders provide the resources required for communication, based on the needs of patients, staff, and management.
	<b>EP 5</b>	Communication supports safety and quality throughout the organization. (See also LD.04.04.05, EPs 6 and 12)
	<b>EP 6</b>	When changes in the environment occur, the organization communicates those changes effectively.
	<b>EP 7</b>	Leaders evaluate the effectiveness of communication methods.
	<b>LD.04.04.01</b>	<b>Leaders establish priorities for performance improvement. (Refer to the "Performance Improvement" (PI) chapter.)</b>
	<b>EP 24</b>	<b>For organizations that elect The Joint Commission Primary Care Home option: Leaders involve patients in performance improvement activities. Note: Patient involvement may include activities such as participating on a quality committee or providing feedback on safety and quality issues.</b>
	<b>LD.04.04.03</b>	<b>New or modified services or processes are well designed.</b>
	<b>EP 1</b>	The organization's design of new or modified services or processes incorporates the needs of patients, staff, and others.
	<b>EP 3</b>	The organization's design of new or modified services or processes incorporates information about potential risks to patients. (See also LD.04.04.05, EPs 6 and 11) Note: A proactive risk assessment is one of several ways to assess potential risks to patients. For suggested components, refer to the Proactive Risk Assessment section at the beginning of this chapter.
	<b>EP 7</b>	Leaders involve staff and patients in the design of new or modified services or processes.
	<b>PC.01.03.01</b>	<b>The organization plans the patient's care.</b>
<b>EP 1</b>	The organization plans the patient's care, treatment, or services based on needs identified by the patient's assessment, reassessment, and results of diagnostic testing. (See also RC.02.01.01, EP 2)	

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	EP 43	For organizations that elect The Joint Commission Primary Care Home option: The primary care clinician and the interdisciplinary team involve the patient in the development of his or her treatment plan.	
	EP 46	For organizations that elect The Joint Commission Primary Care Home option: The primary care clinician and the interdisciplinary team work in partnership with the patient to achieve planned outcomes.	
	<b>PC.02.01.01</b>	<b>The organization provides care, treatment, or services for each patient.</b>	
	EP 1	The organization provides the patient with care, treatment, or services according to his or her individualized plan of care.	
	EP 16	For organizations that elect The Joint Commission Primary Care Home option: Each patient has a designated primary care clinician.	
	EP 17	For organizations that elect The Joint Commission Primary Care Home option: The organization allows the patient to select his or her primary care clinician.	
	<b>PC.02.01.21</b>	<b>For organizations that elect The Joint Commission Primary Care Home option: The organization effectively communicates with patients when providing care, treatment, and services.</b>	
	EP 1	For organizations that elect The Joint Commission Primary Care Home option: The primary care clinician and the interdisciplinary team identify the patient's oral and written communication needs, including the patient's preferred language for discussing health care. Note: Examples of communication needs include the need for personal devices such as hearing aids or glasses, language interpreters, communication boards, and translated or plain language materials.	
	EP 2	For organizations that elect The Joint Commission Primary Care Home option: The primary care clinician and the interdisciplinary team communicate with the patient during the provision of care, treatment, and services in a manner that meets the patient's oral and written communication needs.	
	<b>PC.02.02.01</b>	<b>The organization coordinates the patient's care, treatment, or services based on the patient's needs.</b>	
	EP 17	The organization coordinates care, treatment, or services within a time frame that meets the patient's needs.	
	EP 100	For organizations that elect The Joint Commission Primary Care Home option: The interdisciplinary team identifies the patient's health literacy level.	
	EP 101	For organizations that elect The Joint Commission Primary Care Home option: The primary care clinician and the interdisciplinary team incorporate information from an assessment of the patient's health literacy into the patient's education.	
	<b>PC.02.03.01</b>	<b>The organization provides patient education and training based on each patient's needs and abilities.</b>	
	EP 1	The organization assesses the patient's learning needs.	
	EP 4	The organization provides education and training to the patient based on his or her assessed needs.	

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	<b>EP 10</b>	Based on the patient's condition and assessed needs, the education and training provided to the patient by the organization include the following: <ul style="list-style-type: none"> <li>- An explanation of the plan for care, treatment, or services</li> <li>- Basic health practices and safety</li> <li>- Information on the safe and effective use of medications (See also MM.06.01.01, EP 9)</li> <li>- Nutrition interventions (for example, supplements) and modified diets</li> <li>- Discussion of pain, the risk for pain, the importance of effective pain management, the pain assessment process, and methods for pain management</li> <li>- Information on oral health</li> <li>- Information on the safe and effective use of medical equipment or supplies provided by the organization</li> <li>- Habilitation or rehabilitation techniques to help the patient reach maximum independence</li> </ul>	
	<b>EP 25</b>	The organization evaluates the patient's understanding of the education and training it provided.	
	<b>EP 27</b>	The organization provides the patient education on how to communicate concerns about patient safety issues that occur before, during, and after care is received.	
	<b>EP 28</b>	<b>For organizations that elect The Joint Commission Primary Care Home option: The primary care clinician and the interdisciplinary team educate the patient on self-management tools and techniques based on the patient's individual needs.</b>	
	<b>RC.02.01.01</b>	<b>The clinical record contains information that reflects the patient's care, treatment, or services.</b>	
	<b>EP 1</b>	<b>The clinical record contains the following demographic information:</b> <ul style="list-style-type: none"> <li>- The patient's name, address, phone number, and date of birth, and the name of any legally authorized representative</li> <li>- The patient's sex, height, and weight</li> <li>- The legal status of any patient receiving behavioral health care services</li> <li>- The patient's language and communication needs</li> <li>- For organizations that elect The Joint Commission Primary Care Home option: The patient's communication needs, including preferred language for discussing health care <b>Note: If the patient is a minor, is incapacitated, or has a designated advocate, the communication needs of the parent or legal guardian, surrogate decision-maker, or legally authorized representative is documented in the clinical record. (See also PC.02.01.21, EP 1)</b></li> </ul>	
	<b>EP 28</b>	<b>For organizations that elect The Joint Commission Primary Care Home option: The clinical record contains the patient's race and ethnicity.</b>	
	<b>EP 29</b>	<b>For organizations that elect The Joint Commission Primary Care Home option: The clinical record includes the patient's self-management goals and the patient's progress toward achieving those goals.</b>	
	<b>RI.01.01.01</b>	<b>The organization respects patient rights.</b>	
	<b>EP 1</b>	The organization has written policies on patient rights.	
	<b>EP 3</b>	Information about patient rights is available to the patient. (See also RI.01.01.03, EPs 1-3)	
	<b>EP 4</b>	The organization treats the patient in a dignified and respectful manner that supports his or her dignity.	
	<b>EP 5</b>	The organization respects the patient's right to and need for effective communication. (See also RI.01.01.03, EP 1)	
	<b>EP 6</b>	The organization respects the patient's cultural and personal values, beliefs, and preferences.	

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		<p><b>EP 7</b> The organization respects the patient's right to privacy. (See also IM.02.01.01, EPs 1-5)            Note: This element of performance (EP) addresses a patient's personal privacy. For EPs addressing the privacy of a patient's health information, please refer to Standard IM.02.01.01.</p>	
		<p><b>EP 8</b> The organization respects the patient's right to pain management. (See also HR.01.04.01, EP 4; HR.02.02.01, EP 4; PC.01.02.07, EP 1)</p>	
		<p><b>EP 10</b> The organization allows the patient to access, request amendment to, and obtain information on disclosures of his or her health information, in accordance with law and regulation.</p>	
		<p><b>RI.01.01.03 The organization respects the patient's right to receive information in a manner he or she understands.</b></p>	
		<p><b>EP 1</b> The organization provides information in a manner tailored to the patient's age, language, and ability to understand. (See also RI.01.01.01, EPs 3 and 5; PC.04.01.05, EP 8)</p>	
		<p><b>EP 2</b> The organization provides interpreting and translation services, as necessary. (See also RI.01.01.01, EP 3)</p>	
		<p><b>EP 3</b> The organization communicates with the patient who has vision, speech, hearing, or cognitive impairments in a manner that meets the patient's needs. (See also RI.01.01.01, EP 3)</p>	
		<p><b>EP 6 For organizations that elect The Joint Commission Primary Care Home option: The organization provides language interpreting and translation services. Note: Language interpreting options may include trained bilingual staff, contract interpreting services, or employed language interpreters. These options may be provided in person or via telephone or video. The documents translated and languages into which they are translated are dependent on the organization's patient population.</b></p>	
		<p><b>RI.01.02.01 The organization respects the patient's right to participate in decisions about his or her care, treatment, or services.</b></p>	
		<p><b>EP 1</b> The organization involves the patient in making decisions about his or her care, treatment, or services.</p>	
		<p><b>EP 3</b> The organization respects the patient's right to refuse care, treatment, or services, in accordance with law and regulation.</p>	
		<p><b>EP 6</b> When a patient is unable to make decisions about his or her care, treatment, or services, the organization involves a surrogate decision-maker in making these decisions. (See also RI.01.03.01, EP 6)</p>	
		<p><b>EP 7</b> When a surrogate decision-maker is responsible for making care, treatment, or services decisions, the organization respects the surrogate decision-maker's right to refuse care, treatment, or services on the patient's behalf, in accordance with law and regulation.</p>	
		<p><b>EP 8</b> The organization involves the patient's family in care, treatment, or services decisions to the extent permitted by the patient or surrogate decision-maker, in accordance with law and regulation.</p>	
		<p><b>EP 20</b> The organization provides the patient or surrogate decision-maker with the information about the outcomes of care, treatment, or services that the patient needs in order to participate in current and future health care decisions.</p>	
		<p><b>EP 21</b> The organization informs the patient or surrogate decision-maker about unanticipated outcomes of care, treatment, or services that relate to sentinel events considered reviewable by The Joint Commission. (Refer to the "Sentinel Events" (SE) chapter for a definition of reviewable sentinel events.)</p>	

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	<b>EP 31</b>	For organizations that elect The Joint Commission Primary Care Home option: The organization respects the patient's right to make decisions about the management of his or her care.	
	<b>EP 32</b>	For organizations that elect The Joint Commission Primary Care Home option: The organization respects the patient's right to the following: - Obtain care from other clinicians of the patient's choosing within the Primary Care Home - Seek a second opinion from a clinician of the patient's choosing - Seek specialty care <b>Note:</b> This element of performance does not imply financial responsibility for any activities associated with these rights.	
	<b>RI.01.03.01</b>	<b>The organization honors the patient's right to give or withhold informed consent.</b>	
	<b>EP 1</b>	The organization has a written policy on informed consent.	
	<b>EP 2</b>	The organization's written policy identifies the specific care, treatment, or services that require informed consent, in accordance with law and regulation.	
	<b>EP 3</b>	The organization's written policy describes circumstances that would allow for exceptions to obtaining informed consent.	
	<b>EP 6</b>	The organization's written policy describes when a surrogate decision-maker may give informed consent. (See also RI.01.02.01, EP 6)	
	<b>EP 7</b>	The informed consent process includes a discussion about the patient's proposed care, treatment, or services.	
	<b>EP 9</b>	The informed consent process includes a discussion about potential benefits, risks, and side effects of the patient's proposed care, treatment, or services; the likelihood of the patient achieving his or her goals; and any potential problems that might occur during recuperation.	
	<b>EP 11</b>	The informed consent process includes a discussion about reasonable alternatives to the patient's proposed care, treatment, or services. The discussion encompasses risks, benefits, and side effects related to the alternatives and the risks related to not receiving the proposed care, treatment, or services.	
	<b>EP 12</b>	The informed consent process includes a discussion about any circumstances under which information about the patient must be disclosed or reported. <b>Note:</b> Such circumstances may include requirements for disclosure of information regarding cases of HIV, tuberculosis, viral meningitis, and other diseases that are reported to organizations such as health departments or the Centers for Disease Control and Prevention.	
	<b>EP 13</b>	Informed consent is obtained in accordance with the organization's policy and processes. (See also RC.02.01.01, EP 4)	
	<b>RI.01.04.01</b>	<b>The organization respects the patient's right to receive information about the individual(s) responsible for his or her care, treatment, or services.</b>	
	<b>EP 1</b>	The organization informs the patient of the name of the physician or other practitioner who has primary responsibility for his or her care, treatment, or services.	
	<b>EP 2</b>	The organization informs the patient of the name of the physician(s) or other practitioner(s) who will provide his or her care, treatment, and services.	

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	<b>RI.01.04.03</b>	<b>For organizations that elect The Joint Commission Primary Care Home option: The organization provides patients with information about the functions and services of the Primary Care Home.</b>	
	<b>EP 1</b>	For organizations that elect The Joint Commission Primary Care Home option: The organization provides information to the patient about: The mission, vision, and goals of the Primary Care Home. <b>Note:</b> This may include how it provides for patient- centered and team-based comprehensive care; coordinating care, a systems-based approach to quality and safety, and enhanced patient access. (See also LD.02.01.01, EP 3)	
	<b>EP 2</b>	For organizations that elect The Joint Commission Primary Care Home option: The organization provides information to the patient about: The scope of care and types of services provided by the Primary Care Home. (See also PC.01.01.01, EP 7 and LD.01.03.10, EP 3)	
	<b>EP 3</b>	For organizations that elect The Joint Commission Primary Care Home option: The organization provides information to the patient about: How the Primary Care Home functions, including the following: - Processes supporting patient selection of a primary care physician - Involving the patients in his or her treatment plan - Obtaining and tracking referrals - Coordinating care - Collaborating with patient-selected clinicians who provide specialty care or second opinions	
	<b>EP 4</b>	For organizations that elect The Joint Commission Primary Care Home option: The organization provides information to the patient about: How to access the Primary Care Home for care or information.	
	<b>EP 5</b>	For organizations that elect The Joint Commission Primary Care Home option: The organization provides information to the patient about: Patient responsibilities, including providing health history and current medications, and participating in self-management activities. (See also RI.02.01.01, EP 2)	
	<b>EP 6</b>	For organizations that elect The Joint Commission Primary Care Home option: The organization provides information to the patient about: The patient's right to obtain care from other clinicians within the Primary Care Home, to seek a second opinion, and to seek specialty care. (See also PC.02.03.01, EP 4 and RI.01.01.03, EPs 1 and 3)	
	<b>RI.01.05.01</b>	<b>The organization addresses patient decisions about care, treatment, or services received at the end of life.</b>	
	<b>EP 1</b>	The organization has written policies on advance directives.	
	<b>EP 4</b>	The organization's written policies specify whether the organization will honor advance directives.	
	<b>EP 5</b>	The organization implements its advance directive policies.	
	<b>EP 8</b>	Upon request, the organization communicates its policies on advance directives to patients.	
	<b>EP 10</b>	Upon request, the organization shares with the patient possible sources of help in formulating advance directives.	

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	<b>RI.01.07.01</b> The patient and his or her family have the right to have complaints reviewed by the organization.	<b>EP 1</b> The organization establishes a complaint resolution process. <b>EP 2</b> The organization informs the patient and his or her family about the complaint resolution process. <b>EP 4</b> The organization reviews and, when possible, resolves complaints from the patient and his or her family.	
<b>Operational Characteristic 2</b>	<b>PC.01.02.01</b> The organization assesses and reassesses its patients.		
Comprehensive care	<b>EP 39</b> For organizations that elect The Joint Commission Primary Care Home option: The primary care clinician and the interdisciplinary team assess patients for health risk behaviors.		
	<b>PC.02.01.01</b> The organization provides care, treatment, or services for each patient.	<b>EP 22</b> For organizations that elect The Joint Commission Primary Care Home option: The primary care clinician and the interdisciplinary team are responsible for providing the patient with comprehensive and continuous care. <b>Note:</b> This responsibility would include either directly providing care or arranging for care to be provided by others. (See also HR .01.02.07 EP 2; HR .02.01.03 EP 4)	
	<b>PC.02.01.05</b> The organization provides interdisciplinary, collaborative care, treatment, or services.		
	<b>EP 1</b> Care, treatment, or services are provided to the patient in an interdisciplinary, collaborative manner.		
	<b>EP 27</b> For organizations that elect The Joint Commission Primary Care Home option: The organization identifies the members of the interdisciplinary team.		
	<b>EP 28</b> For organizations that elect The Joint Commission Primary Care Home option: Members of the interdisciplinary team participate in the development of the patient's treatment plan.		
	<b>PC.02.02.01</b> The organization coordinates the patient's care, treatment, or services based on the patient's needs.		
	<b>EP 24</b> For organizations that elect The Joint Commission Primary Care Home option: The primary care clinician works with the interdisciplinary team to provide or coordinate all patient care. <b>Note:</b> Coordination of care may include referring patients to internal and external health care providers, developing and evaluating treatment plans, and resolving conflicts in the provision of care.		
	<b>EP 25</b> For organizations that elect The Joint Commission Primary Care Home option: The organization manages transitions in care and provides or facilitates patient access to care, treatment, and services including the following:	<ul style="list-style-type: none"> <li>- Acute care</li> <li>- Chronic care</li> <li>- Age and gender-specific preventive services</li> <li>- Behavioral health needs</li> <li>- Dental Care</li> </ul>	
	<b>Note:</b> This may be achieved through the use of community resources as available, or in collaboration with other organizations.		

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	EP 102	For organizations that elect The Joint Commission Primary Care Home option: The primary care clinician has the educational background and broad-based knowledge and experience necessary to handle most medical needs of the patient and resolve conflicting recommendations for care.	
	EP 103	For organizations that elect The Joint Commission Primary Care Home option: The primary care clinician works collaboratively with an interdisciplinary team.	
	EP 104	For organizations that elect The Joint Commission Primary Care Home option: The primary care clinician is ultimately accountable for patient care.	
	EP 105	For organizations that elect The Joint Commission Primary Care Home option: A doctor of medicine (MD) or doctor of osteopathy (DO) actively participates on the interdisciplinary team.	
	EP 106	For organizations that elect The Joint Commission Primary Care Home option: The organization provides care that addresses various phases of a patient's lifespan, including end-of-life care.	
	EP 107	For organizations that elect The Joint Commission Primary Care Home option: The organization provides acute, preventive, and chronic care.	
	EP 108	For organizations that elect The Joint Commission Primary Care Home option: The organization provides disease and chronic care management services to its patients.	
<b>Operational Characteristic 3</b>	<b>PC.01.03.01</b>	<b>The organization plans the patient's care.</b>	
Coordinated care	EP 44	For organizations that elect The Joint Commission Primary Care Home option: Patient self-management goals are identified and incorporated into the patient's treatment plan. (See also RI .01.02.01 EP1)	
	<b>PC.02.01.01</b>	<b>The organization provides care, treatment, or services for each patient.</b>	
	EP 18	For organizations that elect The Joint Commission Primary Care Home option: The primary care clinician and the interdisciplinary team use health promotion strategies focused on prevention and management of chronic illness.	
	EP 19	For organizations that elect The Joint Commission Primary Care Home option: The primary care clinician and the interdisciplinary team monitor the patient's progress towards achieving his or her self-management goals.	
	EP 20	For organizations that elect The Joint Commission Primary Care Home option: The organization uses health information technology to do the following: <ul style="list-style-type: none"> <li>- Document, track, and coordinate care</li> <li>- Support disease management, including providing patient education</li> <li>- Support preventive care</li> <li>- Create reports for internal use and external reporting</li> <li>- Facilitate electronic exchange of information among providers</li> </ul>	
	EP 21	For organizations that elect The Joint Commission Primary Care Home option: When a patient is referred to an external organization, the primary care clinician and the interdisciplinary team review and track the care provided to the patient.	
	<b>PC.02.02.01</b>	<b>The organization coordinates the patient's care, treatment, or services based on the patient's needs.</b>	
	EP 1	The organization has a process to receive or share patient information when the patient is referred to other internal or external providers of care, treatment, or services. (See also PC.04.02.01, EP 1)	

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	EP 2	The organization's process for hand-off communication provides for the opportunity for discussion between the giver and receiver of patient information. Note: Such information may include the patient's condition, care, treatment, medications, services, and any recent or anticipated changes to any of these.	
	EP 3	The organization coordinates the patient's care, treatment, or services. Note: Coordination involves resolving scheduling conflicts and duplication of care, treatment, or services.	
	EP 10	When the organization uses external resources to meet the patient's needs, it participates in coordinating the patient's care, treatment, or services.	
	EP 17	The organization coordinates care, treatment, or services within a time frame that meets the patient's needs.	
	EP 26	<b>For organizations that elect The Joint Commission Primary Care Home option: The primary care clinician and the interdisciplinary team act on recommendations from internal and external referrals for additional care, treatment, or services.</b>	
	EP 109	<b>For organizations that elect The Joint Commission Primary Care Home option: The organization provides population-based care.</b>	
	EP 110	<b>For organizations that elect The Joint Commission Primary Care Home option: The primary care clinician and interdisciplinary team function within their scope of practice and in accordance with privileges granted.</b>	
	EP 111	<b>For organizations that elect The Joint Commission Primary Care Home option: The primary care clinician and interdisciplinary team provide care for a panel of patients.</b>	
	PC.02.03.01	<b>The organization provides patient education and training based on each patient's needs and abilities.</b>	
	EP 5	The organization coordinates the patient education and training provided by all disciplines involved in the patient's care, treatment, or services.	
	PC.04.01.01	<b>The organization has a process that addresses the patient's need for continuing care, treatment, or services after discharge or transfer.</b>	
	EP 1	The organization describes the reason(s) for and conditions under which the patient is discharged or transferred.	
	EP 2	The organization describes the method for shifting responsibility for a patient's care from one clinician, organization, program, or service to another.	
	EP 3	The organization describes the mechanisms for external transfer of the patient.	
	EP 4	The organization agrees with the receiving organization about each of their roles to keep the patient safe during transfer.	
	PC.04.01.03	<b>The organization discharges or transfers the patient based on his or her assessed needs and the organization's ability to meet those needs.</b>	
	EP 2	The organization identifies any needs the patient may have for continuing psychosocial or physical care.	
	EP 3	The patient, the patient's family, licensed independent practitioners, physicians, clinical psychologists, and staff involved in the patient's care, treatment, or services participate in planning the patient's discharge or transfer.	

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	<p><b>EP 4</b> Prior to discharge, the organization arranges or assists in arranging the services required by the patient after discharge in order to meet his or her ongoing needs for care and services.</p> <p><b>PC.04.01.05</b> Before the organization discharges or transfers a patient, it informs and educates the patient about his or her follow-up care, treatment, or services.</p> <p><b>EP 1</b> When the organization determines the patient's discharge or transfer needs, it promptly shares this information with the patient.</p> <p><b>EP 7</b> The organization educates the patient about how to obtain any continuing care, treatment, or services that he or she will need.</p> <p><b>EP 8</b> The organization provides written discharge instructions in a manner that the patient and/or the patient's family or caregiver can understand. (See also RI.01.01.03, EP 1)</p> <p><b>PC.04.02.01</b> When a patient is discharged or transferred, the organization gives information about the care, treatment, or services provided to the patient to other service providers who will provide the patient with care, treatment, or services.</p> <p><b>EP 1</b> At the time of the patient's discharge or transfer, the organization informs other service providers who will provide care, treatment, or services to the patient about the following:</p> <ul style="list-style-type: none"> <li>- The reason for the patient's discharge or transfer</li> <li>- The patient's physical and psychosocial status</li> <li>- A summary of care, treatment, or services it provided to the patient</li> <li>- The patient's progress toward goals</li> <li>- A list of community resources or referrals made or provided to the patient (See also PC.02.02.01, EP 1)</li> <li>- A list of the patient's current medications, including any allergies to medications</li> </ul> <p><b>RC.01.01.01</b> The organization maintains complete and accurate clinical records.</p> <p><b>EP 5</b> The clinical record contains the information needed to support the patient's diagnosis and condition.</p> <p><b>EP 7</b> The clinical record contains information that documents the course and result of the patient's care, treatment, or services.</p> <p><b>EP 8</b> The clinical record contains information about the patient's care, treatment, or services that promotes continuity of care among providers.  <b>Note: For organizations that elect The Joint Commission Primary Care Home option: This requirement refers to care provided by both internal and external providers.</b></p> <p><b>EP 11</b> All entries in the clinical record are dated.</p> <p><b>EP 13</b> The organization assembles or makes available in a summary in the clinical record all information required to provide patient care, treatment, or services. (See also MM.01.01.01, EP 1)</p> <p><b>EP 14</b> When needed to provide care, summaries of treatment and other documents provided by the organization are forwarded to other care providers.</p>		
<p><b>Operational Characteristic 4</b></p>		<p><b>PC.10.10.10</b> For organizations that elect The Joint Commission Primary Care Home option: The patient has access to the organization 24 hours a day, seven days a week.  <b>Note: Access may be provided through a number of methods, including telephone, email, flexible hours, websites, and portals.</b></p>	
<p>Superb access to care</p>			

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		<p><b>EP 1</b> For organizations that elect The Joint Commission Primary Care Home option: The organization provides patients with access to the following 24 hours a day, 7 days a week:</p> <ul style="list-style-type: none"> <li>-Appointment availability/scheduling</li> <li>-Requests for prescription renewal</li> <li>-Test results</li> <li>-Billing and registration information</li> <li>-Clinical advice for urgent health needs</li> <li>-General health education information</li> </ul> <p><b>EP 2</b> For organizations that elect The Joint Commission Primary Care Home option: The organization offers flexible scheduling to accommodate patient care needs. Note: This may include open scheduling, same day appointments, expanded hours, and arrangements with other organizations.</p> <p><b>EP 3</b> For organizations that elect The Joint Commission Primary Care Home option: The organization has a process to address patient urgent care needs 24 hours a day, 7 days a week.</p>	
<p><b>Operational Characteristic 5</b></p> <p>Systems-based approach to quality and safety</p>		<p><b>LD.03.04.01</b> The organization communicates information related to safety and quality to those who need it, including staff, licensed independent practitioners, patients, families, and external interested parties.</p>	
		<p><b>EP 1</b> Communication processes foster the safety of the patient and the quality of care.</p>	
		<p><b>EP 2</b> Leaders are able to describe how communication supports a culture of safety and quality.</p>	
		<p><b>EP 3</b> Communication is designed to meet the needs of internal and external users.</p>	
		<p><b>EP 4</b> Leaders provide the resources required for communication, based on the needs of patients, staff, and management.</p>	
		<p><b>EP 5</b> Communication supports safety and quality throughout the organization. (See also LD.04.04.05, EPs 6 and 12)</p>	
		<p><b>EP 6</b> When changes in the environment occur, the organization communicates those changes effectively.</p>	
		<p><b>EP 7</b> Leaders evaluate the effectiveness of communication methods.</p>	
		<p><b>LD.04.04.01</b> Leaders establish priorities for performance improvement. (Refer to the "Performance Improvement" (PI) chapter.)</p>	
		<p><b>EP 1</b> Leaders set priorities for performance improvement activities and patient health outcomes. (See also PI.01.01.01, EPs 1 and 3)</p>	
		<p><b>EP 2</b> Leaders give priority to high-volume, high-risk, or problem-prone processes for performance improvement activities. (See also PI.01.01.01, EPs 4, 6-8, and 14-15)</p>	
		<p><b>EP 3</b> Leaders reprioritize performance improvement activities in response to changes in the internal or external environment.</p>	
		<p><b>EP 4</b> Performance improvement occurs organization-wide.</p>	
		<p><b>EP 25</b> For organizations that elect The Joint Commission Primary Care Home option: The organization uses health information technology to support performance improvement.</p>	

Primary Care Home Characteristics	Joint Commission Equivalent Number	Joint Commission Standards	Attachment A
	<p><b>LD.04.04.03 New or modified services or processes are well designed.</b></p> <p><b>EP 2</b> The organization's design of new or modified services or processes incorporates the results of performance improvement activities.</p> <p><b>EP 4</b> The organization's design of new or modified services or processes incorporates evidence-based information in the decision-making process. Note: For example, evidence-based information could include practice guidelines, successful practices, information from current literature, and clinical standards.</p> <p><b>EP 5</b> The organization's design of new or modified services or processes incorporates information about sentinel events.</p> <p><b>EP 6</b> The organization tests and analyzes its design of new or modified services or processes to determine whether the proposed design or modification is an improvement.</p> <p><b>LD.04.04.05 The organization has an organization-wide, integrated patient safety program.</b></p> <p><b>EP 1</b> The leaders implement an organization-wide patient safety program.</p> <p><b>EP 2</b> One or more qualified individuals manage the safety program.</p> <p><b>EP 3</b> The scope of the safety program includes the full range of safety issues, from potential or no-harm errors (sometimes referred to as near misses, close calls, or good catches) to hazardous conditions and sentinel events.</p> <p><b>EP 4</b> All departments, programs, and services within the organization participate in the safety program.</p> <p><b>EP 5</b> As part of the safety program, the leaders create procedures for responding to system or process failures. (See also PI.03.01.01, EP 10) Note: Responses might include continuing to provide care, treatment, or services to those affected, containing the risk, and preserving factual information for subsequent analysis.</p> <p><b>EP 6</b> The leaders provide and encourage the use of systems for blame-free internal reporting of a system or process failure, or the results of a proactive risk assessment. (See also LD.03.01.01, EP 8; LD.03.04.01, EP 5; LD.04.04.03, EP 3; PI.03.01.01, EP 10)</p> <p><b>EP 7</b> The leaders define "sentinel event" and communicate this definition throughout the organization. (See also PI.03.01.01, EP 10) Note: At a minimum, the organization's definition includes those events subject to review in the "Sentinel Events" (SE) chapter of this manual. The definition may include any process variation that does not affect the outcome or result in an adverse event, but for which a recurrence carries significant chance of a serious adverse outcome or result in an adverse event, often referred to as a near miss.</p> <p><b>EP 8</b> The organization conducts thorough and credible root cause analyses in response to sentinel events as described in the "Sentinel Events" (SE) chapter of this manual.</p> <p><b>EP 9</b> The leaders make support systems available for staff who have been involved in an adverse or sentinel event. Note: Support systems recognize that conscientious health care workers who are involved in sentinel events are themselves victims of the event and require support. Support systems provide staff with additional help and support as well as additional resources through the human resources function or an employee assistance program. Support systems also focus on the process rather than blaming the involved individuals.</p>		

Primary Care Home Characteristics	Joint Commission Equivalent Number	Joint Commission Standards	Attachment A
	<b>EP 11</b>	To improve safety, the organization analyzes and uses information about system or process failures and, when conducted, the results of proactive risk assessments. (See also LD.04.04.03, EP 3)	
	<b>EP 12</b>	The leaders disseminate lessons learned from root cause analyses, system or process failures and, when conducted, the results of proactive risk assessments, to all staff who provide services for the specific situation. (See also LD.03.04.01, EP 5; PI.03.01.01, EP 10)	
	<b>EP 13</b>	At least once a year, the leaders provide governance with written reports on the following: <ul style="list-style-type: none"> <li>- All system or process failures</li> <li>- The number and type of sentinel events</li> <li>- Whether the patients and the families were informed of the event</li> <li>- All actions taken to improve safety, both proactively and in response to actual occurrences</li> </ul>	
	<b>EP 14</b>	The leaders encourage external reporting of significant adverse events, including voluntary reporting programs in addition to mandatory programs. Note: Examples of voluntary programs include The Joint Commission Sentinel Event Database and the U.S. Food and Drug Administration (FDA) MedWatch. Mandatory programs are often state initiated.	
	<b>LD.04.04.09</b>	<b>The organization uses clinical practice guidelines to design or to improve processes that evaluate and treat specific diagnoses, conditions, or symptoms.</b>	
	<b>EP 1</b>	The organization uses clinical practice guidelines to design or improve processes that evaluate and treat specific diagnoses, conditions, or symptoms.	
	<b>EP 2</b>	The organization identifies criteria that guide the selection and implementation of guidelines to design or improve processes that evaluate and treat specific diagnoses, conditions, or symptoms.	
	<b>EP 3</b>	The organization manages and evaluates the implementation of the guidelines to design or improve processes that evaluate and treat specific diagnoses, conditions, or symptoms.	
	<b>EP 4</b>	The leaders of the organization review and approve the clinical practice guidelines that have been selected to design or improve processes that evaluate and treat specific diagnoses, conditions, or symptoms.	
	<b>EP 5</b>	The organization monitors and reviews clinical practice guidelines for their effectiveness and modifies them as needed.	
	<b>MM.04.01.01</b>	<b>Medication orders are clear and accurate.</b>	
	<b>EP 21</b>	<b>For organizations that elect The Joint Commission Primary Care Home option: The organization uses an electronic prescribing process.</b>	
	<b>PC.01.03.01</b>	<b>The organization plans the patient's care.</b>	
	<b>EP 45</b>	<b>For organizations that elect The Joint Commission Primary Care Home option: The organization uses clinical decision support tools to guide decision making (See also LD .04.04.09 EPs 1-5)</b>	
	<b>PI.01.01.01</b>	<b>The organization collects data to monitor its performance.</b>	
	<b>EP 1</b>	The leaders set priorities for data collection. (See also LD.04.04.01, EP 1)	
	<b>EP 2</b>	The organization identifies the frequency for data collection.	
	<b>EP 3</b>	The organization collects data on the following: Performance improvement priorities identified by leaders. (See also LD.04.04.01, EP 1)	

Primary Care Home Characteristics	Joint Commission Equivalent Number	Joint Commission Standards	Attachment A
	<b>EP 16</b>	The organization collects data on the following: Patient perception of the safety and quality of care, treatment, or services.	
	<b>EP 40</b>	<b>For organizations that elect The Joint Commission Primary Care Home option: The organization collects data on the following: Disease management outcomes.</b>	
	<b>EP 41</b>	<b>For organizations that elect The Joint Commission Primary Care Home option: The organization collects data on the following: Patient access to care within timeframes established by the organization.</b>	
	<b>PI.02.01.01</b>	<b>The organization compiles and analyzes data.</b>	
	<b>EP 1</b>	The organization compiles data in usable formats.	
	<b>EP 2</b>	The organization identifies the frequency for data analysis.	
	<b>EP 4</b>	The organization analyzes and compares internal data over time to identify levels of performance, patterns, trends, and variations.	
	<b>EP 5</b>	The organization compares data with external sources, when available.	
	<b>EP 8</b>	The organization uses the results of data analysis to identify improvement opportunities. (See also LD.03.02.01, EP 5; PI.03.01.01, EP 1)	
	<b>PI.03.01.01</b>	<b>The organization improves performance.</b>	
	<b>EP 1</b>	Leaders prioritize the identified improvement opportunities. (See also PI.02.01.01, EP 8)	
	<b>EP 2</b>	The organization takes action on improvement priorities.	
	<b>EP 3</b>	The organization evaluates actions to confirm that they resulted in improvements.	
	<b>EP 4</b>	The organization takes action when it does not achieve or sustain planned improvements.	
	<b>EP 11</b>	<b>For organizations that elect The Joint Commission Primary Care Home option: The primary care clinician and interdisciplinary team actively participate in performance improvement activities.</b>	