Principles of the Patient-Centered Medical Home (PCMH) and the five key functions of the Comprehensive Primary Care (CPC) Initiative. These key functions are:

1. Access and Continuity: PCMH practices optimize continuity and timely, 24/7 access to care supported by the medical record. Practices track continuity of care by physician or panel.
2. Planned Care for Chronic Conditions and Preventive Care: PCMH practices proactively assess their patients to determine their needs and provide appropriate and timely chronic and preventive care, including medication management and review. Physicians develop a personalized plan of care for high-risk patients and use team-based approaches to meet patient needs efficiently.
3. Risk-Stratified Care Management: Patients with serious or multiple medical conditions need extra support to ensure they are getting the medical care and/or medications they need. PCMH practices empanel and risk stratify their whole practice population and implement care management for patients with high needs.
4. Patient and Caregiver Engagement: PCMH practices engage patients and their families in decision-making in all aspects of care. Such practices also integrate into their usual care both culturally competent, self-management support and the use of decision aids for preference sensitive conditions.
5. Coordination of Care Across the Medical Neighborhood: Primary care is the first point of contact for many patients and leads in the coordination of care as the center of patients' experiences with health care. PCMH practices work closely with patients' other health care providers to coordinate and manage care transitions, referrals, and information exchange

The AAFP considers these five key functions equally important for the delivery of advanced primary care. These functions depend on the support of enhanced accountable payment, continuous quality improvement driven by data, and optimal use of health information technology, including a certified electronic health record with a data registry or repository capability. In addition, in an advanced primary care practice, such as a PCMH, the use of annual milestones should guide the development of these five functions and build the capability to deliver them.

The AAFP supports attestation as the method for recognizing whether a practice meets the threshold requirements for a PCMH. A practice would attest to achievement of milestones, similar to those used in the original CPC Initiative. The reporting would be on a quarterly to annual basis, depending on the particular milestones being reported and the evolution of the practice. Practices that are more advanced may have fewer reporting requirements than those at earlier stages on the transformation continuum. The quality, patient experience, and utilization data that practices report will serve to validate whether a practice is delivering what it attests.

The AAFP suggests CMS use a deeming authority to grant any entity which meets the necessary criteria as a PCMH accreditor to be an approved program. The AAFP, the American Academy of Pediatrics, the American College of Physicians, and the American Osteopathic Association have joint Guidelines for Patient-Centered Medical Home Recognition and Accreditation Programs that build on the Joint Principles of the Patient-Centered Medical Home. The four groups developed and adopted the principles in March 2007. CMS could use these guidelines in exercising such a deeming authority. In addition, the AAFP encourages the inclusion of state-based, payer-sponsored, or regional PCMH recognition programs.