



**Stand up. Stand out.**

# Accreditation and the PCMH: *Validating transformative practices*

Commission for Case Manager Certification

Patrice Sminkey, CEO

PCMH Summit, March 2014



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## About the Commission

- First nationally accredited case manager credential
- More than 35,000 board certified case managers in every state, U.S. territory and abroad
- Certification exam based on ongoing scientific research; practice-based questions developed by case management subject matter experts
- Quality of exam and renewal requirements rigorously upheld by the Commission and externally validated through NCCA accreditation



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**35,000 CCM<sup>®</sup>  
Certificant holders**

**Professional  
Standards for  
Individuals**



**Informs**



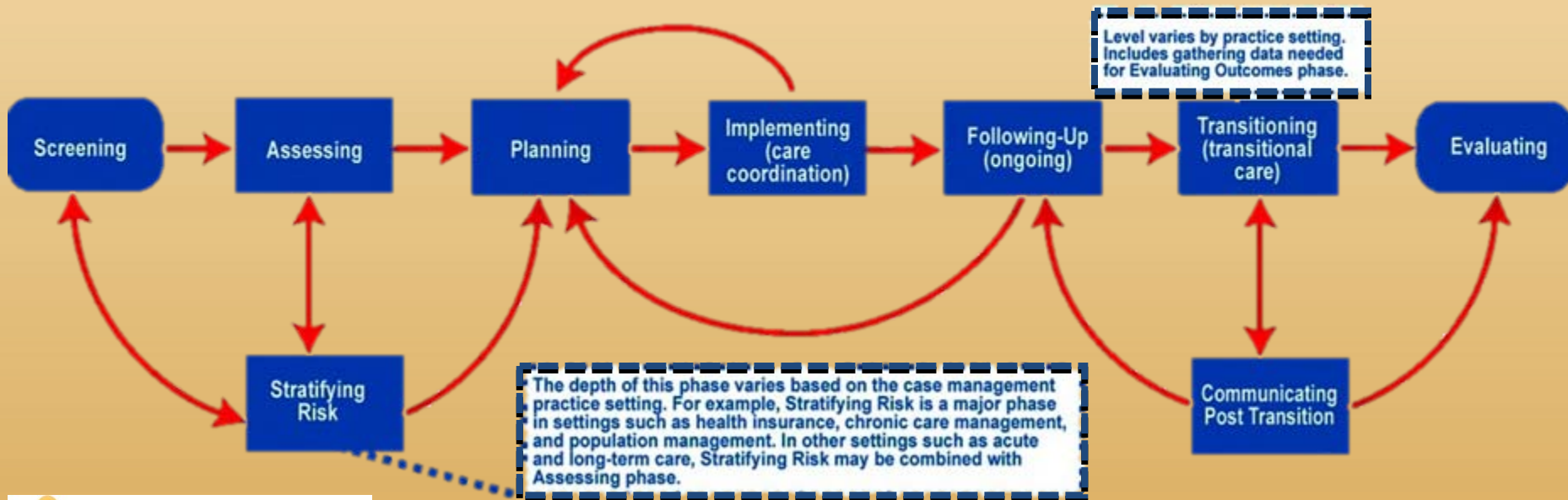
**PCMH  
Accreditation**

**Organizational  
Standards for  
Practices & Medical  
Home Community**



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## Case Management Process





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## AHRQ Definition of PCMH

Comprehensive  
Care

Patient-  
Centered

Coordinated  
Care

Accessible  
Services

Quality &  
Safety



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## Reasons for accreditation

- To identify and validate practices that are structured to align with medical home principles (Joint Principles or AHRQ's PCMH definition)
- To trigger payment mechanisms and minimize administrative burdens for pay-for-performance programs
- To continue to raise the bar via new, progressive standards





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## Early studies:

### Crosswalk of accreditation domains for PCMH

- 10 Provider Survey Tools designed to measure the extent to which a practice is a “patient-centered medical home”
- Report compares operational details (price, site visit requirement, content emphasis)

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#### **Patient-Centered Medical Home Recognition Tools: A Comparison of Ten Surveys' Content and Operational Details**

By Rachel A. Burton, Kelly J. Devers, Robert A. Berenson

The Urban Institute, Health Policy Center  
2100 M Street, NW, Washington, DC 20037

March 2012

For the Centers for Medicare and Medicaid Services (CMS)  
CMS Project Officer: Suzanne Goodwin



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Evidence-Based Care

Culturally Competent Communication

Compact Between Practice and Patient

Quality Improvement

Standard Care (Non-PCMH)

Population Management

Medical Records

Care Plan

Community Resources

Adheres to Current Law & Business Practices





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Access to  
Care

Health  
Information  
Technology

Patient  
Engagement  
& Self -  
Management

Continuity  
of Care

Presence of  
Policies

Comprehen-  
siveness of  
Care

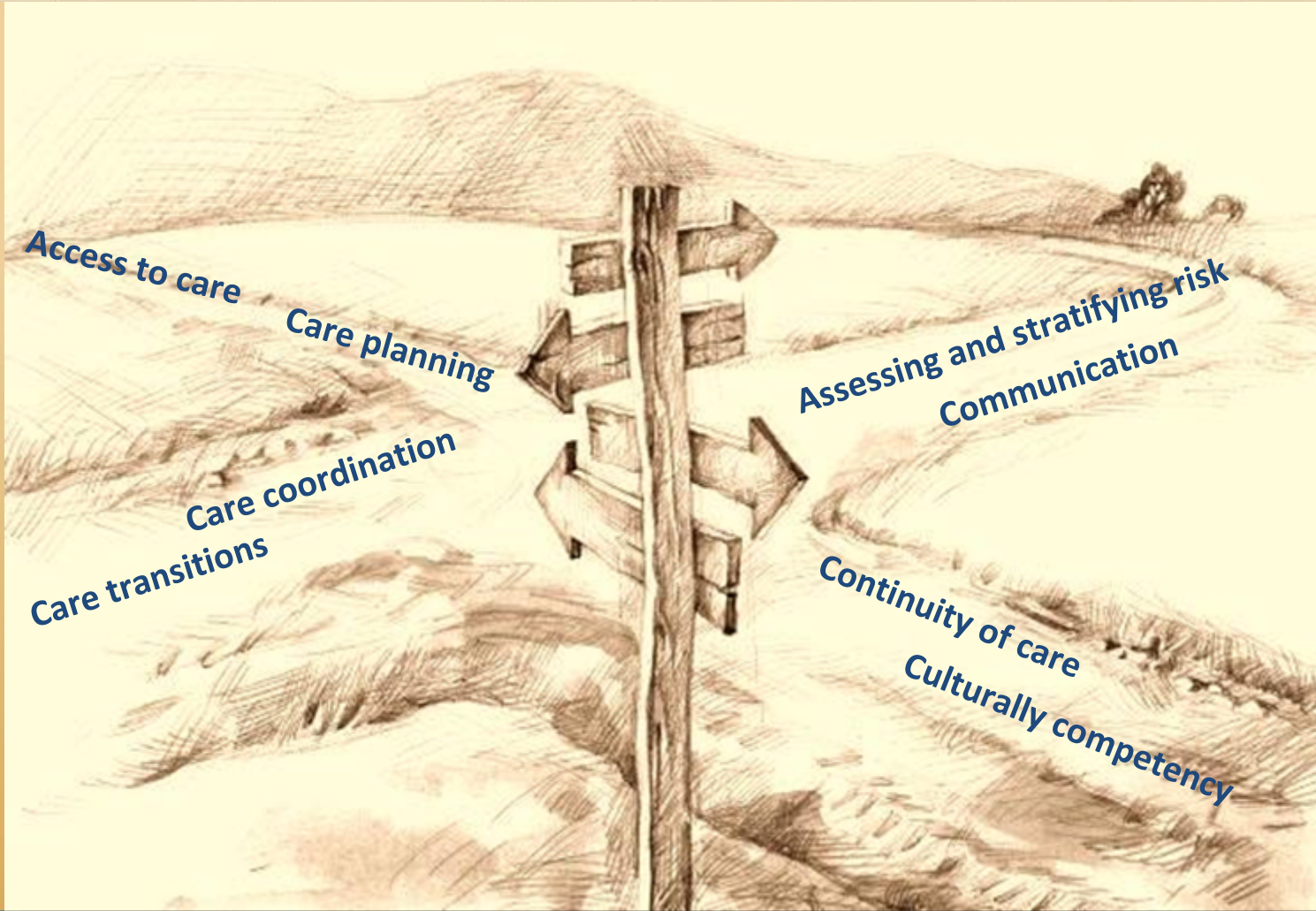
Quality  
Measures

Team-Based  
Care

Coordination  
of Care



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Access to care

Care planning

Care coordination

Care transitions

Assessing and stratifying risk  
Communication

Continuity of care

Culturally competency