Accreditation and the PCMH:

Validating transformative practices

Commission for Case Manager Certification

Patrice Sminkey, CEO

PCMH Summit, March 2014

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

Stand up. Stand out.

35,000 CCM®
Certificant holders

PCMH
Accreditation

Professional Standards for Individuals

Informs

Organizational Standards for Practices & Medical Home Community

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Case Management Process

Level varies by practice setting. Includes gathering data needed for Evaluating Outcomes phase.

Screening → Assessing → Planning → Implementing (care coordination) → Following-Up (ongoing) → Transitioning (transitional care) → Evaluating

Stratifying Risk

Communicating Post Transition

The depth of this phase varies based on the case management practice setting. For example, Stratifying Risk is a major phase in settings such as health insurance, chronic care management, and population management. In other settings such as acute and long-term care, Stratifying Risk may be combined with Assessing phase.

Case Management Body of Knowledge™
Find it. Now. CCMC

AHRQ Definition of PCMH

Comprehensive Care

Patient-Centered

Coordinated Care

Accessible Services

Quality & Safety

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

APPROVED

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)

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

Stand up. Stand out.

- Evidence-Based Care
- Quality Improvement
- Culturally Competent Communication
- Standard Care (Non-PCMH)
- Compact Between Practice and Patient
- Population Management
- Community Resources
- Medical Records
- Adheres to Current Law & Business Practices
- Care Plan

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Access to Care

Continuity of Care

Health Information Technology

Presence of Policies

Patient Engagement & Self - Management

Comprehen-siveness of Care

Coordination of Care

Quality Measures

Team-Based Care

Stand up. Stand out.

Access to care

Care planning

Assessing and stratifying risk

Communication

Care coordination

Care transitions

Continuity of care

Culturally competency