STANDARD 4.0

Establish a dynamic care management plan that addresses all settings throughout the continuum of care

Processes are in place to support the development of an ongoing care management plan, created with input from the patient, provider, primary caregiver, and family. This care plan should be accessible to all care managers and remain with the patient's regular ambulatory care provider for continuity.

	Consistently Performing (4)	Frequently Performing (3)	Inconsistently Performing (2)	Not Performing (1)	SCORE
Review of all available data, including information gathered from patient self-report or from individuals within the patient's support network.					
Review goals for care and potential transitions for settings and levels of care with patient/family/caregiver.					
Tracking methodology for high-risk patients with an ongoing care management plan.					
Identify and document: • Regular ambulatory care provider • Health plan benefits and any requirements or authorizations for services • Designated caregivers • Pharmacy/pharmacies used • Specialty care providers • Home health/home care provider • Social service agencies • Known episodic or longitudinal care manager					
Identification and documentation of advance care planning documents.					
Consult pharmacy as appropriate, with documentation of the outcome and evidence of patient/family/caregiver awareness and understanding of the necessary course of action.					
Evidence of timely reassessments as the patient moves across care settings.					
Documentation of referrals and linkages to community resources and services.					
Documentation of patient and support network to referrals and linkages.					
Supporting documentation that services and referrals meet payer expectations and requirements.					
Utilization of available technologies to maximize accuracy with the ability to efficiently transfer care plan information across the care continuum (patient, caregiver, provider, and longitudinal/episodic care					

managers), using secure data exchanges and paperless systems when possible					
Identification of episodic or longitudinal care managers coordinating transitions across the care continuum.					
Communication and sharing of the care plan to known episodic or longitudinal care managers across the continuum.					
Standard 4.0 Organization Score:					

Consensus Measures

Process: Patient engagement after inpatient discharge (HEDIS)

Outcome: Evidence of longitudinal care management for patients at high risk for adverse health outcomes or risk (CMS IA_PM_14)

SCORING

Consistently is defined as performance of service/task **80% or greater**

Frequently is defined as performance of service/task **50% - 79%**

Inconsistently is defined as performance of service/task **20% - 49%**

Not performing is defined as performance of service/task **less than 20%**