ORGANIZATIONAL SELF-ASSESSMENT

TRANSITIONS OF CARE

STANDARD 4.0

Establish a Dynamic Care Plan That Addresses All Settings Across the Care Continuum

People, Processes, and Technology 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 coordinators and remain with the patient's regular ambulatory care provider, the patient, and the patient's health care plan.

Organizations can meet this standard by demonstrating that the care plan includes the following elements:

	Consistently Performing (3)	Frequently Performing (2)	Inconsistently Performing (1)	Not Performing (0)	Score
Review of all available data, including 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 plan.					
Identify and document: • Regular ambulatory care provider • Health plan benefits and any requirements or authorizations for services • SDOH factors • Designated caregivers • Pharmacy(ies) utilized • Specialty care providers • Home health/home care provider • Community agencies					

TOC-1160-07022024

Identification and documentation of advance care planning documents.					
Pharmacy consult with documentation of the outcome and evidence of patient/family/caregiver awareness, adherence, and understanding of the necessary course of action.					
Evidence of timely reassessments/communication as the patient moves across care settings.					
Documentation of referrals and linkages to community resources and services.					
Utilization of available technologies to maximize accuracy with the ability to efficiently transfer care plan information across the care continuum (patient, caregiver, provider) using secure data exchanges (HIE - Health Information Exchange) and paperless systems when possible.					
Identification and documentation of the personnel coordinating transitions across the care continuum.					
Communication and sharing of the care plan to known care coordinators 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)

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

Copyright American Case Management Association 2024.