Preferred Practices and Performance Measures for Measuring and Reporting Care Coordination

A CONSENSUS REPORT

National Quality Forum

The mission of the National Quality Forum is to improve the quality of American healthcare by setting national priorities and goals for performance improvement, endorsing national consensus standards for measuring and publicly reporting on performance, and promoting the attainment of national goals through education and outreach programs.

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Foreword

CARE COORDINATION IS A VITAL ASPECT of health and healthcare services. When care is poorly coordinated—with inaccurate transmission of information, inadequate communication, and inappropriate follow-up care—patients who see multiple physicians and care providers can face medication errors, hospital readmissions, and avoidable emergency department visits. The effects of poorly coordinated care are particularly evident for people with chronic conditions such as diabetes and hypertension and those at high risk for multiple illnesses who often are expected to navigate a complex healthcare system. Despite efforts to reduce problems through various initiatives and programs—such as care/case management—healthcare is not currently delivered uniformly in a well-coordinated and efficient manner.

In 2006, the National Quality Forum (NQF), an organization dedicated to improving healthcare quality, endorsed a definition of and framework for care coordination. This framework identified five key domains: Healthcare "Home," Proactive Plan of Care and Follow-up, Communication, Information Systems, and Transitions or Handoffs. In addition to endorsing a definition and framework, NQF, in its role as a convener and partner in the National Priorities Partnership (NPP), has focused on care coordination. Specifically, the Partnership established the following goals:

- Improve care and achieve quality by facilitating and carefully considering feedback from all patients regarding coordination of their care;
- Improve communication around medication information;
- Work to reduce 30-day readmission rates; and
- Work to reduce preventable emergency department (ED) visits by 50 percent.

In this report, *Preferred Practices and Performance Measures for Measuring and Reporting Care Coordination: A Consensus Report,* NQF has endorsed a portfolio of care coordination preferred practices and performance measures. These standards will provide the structure, process, and outcome measures required to assess progress toward the care coordination goals listed above and to evaluate access, continuity, communication, and tracking of patients across providers and settings. Given the high-risk nature of transitions in care, this work will build on ongoing efforts among the medical and surgical specialty societies to establish principles for effective patient handoffs between clinicians and providers. Measurement and improvement efforts will be upgraded over time as interoperable health information technology (HIT) systems evolve.

NQF thanks the Care Coordination Steering Committee and NQF Members for their efforts in helping to improve the care coordination in our healthcare system so that all Americans can be confident they are receiving the best care possible.

Janet M. Corrigan, PhD, MBA
President and Chief Executive Officer

Executive Summary

We envision a healthcare system that guides patients and families through their healthcare experience, while respecting patient choice, offering physical and psychological supports, and encouraging strong relationships between patient and the healthcare professionals accountable for their care.

– National Priorities Partnership, 2008

CARE COORDINATION IS A VITAL aspect of health and healthcare services. Many patients often see multiple physicians and care providers a year, which can lead to more harm, disease burden, and overuse of services than if care were coordinated. This is particularly evident for people with chronic conditions and those at high risk for comorbidities, who often are expected to navigate a complex healthcare system. Despite efforts to reduce problems through various initiatives and programs—such as care/case management—poor communication, medication errors, and preventable hospital readmissions are still substantial.

Healthcare cannot be of high quality if it is not delivered in a well-coordinated, efficient manner. In 2006, the National Quality Forum (NQF) endorsed a definition of and framework for care coordination. The framework identified five key domains: Healthcare "Home"; Proactive Plan of Care and Follow-up; Communication; Information Systems; and Transitions or Handoffs. In addition to endorsing a definition and framework, NQF, in its role as a convener and partner in the National Priorities Partnership (NPP), has focused on care coordination. Specifically, the Partnership identified the following goals:

- improve care and achieve quality by facilitating and carefully considering feedback from all patients regarding coordination of their care;
- improve communication around medication information;
- work to reduce 30-day readmission rates; and
- work to reduce preventable emergency department (ED) visits by 50 percent.

This NQF report, *Preferred Practices and Performance Measures for Measuring and Reporting Care Coordination: A Consensus Report,* aims to promote care coordination across settings and providers by endorsing a set of preferred practices and performance measures (Table 1). These standards address the domains of the NQF-endorsed Framework for Care Coordination and the goals of the Partnership. Systematic implementation of these practices will improve the coordination of patient care and healthcare quality.

Table 1: National Voluntary Consensus Standards for Care Coordination

Preferred Practices: Healthcare "Home" Domain

- **Preferred Practice 1:** The patient shall be provided the opportunity to select the healthcare home that provides the best and most appropriate opportunities to the patient to develop and maintain a relationship with healthcare providers.
- **Preferred Practice 2:** The healthcare home or sponsoring organizations shall be the central point for incorporating strategies for continuity of care.
- **Preferred Practice 3:** The healthcare home shall develop infrastructure for managing plans of care that incorporate systems for registering, tracking, measuring, reporting, and improving essential coordinated services.
- **Preferred Practice 4:** The healthcare home should have policies, procedures, and accountabilities to support effective collaborations between primary care and specialist providers, including evidence-based referrals and consultations that clearly define the roles and responsibilities.
- **Preferred Practices 5:** The healthcare home will provide or arrange to provide care coordination services for patients at high risk for adverse health outcomes, high service use, and high costs.

Preferred Practices: Proactive Plan of Care and Follow-up Domain

- **Preferred Practice 6:** Healthcare providers and entities should have structured and effective systems, policies, procedures, and practices to create, document, execute, and update a plan of care with every patient.
- **Preferred Practice 7:** A systematic process of follow-up tests, treatments, or services should be established and be informed by the plan of care.
- **Preferred Practice 8:** The joint plan of care should be developed and include patient education and support for self-management and resources.
- **Preferred Practice 9:** The plan of care should include community and nonclinical services as well as healthcare services that respond to a patient's needs and preferences and contributes to achieving the patient's goals.
- **Preferred Practice 10:** Healthcare organizations should utilize cardiac rehabilitation services to assist the healthcare home in coordinating rehabilitation and preventive care for patients with a recent cardiovascular event.

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Table 1: National Voluntary Consensus Standards for Care Coordination

Preferred Practices: Communication Domain

- **Preferred Practice 11:** The patient's plan of care should always be made available to the healthcare home team, the patient, and the patient's designees.
- **Preferred Practice 12:** All healthcare home team members, including the patient and his or her designees, should work within the same plan of care and share responsibility for their contributions to the plan of care and for achieving the patient's goals.
- **Preferred Practice 13:** A program should be used that incorporates a care partner to support family and friends when caring for a hospitalized patient.
- **Preferred Practice 14:** The provider's perspective of care coordination activities should be assessed and documented.

Preferred Practices: Information Systems Domain

- **Preferred Practice 15:** Standardized, integrated, interoperable, electronic, information systems with functionalities that are essential to care coordination, decision support, and quality measurement and practice improvement should be used.
- **Preferred Practice 16:** An electronic record system should allow the patient's health information to be accessible to caregivers at all points of care.
- **Preferred Practice 17:** Regional health information systems, which may be governed by various partnerships, including public/private, state/local agencies, should enable healthcare home teams to access all patient information.

Preferred Practices: Transitions or Handoffs Domain

- **Preferred Practice 18:** Decisionmaking and planning for transitions of care should involve the patient, and, according to patient preferences, family, and caregivers (including the healthcare home team). Appropriate follow-up protocols should be used to assure timely understanding and endorsement of the plan by the patient and his or her designees.
- **Preferred Practice 19:** Patients and their designees should be engaged to directly participate in determining and preparing for ongoing care during and after transitions.
- **Preferred Practice 20:** Systematic care transitions programs that engage patients and families in self-management after being transferred home should be used whenever available.
- **Preferred Practice 21:** For high-risk chronically ill older adults, an evidence-based multidisciplinary, transitional care practice that provides comprehensive in-hospital planning, home-based visits, and telephone follow-up, such as the Transitional Care Model, should be deployed.
- **Preferred Practice 22:** Healthcare organizations should develop and implement a standardized communication template for the transitions of care process, including a minimal set of core data elements that are accessible to the patient and his or her designees during care.

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Table 1: National Voluntary Consensus Standards for Care Coordination

- **Preferred Practice 23:** Healthcare providers and healthcare organizations should implement protocols and policies for a standardized approach to all transitions of care. Policies and procedures related to transitions and the critical aspects should be included in the standardized approach.
- **Preferred Practice 24:** Healthcare providers and healthcare organizations should have systems in place to clarify, identify, and enhance mutual accountability (complete/confirmed communication loop) of each party involved in a transition of care.
- **Preferred Practice 25:** Healthcare organizations should evaluate the effectiveness of transition protocols and policies, as well as evaluate transition outcomes.

Performance Measures for Care Coordination

- Cardiac rehabilitation patient referral from an inpatient setting
- Cardiac rehabilitation patient referral from an outpatient setting
- Patients with a transient ischemic event ER visit who had a follow-up office visit
- Biopsy follow-up
- Reconciled medication list received by discharged patients (inpatient discharges to home/self care or any other site of care)
- Transition record with specified elements received by discharged patients (inpatient discharges to home/self-care or any other site of care)
- Timely transmission of transition record (inpatient discharges to home/self care or any other site of care)
- Transition record with specified elements received by discharged patients (emergency department discharges to ambulatory care [home/self care])
- Melanoma continuity of care – recall system
- 3-Item Care Transitions Measure (CTM-3)[a]

[a] This NQF-endorsed measure was reviewed for continued endorsement.

Appendix A
Specifications of the National Voluntary Consensus Standards for Care Coordination

THE FOLLOWING TABLE PRESENTS the detailed specifications for the National Quality Forum (NQF)-endorsed® *National Voluntary Consensus Standards for Care Coordination.* All information presented has been derived directly from measure sources/developers without modification or alteration (except when the measure developer agreed to such modification during the NQF Consensus Development Process) and is current as of December 2009. All NQF-endorsed voluntary consensus standards are open source, meaning they are fully accessible and disclosed.

Appendix A – Specifications of the National Voluntary Consensus Standards for Care Coordination

MEASURE TITLE	MEASURE NUMBERS	MEASURE STEWARD[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Cardiac rehabilitation patient referral from an inpatient setting	Measure ID #: 0642 Review #: CC-019-09	ACCF/AHA Task Force	**Numerator Statement** Number of eligible patients with a qualifying event/diagnosis who have been referred to an outpatient cardiac rehabilitation program prior to hospital discharge, or who have a documented medical or patient-oriented reason why such a referral was not made. *(Note: the program may include a traditional program based on face-to-face interactions or training sessions or may include other options such as home-based approaches. If alternative methods are used, they should be designed to meet appropriate safety standards.)* **Numerator Details** A referral is defined as an official communication between the healthcare provider and the patient to recommend and carry out a referral order to an early outpatient cardiac rehabilitation program. This includes the provision of all necessary information to the patient that will allow the patient to enroll in	**Denominator Statement** All hospitalized patients in the reporting period hospitalized with a qualifying cardiovascular disease event who do not meet any of the exclusion criteria. **Denominator Details** Qualifying cardiovascular disease events including the following: (1) Acute myocardial infarction (defined by standardized criteria on the basis of cardiac pain, electrocardiographic data, and biomarker levels, (2) Coronary artery bypass graft (CABG) surgery, (3) Chronic stable angina (characterized as a deep, poorly localized chest or arm discomfort that is reproducibly associated with physical exertion or emotional stress and is relieved promptly (i.e., less than 5 minutes) with rest and/or the use of sublingual nitroglycerin (NTG)) , (4) Cardiac valve surgery (surgical repair or replacement of the aortic, mitral, pulmonic or tricuspid valves), and (5) Cardiac transplantation.	**Denominator Exclusions** Exclusion criteria include documentation of one of more of the following barriers to cardiac rehabilitation participation: (1) Patient factors (patient to be discharged to a nursing care facility for long-term care, for example), (2) Medical factors (patient deemed by provider to have a medically unstable, life-threatening condition, for example), (3) Healthcare system factors (no cardiac rehabilitation program available within 60 minutes of travel time from the patient's home, for example).	• Electronic Health/Medical Record • Electronic Clinical Registry - National Cardiovascular Data Registry (NCDR), ACTION-Get With the Guidelines Inpatient Registry • Electronic Claims • Paper Medical Record

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[a] Measure Steward(s). For the most current specifications and supporting information, please refer to the Measure Steward:

AAD - American Academy of Dermatology (**www.aad.org**)
ACCF (American College of Cardiology Foundation)/AHA (American Heart Association) Task Force (**www.americanheart.org**)
AMA PCPI - American Medical Association (AMA)-convened Physician Consortium for Performance Improvement (**www.ama-assn.org**)
Ingenix (**www.ingenix.com**)
NCQANational Committee for Quality Assurance (**www.ncqa.org**)

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Cardiac rehabilitation patient referral from an inpatient setting *(continued)*			an early outpatient cardiac rehabilitation program. This also includes written or electronic communication between the healthcare provider or healthcare system and the cardiac rehabilitation program that includes the patient's enrollment information for the program. A hospital discharge summary or office note may be potentially formatted to include the necessary patient information to communicate to the cardiac rehabilitation program [the patient's cardiovascular history, testing, and treatments, for instance]. All communications must maintain appropriate confidentiality as outlined by the 1996 Health Insurance Portability and Accountability Act (HIPAA). *Detailed specifications and coding are available at www.qualityforum.org/projects/care_coordination.aspx.*	Patients with a qualifying event who are to be discharged for a short-term stay in an inpatient medical rehabilitation facility are still expected to be referred to an outpatient cardiac rehabilitation program by the in-patient team during the index hospitalization. This referral should be reinforced by the care team at the medical rehabilitation facility. *Detailed specifications and coding are available at www.qualityforum.org/projects/care_coordination.aspx.*		

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MEASURE TITLE	MEASURE NUMBERS	MEASURE STEWARD[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Cardiac rehabilitation patient referral from an outpatient setting	Measure ID #: 0643 Review #: CC-020-09	ACCF/AHA Task Force	**Numerator Statement** Number of patients in an outpatient practice who have had a qualifying event/diagnosis in the previous 12 months who have been referred to an outpatient cardiac rehabilitation/ secondary prevention program. (*Note: the program may include a traditional program based on face-to-face interactions or training sessions or may include other options such as home-based approaches. If alternative methods are used, they should be designed to meet appropriate safety standards.)* **Numerator Details** A referral is defined as an official communication between the healthcare provider and the patient to recommend and carry out a referral order to an early outpatient cardiac rehabilitation program. This includes the provision of all necessary information to the patient that will allow the patient to enroll in an early outpatient cardiac rehabilitation program. This also includes written or electronic communication between the healthcare provider or healthcare system and the cardiac	**Denominator Statement** Number of patients in an outpatient clinical practice who have had a qualifying cardiovascular event in the previous 12 months, who do not meet any of the exclusion criteria, and who have not participated in an outpatient cardiac rehabilitation program since the cardiovascular event. **Denominator Details** Qualifying cardiovascular disease events including the following: (1) Acute myocardial infarction (defined by standardized criteria on the basis of cardiac pain, electrocardiographic data, and biomarker levels), (2) Coronary artery bypass graft (CABG) surgery, (3) chronic stable angina (characterized as a deep, poorly localized chest or arm discomfort that is reproducibly associated with physical exertion or emotional stress and is relieved promptly (i.e., less than 5 minutes) with rest and/or the use of sublingual nitroglycerin (NTG)) , (4) Cardiac valve surgery (surgical repair or replacement of the aortic, mitral, pulmonic or tricuspid valves), and (5) cardiac transplantation. *Detailed specifications and coding are available at www.qualityforum.org/projects/care_coordination.aspx*.	**Denominator Exclusions** Exclusion criteria include documentation of one of more of the following barriers to cardiac rehabilitation participation: (1) Patient factors (patient resides in a long-term nursing care facility, for example), (2) Medical factors (patient deemed by provider to have a medically unstable, life-threatening condition), (3) Healthcare system factors (no cardiac rehabilitation program available within 60 minutes of travel time from the patient's home, for example). The outpatient setting where this measure would apply includes the outpatient practice setting of the clinician who provides the primary cardiovascular-related care for the patient. In general, this would be the patient's cardiologist, but in some cases it might be a family physician, internist, nurse practitioner, or other healthcare provider.	• Electronic Health/Medical Record • Electronic Clinical Registry - National Cardiovascular Data Registry (NCDR), ACTION-Get With the Guidelines Inpatient Registry • Electronic Claims • Paper Medical Record

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Cardiac rehabilitation patient referral from an outpatient setting *(continued)*			rehabilitation program that includes the patient's enrollment information for the program. A hospital discharge summary or office note may be potentially formatted to include the necessary patient information to communicate to the cardiac rehabilitation program [the patient's cardiovascular history, testing, and treatments, for instance.] According to standards of practice for cardiac rehabilitation programs, care coordination communications are sent to the referring provider, including any issues regarding treatment changes, adverse treatment responses, or new non-emergency condition (new symptoms, patient care questions, etc.) that need attention by the referring provider. These communications also include a progress report once the patient has completed the program. All communications must maintain appropriate confidentiality as outlined by the 1996 Health Insurance Portability and Accountability Act (HIPAA). *Detailed specifications and coding are available at www.qualityforum.org/projects/care_coordination.aspx.*			

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MEASURE TITLE	MEASURE NUMBERS	MEASURE STEWARD[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Patients with a transient ischemic event ER visit that had a follow-up office visit	Measure ID #: 0644 Review #: CC-050-09	Ingenix	**Numerator Statement** Create a POST period from the day after the initiating Facility Event (i.e., the ER encounter for the transient cerebral ischemic event) through 14 days after the initiating Facility Event AND During the POST period, did the patient have any professional encounter (code set PR0107, RV0107) with any diagnosis. *Note: Will allow non-physician encounters (e.g., nurse practitioner and physician assistance encounters) to count toward numerator compliance as long as the provider(s) has submitted one of the face-to-face encounter codes (e.g., 99213) listed in our code set.* **Numerator Details** *See www.qualityforum.org/projects/care_coordination.aspx.*	**Denominator Statement** For condition confirmation, patients must meet the following criteria: 1. All males or females that are 18 years or older at the end of the report period 2. Patient must have been continuously enrolled: Medical benefits throughout the 12 months prior to the end of the report period AND Pharmacy benefit plan for 6 months prior to the end of the report period *Note: The standard enrollment break logic allows unlimited breaks of no more than 45 days and no breaks greater than 45 days.* 3. Either one of the following (A or B): A. The patient is listed on the Disease Registry Input File for this condition, if a Disease Registry Input File is available. *Note: Disease Registry is NOT a required input file.* B. During the 24 months prior to the end of the report period, patient has 2 or more that are at least 14 days apart of the following services, where the diagnosis is Occlusive Vascular Disease OR Stroke, non-hemorrhagic OR Transient cerebral	**Denominator Exclusions** None	• Electronic Claims

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MEASURE TITLE	MEASURE NUMBERS	MEASURE STEWARD[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Patients with a transient ischemic event ER visit that had a follow-up office visit *(continued)*				ischemia (code set DX0110, DX0146, DX0149): • Professional Encounter (code set PR0107, RV0107) • Professional Supervision (code set PR0108) • Facility Event – Confinement/Admission • Facility Event – Emergency Room • Facility Event – Outpatient Surgery In addition, for this measure, the patient must meet the following criteria: Create multiple temporary events for transient cerebral ischemic event. Set Episode Start Date to the date of service of any claim (i.e., initiating event) for the service and diagnosis stated below during the following window of time: 365 days prior to the end of the report period through 30 days prior to the end of the report period Facility Event – Emergency Room AND The primary diagnosis on the claim was: Transient cerebral ischemia (code set DX0149). **Denominator Details** *See www.qualityforum.org/projects/care_coordination.aspx.*		

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MEASURE TITLE	MEASURE NUMBERS	MEASURE STEWARD[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Biopsy follow-up	Measure ID #: 0645 Review #: CC-071-09	AAD	**Numerator Statement** Patients who are undergoing a biopsy whose biopsy results have been reviewed by the biopsying physician and communicated to the primary care physician and the patient, denoted by entering said physician's initials into a log, as well as by documentation in the patient's medical record. **Numerator Details** Not available at this time	**Denominator Statement** All patients undergoing a biopsy. **Denominator Details** 2P – Biopsy results not communicated with primary care physician due to patient refusal 3P – Biopsy not entered into log due to system reasons 8P – Reason not otherwise specified. Biopsy Procedure – CPT codes: 11100, 11101, 11755, 19100, 19101, 19102, 19103, 19295, 20200, 20205, 20206, 20220, 20250, 20251, 21550, 21920, 21925, 23065, 23066, 23100, 23101, 23105, 23106, 24065, 24066, 24100, 24101, 25065, 25066, 25100, 25101, 26100, 26105, 26110, 27040, 27041, 27050, 27052, 27323, 27324, 27330, 27331, 27613, 27614, 28050, 28052, 28054, 30100, 31050, 31051, 31237, 31510, 31576, 31625, 31628, 31629, +31632, +31633, 31717, 32095, 32100, 32400, 32402, 32405, 37200, 38500, 38505, 38510, 38520, 38525, 38530, 38570, 38571, 38572, 38792, 39400 37609, 38221,	**Denominator Exclusions** Patients not undergoing a biopsy	• Paper Medical Record

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Biopsy follow-up *(continued)*				40808, 41100-41105, 41108, 40490, 42100, 42405, 42800, 42802, 42804, 42806, 44010, 44020, 44100, 43202, 43600-43605, 44322, 43261, 43239, 44361, 44377, 44382, 44389, 44025, 45100, 45305, 45331, 45380, 45391, 45392, 46606, 47000, 47001, 47100, 47553, 47561, 48100, 49000, 49010, 50200, 50205, 50555, 50557, 50574, 50576, 50955, 50957, 50974, 50976, 52204, 52224, 52250, 52354, 53200, 54100, 54105, 54500, 54505, 54800, 54865, 55700, 55705, 55706, 56605, +56606, 56821, 57100, 57105, 57421, 58100, +58110, 58558, 58900, 59015, 60100, 60540, 60545, 61140, 61332, 61575, 61576, 61750, 61751, 62269, 63275, 63276, 63277, 63278, 63280, 63281, 63282, 63283, 63285, 63286, 63287, 63290, 63615, 65410, 67400, 67415, 67450, 67810, 68100, 69100, 69105, 89290, 89291, 93505		

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MEASURE TITLE	MEASURE NUMBERS	MEASURE STEWARD[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Reconciled medication list received by discharged patients (inpatient discharges to home/self care or any other site of care)	Measure ID #: 0646 Review #: CC-073-09	AMA PCPI	**Numerator Statement** Patients or their caregiver(s) who received a reconciled medication list at the time of discharge including, at a minimum, medications in the following categories: Medications to be TAKEN by patient: • Continued* Medications prescribed before inpatient stay that patient should continue to take after discharge, including any change in dosage or directions AND • New* Medications started during inpatient stay that are to be continued after discharge and newly prescribed medications that patient should begin taking after discharge. **Prescribed dosage, instructions, and intended duration must be included for each continued and new medication listed.* Medications NOT to be taken by patient: • Discontinued Medications taken by patient before the inpatient stay that should be discontinued or held after discharge,	**Denominator Statement** All patients, regardless of age, discharged from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self care or any other site of care. **Denominator Details** The denominator may be identified using UB-04 claims data: UB-04 (Form Locator 04 - Type of Bill): • 0111 (Hospital, Inpatient, Admit through Discharge Claim) • 0121 (Hospital, Inpatient - Medicare Part B only, Admit through Discharge Claim) • 0114 (Hospital, Inpatient, Last Claim) • 0124 (Hospital, Inpatient - Medicare Part B only, Interim - Last Claim) • 0211 (Skilled Nursing - Inpatient, Admit through Discharge Claim) • 0214 (Skilled Nursing - Inpatient, Interim, Last Claim) • 0221 (Skilled Nursing - Inpatient, Medicare Part B only, Admit through Discharge Claim) • 0224 (Skilled Nursing - Interim, Last Claim) • 0281 (Skilled Nursing - Swing Beds, Admit through Discharge Claim)	**Denominator Exclusions** Patients who died. Patients who left against medical advice (AMA) or discontinued care.	• Electronic Health/Medical Record • Paper Medical Record • Hybrid, electronic data collection supplemented with medical record abstraction

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MEASURE TITLE	MEASURE NUMBERS	MEASURE STEWARD[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Reconciled medication list received by discharged patients (inpatient discharges to home/self care or any other site of care) *(continued)*			AND • Allergies and Adverse Reactions Medications administered during the inpatient stay that caused an allergic reaction or adverse event and were therefore discontinued. Time Window: Each time a patient is discharged from an inpatient facility. **Numerator Details** Numerator details to be obtained through medical record abstraction. See Retrospective data collection tool in measure worksheet document for numerator details. Definitions specific to Measure #XXXX: • For the purposes of this measure, "medications" includes prescription, over-the-counter, and herbal products. Generic and proprietary names should be provided for each medication, when available. • Given the complexity of the medication reconciliation process and variability across inpatient facilities in documentation of that process, this measure does not require that the medication list be organized under the "Taken/NOT taken" headings OR the specified sub-categories,	• 0284 (Skilled Nursing - Swing Beds, Interim, Last Claim) AND Discharge Status (Form Locator 17): • 01 (Discharged to home care or self care (routine discharge) • 02 (Discharged/transferred to a short-term general hospital for inpatient care) • 03 (Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care) • 04 (Discharged/transferred to an intermediate-care facility) • 05 Discharged/transferred to a designated cancer center or children's hospital • 06 (Discharged/transferred to home under care of organized home health service org. in anticipation of covered skilled care) • 43 (Discharged/transferred to a federal healthcare facility) • 50 (Hospice – home) • 51 (Hospice - medical facility (certified) providing hospice level of care) • 61 (Discharged/transferred to hospital-based Medicare-approved swing bed)		

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MEASURE TITLE	MEASURE NUMBERS	MEASURE STEWARD[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Reconciled medication list received by discharged patients (inpatient discharges to home/self care or any other site of care) *(continued)*			provided that the status of each medication (continued, new, or discontinued) is specified within the list AND any allergic reactions are identified. Detailed specifications with coding can be found at **http://www.ama-assn.org/ama1/pub/upload/mm/370/care-transitions-ms.pdf.**	• 62 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital) • 63 (Discharged/transferred to a Medicare-certified long-term care hospital (LTCH)) • 64 (Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare) • 65 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital) • 66 (Discharged/transferred to a Critical Access Hospital (CAH)) • 70 (Discharged/transferred to another type of healthcare institution not defined elsewhere in this code list) OR UB-04 (Form Locator 04 - Type of Bill): • 0131 (Hospital Outpatient, Admit through Discharge Claim) • 0134 (Hospital Outpatient, Interim, Last Claim) AND UB-04 (Form Locator 42 - Revenue Code): • 0762 (Hospital Observation)		

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Reconciled medication list received by discharged patients (inpatient discharges to home/self care or any other site of care) *(continued)*				• 0490 (Ambulatory Surgery) • 0499 (Other Ambulatory Surgery) AND Discharge Status (Form Locator 17): • 01 (Discharged to home care or self care (routine discharge) • 02 (Discharged/transferred to a short-term general hospital for inpatient care) • 03 (Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care) • 04 (Discharged/transferred to an intermediate-care facility) • 05 Discharged/transferred to a designated cancer center or children's hospital • 06 (Discharged/transferred to home under care of organized home health service org. in anticipation of covered skilled care) • 43 (Discharged/transferred to a federal healthcare facility) • 50 (Hospice - home) • 51 (Hospice - medical facility (certified) providing hospice level of care) • 61 (Discharged/transferred to hospital-based Medicare-approved swing bed)		

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MEASURE TITLE	MEASURE NUMBERS	MEASURE STEWARD[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Reconciled medication list received by discharged patients (inpatient discharges to home/self care or any other site of care) *(continued)*				• 62 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital) • 63 (Discharged/transferred to a Medicare-certified long-term care hospital (LTCH)) • 64 (Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare) • 65 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital) • 66 (Discharged/transferred to a Critical Access Hospital (CAH)) • 70 (Discharged/transferred to another type of healthcare institution not defined elsewhere in this code list). Detailed specifications with coding can be found at **http://www.ama-assn.org/ama1/pub/upload/mm/370/care-transitions-ms.pdf.**		

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MEASURE TITLE	MEASURE NUMBERS	MEASURE STEWARD[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Transition record with specified elements received by discharged patients (inpatient discharges to home/self care or any other site of care)	Measure ID #: 0647 Review #: CC-074-09	AMA PCPI	**Numerator Statement** Patients or their caregiver(s) who received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, all of the following elements: Inpatient Care: • Reason for inpatient admission, AND • Major procedures and tests performed during inpatient stay and summary of results, AND • Principal diagnosis at discharge Post-Discharge/Patient Self-Management: • Current medication list, AND • Studies pending at discharge (e.g., laboratory, radiological), AND • Patient instructions Advance Care Plan: • Advance directives or surrogate decision maker documented OR • Documented reason for not providing advance care plan • Contact Information/Plan for Follow-up Care:	**Denominator Statement** All patients, regardless of age, discharged from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self care or any other site of care. Time Window: Each time a patient is discharged from an inpatient facility. **Denominator Details** UB-04 (Form Locator 04 - Type of Bill): • 0111 (Hospital, Inpatient, Admit through Discharge Claim) • 0121 (Hospital, Inpatient - Medicare Part B only, Admit through Discharge Claim) • 0114 (Hospital, Inpatient, Last Claim) • 0124 (Hospital, Inpatient - Medicare Part B only, Interim - Last Claim) • 0211 (Skilled Nursing - Inpatient, Admit through Discharge Claim) • 0214 (Skilled Nursing - Inpatient, Interim, Last Claim) • 0221 (Skilled Nursing - Inpatient, Medicare Part B only, Admit through Discharge Claim) • 0224 (Skilled Nursing - Interim, Last Claim)	**Denominator Exclusions** Patients who died. Patients who left against medical advice (AMA) or discontinued care.	• Electronic Health/Medical Record • Paper Medical Record • Hybrid, electronic data collection supplemented with medical record abstraction

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MEASURE TITLE	MEASURE NUMBERS	MEASURE STEWARD[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Transition record with specified elements received by discharged patients (inpatient discharges to home/self care or any other site of care) *(continued)*			• 24-hour/7-day contact information including physician for emergencies related to inpatient stay, AND • Contact information for obtaining results of studies pending at discharge, AND • Plan for follow-up care, AND • Primary physician, other health care professional, or site designated for follow-up care. Time Window: Each time a patient is discharged from an inpatient facility. **Numerator Details:** Numerator details to be obtained through medical record abstraction. See Retrospective data collection tool in measure worksheet document for numerator details. Definitions specific to Measure #XXXX: a. Transition record: a core, standardized set of data elements related to patient's diagnosis, treatment, and care plan that is discussed with and provided to patient in a printed or electronic format at each transition of care, and transmitted to the facility/physician/other healthcare professional providing follow-up care. Electronic format may	• 0281 (Skilled Nursing - Swing Beds, Admit through Discharge Claim) • 0284 (Skilled Nursing - Swing Beds, Interim, Last Claim) AND Discharge Status (Form Locator 17): • 01 (Discharged to home care or self care (routine discharge) • 02 (Discharged/transferred to a short-term general hospital for inpatient care) • 03 (Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care) • 04 (Discharged/transferred to an intermediate-care facility) • 05 Discharged/transferred to a designated cancer center or children's hospital • 06 (Discharged/transferred to home under care of organized home health service org. in anticipation of covered skilled care) • 43 (Discharged/transferred to a federal healthcare facility) • 50 (Hospice - home)		

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MEASURE TITLE	MEASURE NUMBERS	MEASURE STEWARD[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Transition record with specified elements received by discharged patients (inpatient discharges to home/self care or any other site of care) *(continued)*			be provided only if acceptable to patient. b. Current medication list: all medications to be taken by patient after discharge, including all continued and new medications. c. Advance directives: e.g., written statement of patient wishes regarding future use of life-sustaining medical treatment. d. Documented reason for not providing advance care plan: documentation that advance care plan was discussed but patient did not wish or was not able to name a surrogate decisionmaker or provide an advance care plan, OR documentation as appropriate that the patient's cultural and/or spiritual beliefs preclude a discussion of advance care planning as it would be viewed as harmful to the patient's beliefs and thus harmful to the physician-patient relationship. e. Contact information/plan for follow-up care: for patients discharged to an inpatient facility, the transition record may indicate that these four elements are to be discussed between the	• 51 (Hospice - medical facility (certified) providing hospice level of care) • 61 (Discharged/transferred to hospital-based Medicare- approved swing bed) • 62 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital) • 63 (Discharged/transferred to a Medicare-certified long- term care hospital (LTCH)) • 64 (Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare) • 65 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital) • 66 (Discharged/transferred to a Critical Access Hospital (CAH)) • 70 (Discharged/transferred to another type of healthcare institution not defined elsewhere in this code list) UB-04 (Form Locator 04 - Type of Bill): • 0131 (Hospital Outpatient, Admit through Discharge Claim) • 0134 (Hospital Outpatient, Interim, Last Claim)		

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MEASURE TITLE	MEASURE NUMBERS	MEASURE STEWARD[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Transition record with specified elements received by discharged patients (inpatient discharges to home/self care or any other site of care) *(continued)*			discharging and the "receiving" facilities. f. Plan for follow-up care: may include any postdischarge therapy needed (e.g., oxygen therapy, physical therapy, occupational therapy), any durable medical equipment needed, family/psychosocial resources available for patient support, etc. g. Primary physician or other health-care professional designated for follow-up care: may be designated primary care physician (PCP), medical specialist, or other physician or healthcare professional. Detailed specifications with coding can be found at **http://www.ama-assn.org/ama1/pub/upload/mm/370/care-transitions-ms.pdf.**	AND UB-04 (Form Locator 42 - Revenue Code): • 0762 (Hospital Observation) • 0490 (Ambulatory Surgery) • 0499 (Other Ambulatory Surgery) AND Discharge Status (Form Locator 17): • 01 (Discharged to home care or self care (routine discharge) • 02 (Discharged/transferred to a short-term general hospital for inpatient care) • 03 (Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care) • 04 (Discharged/transferred to an intermediate-care facility) • 05 Discharged/transferred to a designated cancer center or children's hospital • 06 (Discharged/transferred to home under care of organized home health service org. in anticipation of covered skilled care) • 43 (Discharged/transferred to a federal healthcare facility) • 50 (Hospice - home)		

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MEASURE TITLE	MEASURE NUMBERS	MEASURE STEWARD[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Transition record with specified elements received by discharged patients (inpatient discharges to home/self care or any other site of care) *(continued)*				• 51 (Hospice - medical facility (certified) providing hospice level of care) • 61 (Discharged/transferred to hospital-based Medicare- approved swing bed) • 62 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital) • 63 (Discharged/transferred to a Medicare-certified long-term care hospital (LTCH)) • 64 (Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare) • 65 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital) • 66 (Discharged/transferred to a Critical Access Hospital (CAH)) • 70 (Discharged/transferred to another type of healthcare institution not defined elsewhere in this code list). Detailed specifications with coding can be found at **http://www.ama-assn.org/ama1/pub/upload/mm/370/care-transitions-ms.pdf.**		

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MEASURE TITLE	MEASURE NUMBERS	MEASURE STEWARD[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Timely transmission of transition record (inpatient discharges to home/self care or any other site of care	Measure ID #: 0648 Review #: CC-075-09	AMA PCPI	**Numerator Statement** Patients for whom a transition record was transmitted to the facility or primary physician or other healthcare professional designated for follow-up care within 24 hours of discharge. Time Window: Each time a patient is discharged from an inpatient facility. **Numerator Details** Numerator details to be obtained through medical record abstraction. See Retrospective data collection tool in measure worksheet document for numerator details. Definitions specific to Measure #XXXX: a. Transition record: a core, standardized set of data elements related to patient's diagnosis, treatment, and care plan that is discussed with and provided to patient in a printed or electronic format at each transition of care, and transmitted to the facility/physician/other healthcare professional providing follow-up care. Electronic format may be provided only if acceptable to patient.	**Denominator Statement** All patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self care or any other site of care. Time Window: Each time a patient is discharged from an inpatient facility. **Denominator Details** UB-04 (Form Locator 04 - Type of Bill): • 0111 (Hospital, Inpatient, Admit through Discharge Claim) • 0121 (Hospital, Inpatient - Medicare Part B only, Admit through Discharge Claim) • 0114 (Hospital, Inpatient, Last Claim) • 0124 (Hospital, Inpatient - Medicare Part B only, Interim - Last Claim) • 0211 (Skilled Nursing - Inpatient, Admit through Discharge Claim) • 0214 (Skilled Nursing - Inpatient, Interim, Last Claim) • 0221 (Skilled Nursing - Inpatient, Medicare Part B only, Admit through Discharge Claim) • 0224 (Skilled Nursing - Interim, Last Claim)	**Denominator Exclusions** Patients who died. Patients who left against medical advice (AMA) or discontinued care.	• Electronic Health/Medical Record • Paper Medical Record • Hybrid, electronic data collection supplemented with medical record abstraction

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MEASURE TITLE	MEASURE NUMBERS	MEASURE STEWARD[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Timely transmission of transition record (inpatient discharges to home/self care or any other site of care *(continued)*			b. Transmitted: transition record may be transmitted to the facility or physician or other healthcare professional designated for follow-up care via fax, secure e-mail, or mutual access to an electronic health record (EHR). c. Primary physician or other healthcare professional designated for follow-up care: may be designated primary care physician (PCP), medical specialist, or other physician or healthcare professional. Detailed specifications with coding can be found at **http://www.ama-assn.org/ama1/pub/upload/mm/370/care-transitions-ms.pdf**	• 0281 (Skilled Nursing - Swing Beds, Admit through Discharge Claim) • 0284 (Skilled Nursing - Swing Beds, Interim, Last Claim) AND Discharge Status (Form Locator 17): • 01 (Discharged to home care or self care (routine discharge) • 02 (Discharged/transferred to a short-term general hospital for inpatient care) • 03 (Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care) • 04 (Discharged/transferred to an intermediate-care facility) • 05 (Discharged/transferred to a designated cancer center or children's hospital) • 06 (Discharged/transferred to home under care of organized home health service org. in anticipation of covered skilled care) • 43 (Discharged/transferred to a federal healthcare facility) • 50 (Hospice - home) • 51 (Hospice - medical facility (certified) providing hospice level of care)		

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MEASURE TITLE	MEASURE NUMBERS	MEASURE STEWARD[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Timely transmission of transition record (inpatient discharges to home/self care or any other site of care *(continued)*				• 61 (Discharged/transferred to hospital-based Medicare-approved swing bed) • 62 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital) • 63 (Discharged/transferred to a Medicare-certified long-term care hospital (LTCH)) • 64 (Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare) • 65 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital) • 66 (Discharged/transferred to a Critical Access Hospital (CAH)) • 70 (Discharged/transferred to another type of healthcare institution not defined elsewhere in this code list) OR UB-04 (Form Locator 04 - Type of Bill): • 0131 (Hospital Outpatient, Admit through Discharge Claim) • 0134 (Hospital Outpatient, Interim, Last Claim) AND		

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MEASURE TITLE	MEASURE NUMBERS	MEASURE STEWARD[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Timely transmission of transition record (inpatient discharges to home/self care or any other site of care *(continued)*				UB-04 (Form Locator 42 - Revenue Code): • 0762 (Hospital Observation) • 0490 (Ambulatory Surgery) • 0499 (Other Ambulatory Surgery) AND Discharge Status (Form Locator 17): • 01 (Discharged to home care or self care (routine discharge) • 02 (Discharged/transferred to a short-term general hospital for inpatient care) • 03 (Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care) • 04 (Discharged/transferred to an intermediate-care facility) • 05 (Discharged/transferred to a designated cancer center or children's hospital) • 06 (Discharged/transferred to home under care of organized home health service org. in anticipation of covered skilled care) • 43 (Discharged/transferred to a federal healthcare facility) • 50 (Hospice - home) • 51 (Hospice - medical facility (certified) providing hospice level of care)		

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MEASURE TITLE	MEASURE NUMBERS	MEASURE STEWARD[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Timely transmission of transition record (inpatient discharges to home/self care or any other site of care *(continued)*				• 61 (Discharged/transferred to hospital-based Medicare-approved swing bed) • 62 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital) • 63 (Discharged/transferred to a Medicare-certified long-term care hospital (LTCH)) • 64 (Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare) • 65 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital) • 66 (Discharged/transferred to a Critical Access Hospital (CAH)) • 70 (Discharged/transferred to another type of healthcare institution not defined elsewhere in this code list). Detailed specifications with coding can be found at **http://www.ama-assn.org/ama1/pub/upload/mm/370/care-transitions-ms.pdf.**		

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MEASURE TITLE	MEASURE NUMBERS	MEASURE STEWARD[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Transition record with specified elements received by discharged patients (emergency department discharges to ambulatory care [home/self care])	Measure ID #: 0649 Review #: CC-076-09	AMA PCPI	**Numerator Statement** Patients or their caregiver(s) who received a transition record at the time of emergency department (ED) discharge including, at a minimum, all of the following elements: • Major procedures and tests performed during ED visit, AND • Principal diagnosis at discharge OR chief complaint, AND • Patient instructions, AND • Plan for follow-up care (OR statement that none required), including primary physician, other healthcare professional, or site designated for follow-up care, AND • List of new medications and changes to continued medications that patient should take after ED discharge, with quantity prescribed and/or dispensed (OR intended duration) and instructions for each. **Numerator Details** Numerator details to be obtained through medical record abstraction. See Retrospective data collection tool in measure worksheet document for numerator details.	**Denominator Statement** All patients, regardless of age, discharged from an emergency department (ED) to ambulatory care (home/self care) or home health/ **Denominator Details** UB-04 (Form Locator 4 - Type of Bill): • 0131 (Hospital, Outpatient, Admit through Discharge Claim) AND UB-04 (Form Locator 42 - Revenue Code): • 0450 (Emergency Room) AND UB-04 (Form Locator 17 - Discharge Status): • 01 (Discharged to home care or self care (routine discharge)) • 06 (Discharged/transferred to home under care of organized home health service org. in anticipation of covered skilled care). Detailed specifications with coding can be found at **http://www.ama-assn.org/ama1/pub/upload/mm/370/care-transitions-ms.pdf.**	**Denominator Exclusions** Patients who died. Patients who left against medical advice (AMA) or discontinued care. Patients who declined receipt of transition record.	• Electronic Health/Medical Record • Paper Medical Record • Hybrid, electronic data collection supplemented with medical record abstraction

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MEASURE TITLE	MEASURE NUMBERS	MEASURE STEWARD[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Transition record with specified elements received by discharged patients (emergency department discharges to ambulatory care [home/self care]) *(continued)*			Definitions specific to Measure #XXXX: a. Transition record (for ED discharges): a core, standardized set of data elements related to patient's diagnosis, treatment, and care plan that is discussed with and provided to patient in written, printed, or electronic format. Electronic format may be provided only if acceptable to patient. b. Primary physician or other healthcare professional designated for follow-up care: may be primary care physician (PCP), medical specialist, or other physician or health care professional. If no physician, other healthcare professional, or site designated or available, patient may be provided with information on alternatives for obtaining follow-up care needed, which may include a list of community health services/other resources. Detailed specifications with coding can be found at **http://www.ama-assn.org/ama1/pub/upload/mm/370/care-transitions-ms.pdf.**			

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MEASURE TITLE	MEASURE NUMBERS	MEASURE STEWARD[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Melanoma continuity of care – recall system	Measure ID #: 0650 Review #: CC-078-09	AMA PCPI/ AAD/NCQA	**Numerator Statement** Patients whose information is entered, at least once within a 12-month period, into a recall system* that includes: • A target date for the next complete physical skin exam, AND • A process to follow up with patients who either did not make an appointment within the specified timeframe or who missed a scheduled appointment. **Numerator Details** Patient information entered into a recall system that includes target date for the next exam specified AND a process to follow up with patients regarding missed or unscheduled appointments (7010F) **To satisfy this measure, the recall system must be linked to a process to notify patients when their next physical exam is due and to follow up with patients who either did not make an appointment within the specified timeframe or who missed a scheduled appointment and must include the following elements at a minimum: patient identifier, patient contact information, cancer diagnosis(es), dates(s) of initial cancer diagnosis (if known), and the target date for the next complete physical exam.*	**Denominator Statement** All patients with a current diagnosis of melanoma or a history of melanoma. **Denominator Details** All patients, regardless of age, with a current diagnosis of melanoma or history of melanoma. ICD-9 diagnosis codes: 172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9, V10.82 AND CPT E/M codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245	**Denominator Exclusions** Documentation of system reason(s) for not entering patients into a recall system (e.g., melanoma being monitored by another provider): Append modifier to CPT Category II codes: 7010F-3P.	• Claims • Medical Record • Electronic Health/Medical Record • Hybrid, electronic data collection supplemented with medical record abstraction

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MEASURE TITLE	MEASURE NUMBERS	MEASURE STEWARD[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
3-Item Care Transition Measure (CTM-3)[1]	Measure ID #: 0228	Care Transitions Program	The 15-item and the 3-item CTM share the same set of response patterns: Strongly Disagree; Disagree; Agree; Strongly Agree (there is also a response for Don't Know; Don't Remember; Not Applicable). Based on a subject's response, a score can be assigned to each item as follows: • Strongly Disagree = 1 • Disagree = 2 • Agree = 3 • Strongly Agree = 4 Next, the scores can be aggregated across either the 15 or 3 items, and then transformed to a scale ranging from 0 to 100. Thus the denominator is 100 and the numerator can range from 0 to 100. Recommended to survey within 30 days of event.	The CTM has application to all hospitalized adults. Testing has not included children, but the measure may have potential application to this population as well. Persons with cognitive impairment have been included in prior testing, provided they are able to identify a willing and able proxy. The CTM has been tested in English- and Spanish-speaking (using an available Spanish version of the CTM) populations.		Standardized patient survey

[1] NQF-endorsed measure, recommended for continued endorsement.