# APPENDIX A-1: Data Abstraction Tool: Care Coordination Measures (CCM-1, CCM-2, CCM-3)

**INSTRUCTIONS**: Hospitals must refer to the appropriate version of data dictionary for abstraction guidelines that apply to this measure. Updated text throughout this tool is marked by the use of the *Emphasis* font style. The capital letters in parenthesis represents the field name that corresponds to the data element name.

# Provider Name (PROVNAME) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Provider ID (PROVIDER-ID)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (AlphaNumeric)

# First Name (FIRST-NAME) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Last Name (LAST-NAME)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Birthdate (BIRTHDATE) \_\_\_ \_\_\_ -\_\_\_ \_\_\_ - \_\_\_ \_\_\_ \_\_\_ \_\_\_

# Sex (SEX)

* *Male*
* *Assigned/Designated Male at Birth*
* *Female*
* *Assigned/Designated Female at Birth*
* *LGBTQ*
* *Unknown*

# Race Code (MHRACE) Select One Option

* R1 American Indian or Alaska Native
* R2 Asian
* R3 Black/African American
* R4 Native Hawaiian or other Pacific Islander
* R5 White
* R9 Other Race
* UNKNOW Unknown/not specified

# Hispanic Indicator (ETHNIC)

* Yes
* No

# Patient ID i.e. Medical Record Number (PATIENT-ID) \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ (Alpha/Numeric)

# Admission Date (ADMIT-DATE) \_\_\_ \_\_\_-\_\_\_ \_\_\_-\_\_\_ \_\_\_ \_\_\_ \_\_\_

# Discharge Date (DISCHARGE-DATE) \_\_\_ \_\_\_-\_\_\_ \_\_\_-\_\_\_ \_\_\_ \_\_\_ \_\_\_

# What was the patient’s discharge disposition on the day of discharge? (DISCHGDISP) (Select One Option)

* 01 = Home
* 02 = Hospice- Home
* 03 = Hospice- Health Care Facility
* 04 = Acute Care Facility
* 05 = Other Health Care Facility
* 06 = Expired (Review Ends)
* 07 = Left Against Medical Advice / AMA (Review Ends)
* 08 = Not Documented or Unable to Determine (UTD)

# What is the patient's primary source of Medicaid payment for care provided? (PMTSRCE)

|  |  |
| --- | --- |
| * 103 | MassHealth FFS Network, MassHealth Limited Plans |
| * 103 | Primary Care Clinician Management (PCCM) Plan |
| * 118 | Medicaid Managed Care: Massachusetts Behavioral Health Partnership |
| * *103* | *Medicaid Managed Care: Other (not listed elsewhere)* |
| * *288* | *Medicaid Managed Care: WellSense Health Plan* |
| * 7 | Medicaid Managed Care: Tufts Health Plan |
| * 311 | Medicaid Other ACO |
| * *4* | *Fallon Health-Atrius Health Care Collaborative* |
| * 4 | Berkshire Fallon Health Collaborative |
| * 4 | Fallon 365 Care |
| * 24 | Be Healthy Partnership with Health New England |
| * *288* | *East Boston Neighborhood Health WellSense Alliance* |
| * *288* | *WellSense Beth Israel Lahey Health (BILH) Performance Network ACO* |
| * *288* | *WellSense Boston Children’s ACO* |
| * *288* | *WellSense Care Alliance* |
| * *288* | *WellSense Community Alliance* |
| * 288 | WellSense Mercy Alliance |
| * 288 | WellSense Signature Alliance |
| * 288 | WellSense Southcoast Alliance |
| * 320 | Community Care Cooperative |
| * *322* | *Mass General Brigham Health Plan with Mass General Brigham ACO with Mass General Brigham (ACO)* |
| * 323 | Steward Health Choice (ACO) |
| * *7* | *Tufts Health Together with UMass Memorial Health* |
| * *7* | Tufts Health Together with Cambridge Health Alliance |
| * 328 | Tufts Medicine (ACO) |

# What is the patient’s MassHealth Member ID? (MHRIDNO) All alpha characters must be upper case.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Did the patient/ caregiver(s) or the next site of care for a transfer receive a Reconciled Medication List at the time of discharge? (RECONMEDLIST)

* Yes
* No

# Did the patient/ caregiver(s) (or the next site of care for a transfer) receive a Transition Record at the time of discharge? (Note: Only abstract from documents given to the patient. If the patient is a transfer, abstract from documentation provided to the next site of care) (TRREC)

* Yes
* No (Skip to Question #28)

# Does the Transition Record include the Reason for Inpatient Admission? (Note: Must be documented separately from the discharge diagnosis) (INPTADMREAS)

* Yes
* No

# Does the Transition Record include the Medical Procedure(s) and Test(s) and a Summary of Results or documentation of no procedures and tests? (PROCTEST)

* Yes
* No

# Does the Transition Record include the Discharge Diagnosis? (Note: Must be documented separately from the Reason for Inpatient Admission) (PRINDXDC)

* Yes
* No

# Does the Transition Record include a Current Medication List or documentation of no medications? (MEDLIST)

* Yes
* No

# Does the Transition Record include documentation of Studies Pending at Discharge or that no studies were pending? (STUDPENDDC)

* Yes
* No

# Does the Transition Record include Patient Instructions? (PATINSTR)

* Yes
* No

# Does the Transition Record include documentation of an Advance Care Plan? (ADVCAREPLN)

(Note: Patients < 18 years of age are excluded from Advance Care Plan)

* Yes
* No

# Does the Transition Record include 24 hr/ 7 day Contact Information for questions, concerns, or emergencies related to the inpatient stay*?* (CONTINFOHRDY)

* Yes
* No

# Does the Transition Record include Contact Information for obtaining results of Studies Pending at Discharge or documentation that no studies were pending? (Note- If documentation of “no studies pending”, select Yes) (CONTINFOSTPEND)

* Yes
* No

# Does the Transition Record include a Plan for Follow-up Care related to the inpatient stayOR documentation by a physician of no follow-up care required OR patient is a transfer to another inpatient site of care? (PLANFUP)

* Yes
* No

# Does the Transition Record include the name of the Primary Physician or other Health Care Professional or site designated for follow-up care? (PPFUP)

* Yes
* No

# Is there documentation in the medical record of patient refusal of transmission to the next site of care, physician, or other health care professional designated for follow-up care? (PATROT)

* Yes. If yes, review ends.
* No

# What was the date documented in the medical record that the Transition Record was transmitted to the next provider or site of care? (Note: For patients transferred to another site of care, document the date of discharge) (TRDATE)

\_\_\_ \_\_\_-\_\_\_ \_\_\_-\_\_\_ \_\_\_ \_\_\_ \_\_\_ (MM-DD-YY or UTD)