**APPENDIX A-5:**

**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. Use of **italic and underlined font** throughout this tool indicates updated text has been inserted. The capital letters in parenthesis represents the field name that corresponds to the data element name.

1. Provider Name (PROVNAME) __________________________________________________________
2. Provider ID (PROVIDER-ID) ___________________________ (AlphaNumeric)
3. First Name (FIRST-NAME) _________________________________________________________
4. Last Name (LAST-NAME) __________________________________________________________
5. Birthdate (BIRTHDATE) ___ ___ ‘ ___ ‘ ___ ___ ___ ___
6. Sex (SEX) □ Female □ Male □ Unknown
7. Postal Code What is the postal code of the patient’s residence? (POSTAL-CODE) ___ ___ ___ ___ ___ ___ ___
   Five or nine digits, HOMELESS, or Non-US
8. 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
   □ UNKNOWN Unknown/not specified
9. Ethnicity Code – (ETHNICCODE) __ ______ __________
   (Alpha 6 characters, numeric is 5 numbers with – after 4th number)
10. Hispanic Indicator- (ETHNIC)
    □ Yes
    □ No
11. Hospital Bill Number (HOSPBILL#) _______ _______ _______ _______ _______ _______ _______ _______ _______ _______ _______ _______ _______ _______ _______ _______ _______ _______ _______ _______ _______ _______ _______ _______ _______ _______ _______ _______ _______ _______ _______ _______ (Alpha/Numeric – field size up to 20)
12. Patient ID i.e. Medical Record Number (PATIENT-ID) _____________________________ (Alpha/Numeric)
13. Admission Date (ADMIT-DATE) ____-____-____
14. Discharge Date (DISCHARGE-DATE) ____-____-____
15. 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)
16. What is the patient’s primary source of Medicaid payment for care provided? (PMTSRCE)

<table>
<thead>
<tr>
<th>Patient Source of Medicaid Payment for Care Provided</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid (includes MassHealth)</td>
<td>103</td>
</tr>
<tr>
<td>Medicaid Managed Care – Primary Care Clinician (PCC) Plan</td>
<td>104</td>
</tr>
<tr>
<td>MCD Managed Care - Fallon Community Health Plan</td>
<td>108</td>
</tr>
<tr>
<td>MCD Managed Care - Health New England</td>
<td>110</td>
</tr>
<tr>
<td>MCD – Neighborhood Health Plan</td>
<td>113</td>
</tr>
<tr>
<td>MCD Managed Care - Mass Behavioral Health Partnership Plan</td>
<td>118</td>
</tr>
<tr>
<td>MCD Managed Care- Network Health (Cambridge Health Alliance)</td>
<td>207/274</td>
</tr>
<tr>
<td>MCD Managed Care - HealthNet (Boston Medical Center)</td>
<td>208</td>
</tr>
<tr>
<td>BMC- MassHealth CarePlus</td>
<td>282</td>
</tr>
<tr>
<td>Fallon - MassHealth CarePlus</td>
<td>283</td>
</tr>
<tr>
<td>NHP- MassHealth CarePlus</td>
<td>284</td>
</tr>
<tr>
<td>Network Health- MassHealth CarePlus</td>
<td>285</td>
</tr>
<tr>
<td>Celticare- MassHealth CarePlus</td>
<td>286</td>
</tr>
<tr>
<td>MassHealthCarePlus</td>
<td>287</td>
</tr>
<tr>
<td>Medicaid Managed Care Other</td>
<td>119</td>
</tr>
<tr>
<td>Children’s Medical Security Plan (CMSP)</td>
<td>178</td>
</tr>
</tbody>
</table>

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

18. Does this case represent part of a sample? (SAMPLE)

- Yes
- No

19. 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

20. 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 #32)

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

- Yes
- No

22. 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

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

- Yes
- No

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

- Yes
- No
25. Does the Transition Record include documentation of Studies Pending at Discharge or that no studies were pending? (STUDPENDDC)
   □ Yes
   □ No

26. Does the Transition Record include Patient Instructions? (PATINSTR)
   □ Yes
   □ No

27. Does the Transition Record include documentation of an Advance Care Plan? (ADVACAREPLN)
   (Note: Patients < 18 years of age are excluded from Advance Care Plan)
   □ Yes
   □ No

28. Does the Transition Record include 24 hr/7 day Contact Information for questions, concerns, or emergencies related to the inpatient stay? (CONTINFOHRDY)
   □ Yes
   □ No

29. 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

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

31. 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

32. 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)