Quality Measures Fact Sheet

3-Item Care Transition Measure (CTM-3) (NQF #0228)

National Quality Strategy Domain: Communication and Care Coordination

Quality Measures Set: Alternate ***Data Source: Hospital Inpatient Quality Reporting Program***

BPCI Advanced and Quality

The Center for Medicare & Medicaid Innovation's (the CMS Innovation Center's) BPCI Advanced Model rewards health care providers for delivering services more efficiently, supports enhanced care coordination, and recognizes high quality care. Hospitals and clinicians should work collaboratively to achieve these goals, which have the potential to improve the BPCI Advanced Beneficiary experience and align to the CMS Quality Strategy goals of promoting effective communication and care coordination, highlighting best practices, and making care safer and more affordable. A goal of the BPCI Advanced Model is to promote seamless, patient-centered care throughout each Clinical Episode, regardless of who is responsible for a specific element of that care.

Background on 3-Item Care Transition Measure

The 3-Item Care Transition Measure (CTM-3) is a patient-centered survey measure that assesses patient self-reported preparation for hospital discharge by asking three key questions involving shared decision making, clearly communicating what the patient is responsible for after discharge, and educating the patient about the purpose of medications prescribed. The CTM-3 is one component of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey instrument. CMS has used, or is currently using, this measure in the following Federal programs: the Community-Based Care Transitions Model, the Hospital Inpatient Quality Reporting (IQR) Program, and the Hospital Value-Based Purchasing Program. CTM-3 performance reflects responses drawn from all adult patients discharged from general acute care hospitals (ACHs) within the past 30 days.

CMS Innovation Center Rationale for Including the CTM-3 Measure in BPCI Advanced

The CMS Innovation Center selected the CTM-3 measure because discharge from an ACH is a vulnerable time for Medicare beneficiaries.[1] Higher clinical acuity, combined with shorter lengths of stay, has contributed to increased complexity in hospital discharge instructions and higher expectations for patients to perform challenging self-care activities. Many factors may contribute to patients' lack of

[1] Coleman, E. A. (2003). Falling through the cracks: challenges and opportunities for improving transitional care for persons with continuous complex care needs. *Journal of the American Geriatrics Society*, *51*(4), 549-555. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/12657078.

understanding, including the volume of information conveyed, the relatively brief period allotted for hospital discharge education, and the influence of acute illness, sleep deprivation, and medication side effects. Patients often are unable to recall their discharge diagnoses, treatment plan, or explain how to take prescribed medications.[2] This lack of understanding may have serious consequences, including a preventable decline in health and functional status, suboptimal chronic illness management, and harm related to adverse effects from medications. Suboptimal care transitions may also lead to increased cost due to duplicative testing, emergency room visits, and readmissions.[3] Numerous interventions can improve the quality of care transitions including involving family and care givers in care planning, providing clear written materials, and facilitating early post-discharge follow-up.

Applicable Clinical Episodes

The CTM-3 measure is included in the Alternate Quality Measures Set and applies to the following inpatient Clinical Episodes[4]:

- Acute Myocardial Infarction: Medicare Severity–Diagnosis-Related Groups (MS-DRGs) 280, 281, and 282
- Back and Neck Except Spinal Fusion: MS-DRGs 518, 519, and 520
- Cardiac Arrhythmia: MS-DRGs 308, 309, and 310
- Cardiac Defibrillator Clinical Episode: MS-DRGs 222, 223, 224, 225, 226, and 227
- Cellulitis: MS-DRGs 602 and 603
- COPD, bronchitis, asthma: MS-DRGs 190, 191, 192, 202, and 203
- Disorders of the liver excluding malignancy, cirrhosis, alcoholic hepatitis: MS-DRGs 441, 442, and 443
- Fractures of the Femur and Hip or Pelvis: MS-DRGs 533, 534, 535, and 536
- Gastrointestinal hemorrhage: MS-DRGs 377, 378, and 379
- Gastrointestinal obstruction: MS-DRGs 388, 389, and 390
- Hip and Femur Procedures Except Major Joint: MS-DRGs 480, 481, and 482
- Inflammatory Bowel Disease: MS-DRGs 385, 386, and 387
- Lower Extremity and Humerus Procedure Except Hip, Foot, Femur: MS-DRGs 492, 493, and 494
- Major Bowel Procedure: MS-DRGs 329, 330, and 331
- Major Joint Replacement of the Upper Extremity: MS-DRG 483
- Pacemaker: MS-DRGs 242, 243, and 244
- Renal failure: MS-DRGs 682, 683, and 684
- Sepsis: MS-DRGs 870, 871, and 872
- Seizures: MS-DRGs 100 and 101
- Simple pneumonia and respiratory infections: MS-DRGs 177, 178, 179, 193, 194, and 195
- Spinal Fusion: MS-DRGs 453, 454, 455, 459, 460, 471, 472, and 473

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[2] Makaryus, A., & Friedman, E. (2005). Patients' understanding of their treatment plans and diagnosis at discharge. *Mayo Clinic Proceedings*, *80*(8), 991-994. Retrieved from: https://com-dom-im.sites.medinfo.ufl.edu/files/2012/07/5.17.04.-Help-patients-understand-their-hospitalizations.pdf.

[3] National Quality Forum (2018). Measure information for NQF #0228. Retrieved from: http://www.qualityforum.org/QPS/0228.

[4] MS-DRGs are up to date as of Model Year 3 (2020) and will be updated for Model Year 4 as needed.

- Transcatheter Aortic Valve Replacement (TAVR): MS-DRGs 266 and 267
- Urinary Tract Infection: MS-DRGs 689, and 690

Measure Specifications

The CTM-3 measure selected for BPCI Advanced follows National Quality Forum (NQF) #0228 measure specifications. The CTM-3 is a hospital-wide measure derived from HCAHPS survey data. Members of the care team can administer the HCAHPS survey by phone and/or mail within 48 hours to 30 days post discharge. For the three CTM-3 survey questions listed below, there are four response options for Question 1 and Question 2 (Strongly Disagree = 1, Disagree = 2, Agree = 3, and Strongly Agree = 4) and five response options for Question 3 (Strongly Disagree = 1, Disagree = 2, Agree = 3, Strongly Agree = 4, and "I was not given any medication when I left the hospital" = 5).

Q1: During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left.

Q2: When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.

Q3: When I left the hospital, I clearly understood the purpose for taking each of my medications.

The CMS Innovation Center will calculate ACH performance at the hospital level for all Medicare beneficiaries included in the denominator. For Physician Group Practices (PGPs), the CMS Innovation Center will calculate the measure as specified at the hospital level, then weight the measure based on PGP Clinical Episode volume for each ACH where a PGP triggers an episode.

Denominator

The denominator for the CTM-3 measure includes all sampled patients aged 18 years and older. The exclusions for this measure include patients:

- who died in the hospital
- who did not stay at least one night in the hospital
- as required by law or regulation in the state in which the hospital operates

Numerator

The numerator is the hospital level sum of CTM-3 scores for all eligible sampled Beneficiaries, where the Beneficiaries include individuals in the previously defined denominator. Hospitals (or their vendors) develop HCAHPS sampling frames of relevant discharges, draw samples of discharges to survey, and collect data from each sampled discharge.

Measure Submission

The CMS Innovation Center will calculate this measure using Medicare claims data and does not require action or reporting by Model Participants beyond what is currently involved in the Hospital IQR Program. To better align with the performance years of the BPCI Advanced Model, the Model uses January 1 through December 31 for measure calculation. The date of discharge on the index admission will determine the calendar year in which the claim belongs.

Revisions to the Published Specifications

The BPCI Advanced version of this measure is calculated using a one-year calendar period of data rather than any 12-month period. In Model Year 4, the data will be collected from January 1, 2021 to December 31, 2021.

Composite Quality Score

The CTM-3 measure is one component of the BPCI Advanced Composite Quality Score (CQS) calculation. The CMS Innovation Center uses the CQS to adjust a portion of any Positive Total Reconciliation Amount and any Negative Total Reconciliation Amount. The CQS adjustment will not adjust the Positive Total Reconciliation Amount down by more than 10 percent, nor will it adjust the Negative Total Reconciliation Amount up by more than 10 percent. More information is available at the BPCI Advanced website provided below.

Other Resources

Organization/Resource	Website Address
NQF #0228 specifications	http://www.qualityforum.org/QPS/0228
BPCI Advanced	https://innovation.cms.gov/initiatives/bpci-advanced
HCAHPS overview	https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalHCAHPS.html