

Measure #9a. Care Transitions Measure (CTM-3)

CARE COORDINATION MEASURE MAPPING TABLE

	MEASUREMENT PERSPECTIVE		
	<i>Patient/Family</i>	<i>Health Care Professional(s)</i>	<i>System Representative(s)</i>
CARE COORDINATION ACTIVITIES			
Establish accountability or negotiate responsibility			
Communicate			
<i>Interpersonal communication</i>			
<i>Information transfer</i>			
Facilitate transitions			
<i>Across settings</i>	■		
<i>As coordination needs change</i>			
Assess needs and goals	□		
Create a proactive plan of care			
Monitor, follow up, and respond to change			
Support self-management goals	□		
Link to community resources			
Align resources with patient and population needs			
BROAD APPROACHES POTENTIALLY RELATED TO CARE COORDINATION			
Teamwork focused on coordination			
Health care home			
Care management			
Medication management	□		
Health IT-enabled coordination			

Legend:

- = ≥ 3 corresponding measure items
- = 1-2 corresponding measure items

Care Transitions Measure (CTM-3)

Purpose: To evaluate the essential processes of care involved in successful care transitions, including information transfer, patient and caregiver preparation, self-management support, empowerment to assert preferences, from a patient-centered perspective.

Format/Data Source: 3-item written survey administered at time of discharge. All questions are answered on a 5-point Likert scale.

Date: Measure published in 2002.¹

Perspective: Patient/Family

Measure Item Mapping:

- **Facilitate transitions:**
 - Across settings: 1-3
- **Assess needs and goals:** 1
- **Support self-management goals:** 2, 3
- **Medication management:** 3

Development and Testing: Key domains and measure items were developed using input from patient focus groups. Psychometric evaluation established content validity, construct validity, absence of floor and ceiling effects, and intra-item variation.¹ The 3-item CTM explained 88 percent of the variance in the 15-item CTM score. No differential item difficulty by age, gender, education, self-rated health, or ethnic group was identified after differential item function analysis.² The CTM is an NQF-endorsed measure and has been applied to a range of high-risk patient populations, including frail older adults, adults with chronic health conditions, cancer patients, and children with special health care needs. Translated Hebrew and Arabic versions of the questionnaire have also been found to be reliable and valid.³

Link to Outcomes or Health System Characteristics: Patients with lower self-rated health status had significantly lower CTM scores, a result that is consistent with previous studies, suggesting that care coordination is especially important for individuals with complex health conditions. The measure also demonstrated the power to discriminate between: (1) patients discharged from the hospital that did/did not experience a subsequent emergency visit or rehospitalization for their index condition and (2) health care facilities with differing levels of commitment to care coordination.⁴

Logic Model/Conceptual Framework: None described in the sources identified.

Country: United States; translations available for use in other countries (see notes below).

Past or Validated Applications*:

- **Patient Age:** Children, Adults, Older Adults
- **Patient Condition:** General Population/Not Condition Specific
- **Setting:** Inpatient Facility, Primary Care Facility

*Based on the sources listed below and input from the measure developer.

Notes:

- All instrument items are located online.⁴
- This instrument contains 3 items; all 3 were mapped.
- Finnish and French translations of the CTM-3 are available online.⁴
- A validated 15-item version (CTM-15) is also available online in English, Spanish, Arabic, Hebrew, and Russian.⁴

Sources:

1. Coleman EA, Smith JD, Frank JC, et al. Development and testing of a measure designed to assess the quality of care transitions. *Int J Integr Care* 2002;2(1):1-9.
2. Parry C, Mahoney E, Chalmers SA, et al. Assessing the quality of transitional care: further applications of the care transitions measure. *Medical Care* 2008;46(3):317-22.
3. Shadmi E, Zisberg A, Coleman EA. Translation and validation of the Care Transition Measure into Hebrew and Arabic. *Int J Quality Health Care* 2009;21(2):97-102.
4. The Care Transitions Program: Improving Quality and Safety During Care Hand-Offs Web site. Available at: <http://www.caretransitions.org/articles.asp>. Accessed: 15 September 2010.
5. Coleman EA, Mahoney E, Parry C. Assessing the quality of preparation for post-hospital care from the patient's perspective: The Care Transitions Measure. *Med Care* 2005; 43(3):246-255.
6. Coleman EA, Parry C, Chalmers S, et al. The central role of performance measurement in improving the quality of transitional care. *Home Health Care Services Quarterly*. 2007; 26(4):93-104.