

MEDICAID PROMOTING INTEROPERABILITY PROGRAM ELIGIBLE PROFESSIONALS OBJECTIVES AND MEASURE FOR 2019 OBJECTIVE 7 of 8

Health Information Exchange	
Objective	The eligible professional (EP) provides a summary of care record when transitioning or referring their patient to another setting of care, receives or retrieves a summary of care record upon the receipt of a transition or referral or upon the first patient encounter with a new patient, and incorporates summary of care information from other providers into their electronic health record (EHR) using the functions of certified EHR technology (CEHRT).
Measures	<p>An EP must attest to all three measures and meet the threshold for two measures for this objective. If the EP meets the criteria for exclusion from two measures, they must meet the threshold for the one remaining measure. If they meet the criteria for exclusion from all three measures, they may be excluded from meeting this objective.</p> <p>Measure 1: For more than 50 percent of transitions of care and referrals, the EP that transitions or refers their patient to another setting of care or provider of care: (1) Creates a summary of care record using CEHRT; and (2) Electronically exchanges the summary of care record</p> <p>Measure 2: For more than 40 percent of transitions or referrals received and patient encounters in which the EP has never before encountered the patient, he/she incorporates into the patient’s EHR an electronic summary of care document.</p> <p>Measure 3: For more than 80 percent of transitions or referrals received and patient encounters in which the EP has never before encountered the patient, he/she performs a clinical information reconciliation. The EP must implement clinical information reconciliation for the following three clinical information sets: (1) Medication. Review of the patient’s medication, including the name, dosage, frequency, and route of each medication. (2) Medication allergy. Review of the patient’s known medication allergies.</p>



	(3) Current Problem list. Review of the patient’s current and active diagnoses.
Exclusions	<p>Measure 1: An EP may take an exclusion if either or both of the following apply:</p> <p>(1) He or she transfers a patient to another setting or refers a patient to another provider fewer than 100 times during the EHR reporting period.</p> <p>(2) He or she conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the Federal Communications Commission (FCC) on the first day of the EHR reporting period.</p>
	<p>Measure 2: An EP may take an exclusion if either or both of the following apply:</p> <p>(1) The total transitions or referrals received and patient encounters in which he or she has never before encountered the patient, is fewer than 100 during the EHR reporting period.</p> <p>(2) He or she conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period.</p>
	<p>Measure 3: An EP may take an exclusion if the total transitions or referrals received and patient encounters in which he or she has never before encountered the patient, is fewer than 100 during the EHR reporting period.</p>

Table of Contents

- Definition of Terms
- Attestation Requirements
- Additional Information
- Regulatory References
- Certification and Standards Criteria

Definition of Terms

Transition of Care: The movement of a patient from one setting of care (hospital, ambulatory primary care practice, ambulatory, specialty care practice, long-term care, home health, rehabilitation facility) to another. At a minimum this includes all transitions of care and referrals that are ordered by the EP.

Summary of Care Record: All summary of care documents used to meet this objective must include the following information if the provider knows it:

- Patient name
- Demographic information (preferred language, sex, race, ethnicity, date of birth)
- Smoking status
- Current problem list (providers may also include historical problems at their discretion)*
- Current medication list*
- Current medication allergy list*
- Laboratory test(s)
- Laboratory value(s)/result(s)
- Vital signs (height, weight, blood pressure, Body Mass Index (BMI))
- Procedures
- Care team member(s) (including the primary care provider of record and any additional known care team members beyond the referring or transitioning provider and the receiving provider)*
- Immunizations
- Unique device identifier(s) for a patient's implantable device(s)
- Care plan, including goals, health concerns, and assessment and plan of treatment
- Referring or transitioning provider's name and office contact information
- Encounter diagnosis
- Functional status, including activities of daily living, cognitive and disability status
- Reason for referral

**Note: An EP must verify that the fields for current problem list, current medication list, and current medication allergy list are not blank and include the most recent information known by the EP as of the time of generating the summary of care document or include a notation of no current problem, medication and/or medication allergies.*

Current problem lists: At a minimum a list of current and active diagnoses.

Active/current medication list: A list of medications that a given patient is currently taking.

Active/current medication allergy list: A list of medications to which a given patient has known allergies.

Allergy: An exaggerated immune response or reaction to substances that are generally not harmful.

Care Plan: The structure used to define the management actions for the various conditions, problems, or issues. A care plan must include at a minimum the following components: goals, health concerns, assessment, and plan of treatment.

Attestation Requirements

Measure 1:

- **DENOMINATOR:** Number of transitions of care and referrals during the EHR reporting period for which the EP was the transferring or referring provider.
- **NUMERATOR:** The number of transitions of care and referrals in the denominator where a summary of care record was created using certified EHR technology and exchanged electronically.
- **THRESHOLD:** The percentage must be more than 50 percent in order for an EP to meet this measure.
- **EXCLUSION:** An EP may take an exclusion from the measure if any of the following apply:
 - He or she transfers a patient to another setting or refers a patient to another provider fewer than 100 times during the EHR reporting period.
 - He or she conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period.

Measure 2:

- **DENOMINATOR:** Number of patient encounters during the EHR reporting period for which an EP was the receiving party of a transition or referral or has never before encountered the patient and for which an electronic summary of care record is available.
- **NUMERATOR:** Number of patient encounters in the denominator where an electronic summary of care record received is incorporated by the provider into the certified EHR technology.
- **THRESHOLD:** The percentage must be more than 40 percent in order for an EP to meet this measure.
- **EXCLUSION:** An EP may take an exclusion from the measure if any of the following apply:
 - The total transitions or referrals received and patient encounters in which he or she has never before encountered the patient, is fewer than 100 during the EHR reporting period.
 - He or she conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period.

Measure 3:

- DENOMINATOR: Number of transitions of care or referrals during the EHR reporting period for which the EP was the recipient of the transition or referral or has never before encountered the patient.
- NUMERATOR: The number of transitions of care or referrals in the denominator where the following three clinical information reconciliations were performed: medication list, medication allergy list, and current problem list.
- THRESHOLD: The resulting percentage must be more than 80 percent in order for an EP to meet this measure.
- EXCLUSION: An EP may take an exclusion from this measure if the total transitions or referrals received and patient encounters in which the he or she has never before encountered the patient, is fewer than 100 during the EHR reporting period.

Additional Information

- EPs must use [2015 Edition CEHRT](#) to meet Stage 3 meaningful use.
- For Measure 1 in order to count in the numerator, the exchange must occur within the EHR reporting period if that period is a full calendar year, or if it is less than a full calendar year, within the calendar year in which the EHR reporting period occurs.
- For Measure 1, the referring EP must have reasonable certainty of receipt by the receiving provider to count the action toward the measure. An EP must have a confirmation of receipt or that a query of the summary of care record has occurred in order to count the action in the numerator.
- Apart from the three fields noted as required for the summary of care record (i.e., current problem list, current medication list, and current medication allergy list), in circumstances where there is no information available to populate one or more of the fields listed (because the EP does not record such information or because there is no information to record), the EP may leave the field(s) blank and still meet the objective and its associated measure.
- While an EP's CEHRT must be capable of sending the full consolidated clinical document architecture (C-CDA) summary of care and an EP must do so upon request, an EP may use any document template within the C-CDA HL-7 standard for purposes of meeting these measures.
- An EP must have the ability to transmit all data pertaining to laboratory test results in the summary of care document, but may work with their system developer to establish clinically relevant parameters for the most appropriate results for the given transition or referral.
- An EP who limits the transmission of laboratory test result data in a summary of care document must send the full results upon request (i.e., all lab results as opposed to a subset).

- The exchange must comply with the privacy and security protocols for electronic protected health information (ePHI) under the Health Insurance Portability and Accountability Act (HIPAA).
- In cases where the providers share access to an EHR, a transition or referral may still count toward the measure if the referring provider creates the summary of care document using CEHRT and sends the summary of care document electronically. If an EP chooses to include such transitions to providers where access to the EHR is shared, they must do so universally for all patient and all transitions or referrals.
- For Measure 1, the initiating EP must send a C–CDA document that the receiving provider would be capable of electronically incorporating as a C–CDA on the receiving end. In other words, if an EP sends a C–CDA and the receiving provider converts the C–CDA into a pdf, a fax, or some other format, the sending EP may still count the transition or referral in the numerator. If the sending provider converts the file to a format the receiving provider could not electronically receive and incorporate as a C–CDA, the initiating EP may not count the transition in their numerator.
- For the purposes of defining the cases in the denominator for Measure 2, we stated that what constitutes “unavailable” and, therefore, may be excluded from the denominator, will be that an EP—
 - Requested an electronic summary of care record to be sent and did not receive an electronic summary of care document; and
 - The EP either:
 - Queried at least one external source via HIE functionality and did not locate a summary of care for the patient, or the provider does not have access to HIE functionality to support such a query, or
 - Confirmed that HIE functionality supporting query for summary of care documents was not operational in the provider’s geographic region and not available within the EP’s EHR network as of the start of the EHR reporting period.
- For Measure 2, a record cannot be considered incorporated if it is discarded without the reconciliation of clinical information or if it is stored in a manner that is not accessible for EP use within the EHR.
- For Measure 3, the process may include both automated and manual reconciliation to allow the receiving EP to work with both the electronic data provided with any necessary review, and to work directly with the patient to reconcile their health information.
- For Measure 3, if no update is necessary, the process of reconciliation may consist of simply verifying that fact or reviewing a record received on referral and determining that such information is merely duplicative of existing information in the patient record.

- Non-medical staff may conduct reconciliation under the direction of the EP so long as the EP or other credentialed medical staff is responsible and accountable for review of the information and for the assessment of and action on any relevant clinical decision support alert.

Regulatory References

This objective may be found at [42 C.F.R. § 495.24 \(d\)\(7\)\(i\)\(A\) and \(B\)](#). For further discussion please see [80 FR 62861](#).

Certification Standards and Criteria

Below is the corresponding certification and standards criteria for EHR technology that supports achieving the meaningful use of this objective.

Certification Criteria

Information about certification for 2015 Edition CEHRT can be found at:

[§170.315\(b\)\(1\) Transitions of care](#)

[§170.315\(b\)\(1\) Transitions of care](#)

[§170.315\(b\)\(2\) Clinical information reconciliation and incorporation](#)

Standards Criteria

Standards for 2015 Edition CEHRT can be found at the ONC's 2015 Standards Hub:

<https://www.healthit.gov/topic/certification/2015-standards-hub>