Eligible Hospital and Critical Access Hospital Medicaid EHR Incentive Program Stage 3 Objectives and Measures Objective 7 of 8

Updated: August 2017

Health Information Exchange	
Objective	The eligible hospital or CAH 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 EHR using the functions of CEHRT.
Measures	Providers must attest to all three measures and must meet the thresholds for at least two measures to meet the objective. • Measure 1: For more than 50 percent of transitions of care and referrals, the eligible hospital or CAH 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. • Measure 2: For more than 40 percent of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, the eligible hospital or CAH incorporates into the patient's EHR an electronic summary of care document. • Measure 3: For more than 80 percent of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, the eligible hospital or CAH performs a clinical information reconciliation. The provider 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. 3) Current Problem list. Review of the patient's current and active diagnoses.
Exclusions	• Measure 1: Any eligible hospital or CAH will be excluded from the measure if it is located in a county that does not have 50 percent or more of their housing units with 4Mbps broadband availability according to the latest information available from the FCC at the start of the EHR reporting period. • Measure 2: A provider may exclude from the measure if any of the following apply: ○ Any eligible hospital or CAH for whom the total of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, is fewer than 100 during the EHR reporting period is excluded from this measure. ○ Any eligible hospital or CAH that is located in a county that does not have 50 percent or more of their housing units with 4Mbps broadband availability according to the latest information available from the FCC at the start of the EHR reporting period.

- Measure 3: Any eligible hospital or CAH for whom the total of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, is fewer than 100 during the EHR reporting period is excluded from this measure.

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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 discharges from the inpatient department and after admissions to the emergency department when follow-up care is ordered by an authorized provider of the hospital

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, 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
- Encounter diagnosis
- Functional status, including activities of daily living, cognitive and disability status
- Discharge instructions (eligible hospital and CAH only)

**Note: An eligible hospital or CAH 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 eligible hospital or CAH 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

DENOMINATOR/NUMERATOR/THRESHOLD/EXCLUSIONS

MEASURE 1:

- DENOMINATOR: Number of transitions of care and referrals during the EHR reporting period for which the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) 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 CEHRT and exchanged electronically.
- THRESHOLD: The percentage must be more than 50 percent in order for an eligible hospital or CAH to meet this measure.
- EXCLUSION: Any eligible hospital or CAH will be excluded from the measure if it is located in a county that does not have 50 percent or more of their housing units with 4Mbps broadband availability according to the latest information available from the FCC at the start of the EHR reporting period.

MEASURE 2:

- DENOMINATOR: Number of patient encounters during the EHR reporting period for which an eligible hospital or CAH 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 eligible hospital or CAH to meet this measure.
- EXCLUSION: A provider may exclude from the measure if any of the following apply:
    - Any eligible hospital or CAH for whom the total of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, is fewer than 100 during the EHR reporting period is excluded from this measure.
    - Any eligible hospital or CAH that is located in a county that does not have 50 percent or more of their housing units with 4Mbps broadband availability according to the latest information available from the FCC at the start of the EHR reporting period.

MEASURE 3:

- DENOMINATOR: Number of transitions of care or referrals during the EHR reporting period for which the eligible hospital or CAH inpatient or emergency department (POS 21 or 23) 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 eligible hospital or CAH to meet this measure.
- EXCLUSION: Any eligible hospital or CAH for whom the total of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, is fewer than 100 during the EHR reporting period is excluded from this measure.

Additional Information

- To meet Stage 3 requirements, all providers must use technology certified to the 2015 Edition for the Health Information Exchange Objective.
- For measure 1 and measure 3, only patients whose records are maintained using certified EHR technology must be included in the denominator for transitions of care.
- For measure 1, beginning in 2017, the action 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 (between January 1st and December 31st).
- For measure 1, the referring provider must have reasonable certainty of receipt by the receiving provider to count the action toward the measure. This may include 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 either because the eligible hospital/CAH does not record such information or because there is no information to record, the eligible hospital/CAH may leave the field(s) blank and still meet the objective and its associated measure.
- A provider 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.
- A provider 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 ePHI under 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 a provider 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 provider 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 a provider sends a C–CDA and the receiving provider converts the C–CDA into a pdf or a fax or some other format, the sending provider 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 provider 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 a provider—
    - Requested an electronic summary of care record to be sent and did not receive an electronic summary of care document; and
    - The provider 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 provider's HER network as of the start of the HER reporting period.
- For measure 2, a record cannot be considered to be incorporated if it is discarded without the reconciliation of clinical information or if it is stored in a manner that is not accessible for provider use within the EHR.
- For measure 3, the process may include both automated and manual reconciliation to allow the receiving provider 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 provider so long as the provider or other credentialed medical staff is responsible and accountable for review of the information and for the assessment of and action on any relevant CDS.

Regulatory References

- This objective may be found in Section 42 of the code of the federal register at 495.24 (d)(7)(ii)(A) and (B). For further discussion please see 80 FR 62861.
- In order to meet this objective and measure, an EP must use the capabilities and standards of CEHRT at 45 CFR 170.315(b)(1) through (b)(3), (a)(6) through (a)(8).

Certification and Standards Criteria

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

Certification Criteria*	
§ 170.315(b)(1) Care Coordination	(1) Transitions of care—(i) Send and receive via edge protocol—(A) Send transition of care/referral summaries through a method that conforms to the standard specified in §170.202(d) and that leads to such summaries being processed by a service that has implemented the standard specified in §170.202(a)(2); and (B) Receive transition of care/referral summaries through a method that conforms to the standard specified in §170.202(d) from a service that has implemented the standard specified in §170.202(a)(2). (C) XDM processing. Receive and make available the contents of a XDM package formatted in accordance with the standard adopted in §170.205(p)(1) when the technology is also being certified using an SMTP-based edge protocol. (ii) Validate and display—(A) Validate C-CDA conformance—system performance. Demonstrate the ability to detect valid and invalid transition of care/referral summaries received and formatted in accordance with the standards specified in §170.205(a)(3) and §170.205(a)(4) for the Continuity of Care Document, Referral Note, and (inpatient setting only) Discharge Summary document templates. This includes the ability to: (1) Parse each of the document types. (2) Detect errors in corresponding "document-templates," "section-templates," and "entry-templates," including invalid vocabulary standards and codes not specified in the standards adopted in §170.205(a)(3) and §170.205(a)(4). (3) Identify valid document-templates and process the data elements required in the corresponding section-templates and entry-templates from the standards adopted in §170.205(a)(3) and §170.205(a)(4). (4) Correctly interpret empty sections and null combinations. (5) Record errors encountered and allow a user through at least one of the following ways to: (i) Be notified of the errors produced. (ii) Review the errors produced. (B) Display. Display in human readable format the data included in transition of care/referral summaries received and formatted according to the standards specified in §170.205(a)(3) and §170.205(a)(4).

(C) Display section views. Allow for the individual display of each section (and the accompanying document header information) that is included in a transition of care/referral summary received and formatted in accordance with the standards adopted in §170.205(a)(3) and §170.205(a)(4) in a manner that enables the user to:

(1) Directly display only the data within a particular section;

(2) Set a preference for the display order of specific sections; and

(3) Set the initial quantity of sections to be displayed.

(iii) Create. Enable a user to create a transition of care/referral summary formatted in accordance with the standard specified in §170.205(a)(4) using the Continuity of Care Document, Referral Note, and (inpatient setting only) Discharge Summary document templates that includes, at a minimum:

(A) The Common Clinical Data Set.

(B) Encounter diagnoses. Formatted according to at least one of the following standards:

(1) The standard specified in §170.207(i).

(2) At a minimum, the version of the standard specified in §170.207(a)(4).

(C) Cognitive status.

(D) Functional status.

(E) Ambulatory setting only. The reason for referral; and referring or transitioning provider's name and office contact information.

(F) Inpatient setting only. Discharge instructions.

(G) Patient matching data. First name, last name, previous name, middle name (including middle initial), suffix, date of birth, address, phone number, and sex. The following constraints apply:

(1) Date of birth constraint—(i) The year, month and day of birth must be present for a date of birth. The technology must include a null value when the date of birth is unknown.

(ii) Optional. When the hour, minute, and second are associated with a date of birth the technology must demonstrate that the correct time zone offset is included.

	(2) Phone number constraint. Represent phone number (home, business, cell) in accordance with the standards adopted in §170.207(q)(1). All phone numbers must be included when multiple phone numbers are present. (3) Sex constraint. Represent sex in accordance with the standard adopted in §170.207(n)(1).
§ 170.315(b)(2) Care Coordination	(2) Clinical information reconciliation and incorporation—(i) General requirements. Paragraphs (b)(2)(ii) and (iii) of this section must be completed based on the receipt of a transition of care/referral summary formatted in accordance with the standards adopted in §170.205(a)(3) and §170.205(a)(4) using the Continuity of Care Document, Referral Note, and (inpatient setting only) Discharge Summary document templates. (ii) Correct patient. Upon receipt of a transition of care/referral summary formatted according to the standards adopted §170.205(a)(3) and §170.205(a)(4), technology must be able to demonstrate that the transition of care/referral summary received can be properly matched to the correct patient. (iii) Reconciliation. Enable a user to reconcile the data that represent a patient's active medication list, medication allergy list, and problem list as follows. For each list type: (A) Simultaneously display (i.e., in a single view) the data from at least two sources in a manner that allows a user to view the data and their attributes, which must include, at a minimum, the source and last modification date. (B) Enable a user to create a single reconciled list of each of the following: Medications; medication allergies; and problems. (C) Enable a user to review and validate the accuracy of a final set of data. (D) Upon a user's confirmation, automatically update the list, and incorporate the following data expressed according to the specified standard(s): (1) Medications. At a minimum, the version of the standard specified in §170.207(d)(3); (2) Medication allergies. At a minimum, the version of the standard specified in §170.207(d)(3); and
§ 170.315(b)(3) Care Coordination	(3) Problems. At a minimum, the version of the standard specified in §170.207(a)(4).

	(iv) System verification. Based on the data reconciled and incorporated, the technology must be able to create a file formatted according to the standard specified in §170.205(a)(4) using the Continuity of Care Document document template.
§ 170.315(a)(6) Problem list	Enable a user to record, change, and access a patient's active problem list: (i) Ambulatory setting only. Over multiple encounters in accordance with, at a minimum, the version of the standard specified in §170.207(a)(4). (ii) Inpatient setting only. For the duration of an entire hospitalization in accordance with, at a minimum, the version of the standard specified in §170.207(a)(4).
§ 170.315(a)(7) Medication list	Enable a user to record, change, and access a patient's active medication list as well as medication history: (i) Ambulatory setting only. Over multiple encounters. (ii) Inpatient setting only. For the duration of an entire hospitalization.
§ 170.315(a)(8) Medication allergy list	Enable a user to record, change, and access a patient's active medication allergy list as well as medication allergy history: (i) Ambulatory setting only. Over multiple encounters. (ii) Inpatient setting only. For the duration of an entire hospitalization.

**Depending on the type of certification issued to the EHR technology, it will also have been certified to the certification criterion adopted at 45 CFR 170.315 (g)(1), (g)(2), or both, in order to assist in the calculation of this meaningful use measure.*

Standards Criteria	
§ 170.202(a) Transport standards	ONC Applicability Statement for Secure Health Transport, Version 1.0 (incorporated by reference in §170.299).
§ 170.202(b)(2) Transport standards	ONC Applicability Statement for Secure Health Transport, Version 1.2 (incorporated by reference in §170.299). (b) Standard. ONC XDR and XDM for Direct Messaging Specification (incorporated by reference in §170.299).
§ 170.202(c)(2) Transport standards	ONC Transport and Security Specification (incorporated by reference in §170.299).
§ 170.205(a)(1) Patient Summary Record	Health Level Seven Clinical Document Architecture (CDA) Release 2, Continuity of Care Document (CCD) (incorporated by reference in §170.299). Implementation specifications. The Healthcare Information Technology Standards Panel (HITSP) Summary Documents Using HL7 CCD Component HITSP/C32 (incorporated by reference in §170.299).

§ 170.205(a)(2)	ASTM E2369 Standard Specification for Continuity of Care Record and Adjunct to ASTM E2369 (incorporated by reference in §170.299).
§ 170.205(a)(3)	HL7 Implementation Guide for CDA® Release 2: IHE Health Story Consolidation, (incorporated by reference in §170.299). The use of the "unstructured document" document-level template is prohibited.
§ 170.205(a)(4)	HL7 Implementation Guide for CDA® Release 2: Consolidated CDA Templates for Clinical Notes (US Realm), Draft Standard for Trial Use, Volume 1—Introductory Material, Release 2.1 and HL7 Implementation Guide for CDA® Release 2: Consolidated CDA Templates for Clinical Notes (US Realm), Draft Standard for Trial Use, Volume 2—Templates and Supporting Material, Release 2.1 (incorporated by reference in §170.299).
§170.207(a)(3) Problem List	IHTSDO SNOMED CT® International Release July 2012 (incorporated by reference in §170.299) and US Extension to SNOMED CT® March 2012 Release (incorporated by reference in §170.299).
§170.207(a)(4) Problem List	IHTSDO SNOMED CT®, U.S. Edition, September 2015 Release (incorporated by reference in §170.299).
§170.207(d)(2) Medications	RxNorm, a standardized nomenclature for clinical drugs produced by the United States National Library of Medicine, August 6, 2012 Release (incorporated by reference in §170.299).
§170.207(d)(3) Medications	RxNorm, a standardized nomenclature for clinical drugs produced by the United States National Library of Medicine, September 8, 2015 Release (incorporated by reference in §170.299).
§170.207(e)(2) Immunizations	HL7 Standard Code Set CVX—Vaccines Administered, updates through July 11, 2012 (incorporated by reference in §170.299).
§170.207(e)(3) Immunizations	HL7 Standard Code Set CVX—Vaccines Administered, updates through August 17, 2015 (incorporated by reference in §170.299).
§170.207(4) Immunizations	National Drug Code Directory (NDC)—Vaccine NDC Linker, updates through August 17, 2015 (incorporated by reference in §170.299).
§170.207(i) Encounter Diagnoses	The code set specified at 45 CFR 162.1002(c)(2) for the indicated conditions.

Additional standards criteria may apply. Review the ONC 2015 Edition Final Rule for more information.