Eligible Hospitals, Critical Access Hospitals and Dual-Eligible Hospitals Attesting To CMS EHR Incentive Program Modified Stage 2 Objectives and Measures for 2017
Objective 3 of 7
Updated: November 2016

Health Information Exchange	
Objective	The eligible hospital or CAH who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care provides a summary care record for each transition of care or referral.
Measure	Health Information Exchange: The eligible hospital or CAH that transitions or refers their patient to another setting of care or provider of care must (1) use CEHRT to create a summary of care record; and (2) electronically transmit such summary to a receiving provider for more than 10 percent of transitions of care and referrals.

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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
- Procedures
- Encounter diagnosis
- Immunizations
- Laboratory test results
- Vital signs (height, weight, blood pressure, BMI)
- Smoking status
- Functional status, including activities of daily living, cognitive and disability status
- Demographic information (preferred language, sex, race, ethnicity, date of birth)
- Care plan field, including goals and instructions
- Care team including the primary care provider of record and any additional known care team members beyond the referring or transitioning provider and the receiving provider
- Discharge instructions (eligible hospital and CAH only)
- Current problem list (Hospitals may also include historical problems at their discretion)*
- Current medication list*
- Current medication allergy list*

**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: problem (the focus of the care plan), goal (the target outcome) and any instructions that the provider has given to the patient. A goal is a defined target or measure to be achieved in the process of patient care (an expected outcome).

Attestation Requirements

DENOMINATOR/NUMERATOR/THRESHOLD

- 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 10 percent in order for an eligible hospital or CAH to meet this measure.

Additional Information

- Only patients whose records are maintained using certified EHR technology must be included in the denominator for transitions of care.
- 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 in order to count in the numerator.
- Apart from the three fields noted as required (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 as required information in the summary of care document, either because the eligible hospital or CAH can be excluded from recording such information (for example, vital signs) or because there is no information to record (for example, laboratory tests), the eligible hospital or 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. This policy is limited to laboratory test results.

- 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 referring provider must have reasonable certainty of receipt by the receiving provider to count the action toward the measure.
- 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.

Regulatory References

- This objective may be found in Section 42 of the code of the federal register at 495.22 (f)(5)(i) and (ii). For further discussion please see 80 FR 62806.
- In order to meet this objective and measure, an EP must use the capabilities and standards of CEHRT at 45 CFR 170.314(b)(1), (b)(2), (a)(5), (a)(6) and (a)(7).

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*	
§ 170.314 (b)(1) Transitions of care – receive, display, and incorporate transition of care/referral summaries	(i) Receive. EHR technology must be able to electronically receive transition of care/referral summaries in accordance with: A. The standard specified in § 170.202(a). B. Optional. The standards specified in § 170.202(a) and (b). C. Optional. The standards specified in § 170.202(b) and (c). (ii) Display. EHR technology must be able to electronically display in human readable format the data included in transition of care/referral summaries received and formatted according to any of the following standards (and applicable implementation specifications) specified in: § 170.205(a)(1), § 170.205(a)(2), and § 170.205(a)(3). (iii) Incorporate. Upon receipt of a transition of care/referral summary formatted according to the standard adopted at § 170.205(a)(3), EHR technology must be able to: A. Correct patient. Demonstrate that the transition of care/referral summary received is or can be properly matched to the correct patient. B. Data incorporation. Electronically incorporate the following data expressed according to the specified standard(s): ▪ Medications. At a minimum, the version of the standard specified in § 170.207(d)(2); ▪ Problems. At a minimum, the version of the standard specified in § 170.207(a)(3); ▪ Medication allergies. At a minimum, the version of the standard specified in § 170.207(d)(2). C. Section views. Extract and allow for individual display each additional section or sections (and the accompanying document header information) that were included in a transition of care/referral summary received and formatted in accordance with the standard adopted at § 170.205(a)(3).
§ 170.314(b)(2) Transitions of care – create and transmit transition of care/referral summaries	(i) Create. Enable a user to electronically create a transition of care/referral summary formatted according to the standard adopted at § 170.205(a)(3) that includes, at a minimum, the Common MU Data Set and the following data expressed, where applicable, according to the specified standard(s): A. Encounter diagnoses. The standard specified in § 170.207(i) or, at a minimum, the version of the standard specified § 170.207(a)(3); B. Immunizations. The standard specified in § 170.207(e)(2); C. Cognitive status; D. Functional status; and 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. (ii) Transmit. Enable a user to electronically transmit the transition of care/referral summary created in paragraph (b)(2)(i) of this section in accordance with: A. The standard specified in § 170.202(a).

	B. Optional. The standards specified in § 170.202(a) and (b). C. Optional. The standards specified in § 170.202(b) and (c).
§ 170.314(a)(5) Problem list	Enable a user to electronically record, change, and access a patient's problem list: (i) Ambulatory setting. Over multiple encounters in accordance with, at a minimum, the version of the standard specified in § 170.207(a)(3); or (ii) Inpatient setting. For the duration of an entire hospitalization in accordance with, at a minimum, the version of the standard specified in § 170.207(a)(3).
§ 170.314(a)(6) Medication list	Enable a user to electronically record, change, and access a patient's active medication list as well as medication history.
§ 170.314(a)(7) Medication allergy list	Enable a user to electronically record, change, and access a patient's active medication allergy list as well as medication allergy history: (i) Ambulatory setting. Over multiple encounters; or (ii) Inpatient setting. 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 170.314 (g)(1), (g)(2), or both, in order to assist in the calculation of this meaningful use measure.*

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

Standards Criteria	
§ 170.202(a) Transport standards	ONC Applicability Statement for Secure Health Transport (incorporated by reference in § 170.299).
§ 170.202(b) Transport standards	ONC XDR and XDM for Direct Messaging Specification (incorporated by reference in § 170.299).
§ 170.202(c) Transport standards	ONC Transport and Security Specification (incorporated by reference in § 170.299).
§ 170.205(a)(1)	HL7 Implementation Guide for CDA® Release 2, CCD. Implementation specifications: HITSP Summary Documents Using HL7 CCD Component HITSP/C32.
§ 170.205(a)(2)	ASTM E2369 Standard Specification for Continuity of Care Record and Adjunct to ASTM E2369.
§ 170.205(a)(3)	HL7 Implementation Guide for CDA Release 2: IHE Health Story Consolidation. The use of the "unstructured document" document-level template is prohibited.

§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(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(e)(2) Immunizations	HL7 Standard Code Set CVX – Vaccines Administered, updates through July 11, 2012.
§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.