Eligible Hospital and Critical Access Hospital Meaningful Use Menu Set Measures

Measure 7

Stage 1

Last Updated: April 2013

Transition of Care Summary	
Objective	The eligible hospital or CAH that transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care or referral.
Measure	The eligible hospital or CAH that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50 percent of transitions of care and referrals.
Exclusion	No exclusion.

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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.

Attestation Requirements

NUMERATOR / DENOMINATOR

- 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 to 23) was the transferring or referring provider.
- NUMERATOR: Number of transitions of care and referrals in the denominator where a summary of care record was provided.

The resulting percentage (Numerator ÷ Denominator) must be more than 50 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 should be included in the denominator for transitions of care.
- The transferring party must provide the summary care record to the receiving party.
- The eligible hospital or CAH can send an electronic or paper copy of the summary care record directly to the next provider or can provide it to the patient to deliver to the next provider, if the patient can reasonably expected to do so.
- If the provider to whom the referral is made or to whom the patient is transitioned to has access to the medical record maintained by the referring provider then the summary of care record would not need to be provided, and that patient should not be included in the denominator for transitions of care. For example, different settings within a hospital using the same certified EHR technology have access to the same information, so providing a clinical care summary under these circumstances would not be necessary.

Related Meaningful Use FAQs

To see the FAQs, click the New ID # hyperlinks below, or visit the CMS FAQ web page at https://questions.cms.gov/ and enter the New ID # into the Search Box, clicking the "FAQ #" option to view the answer to the FAQ. (Or you can enter the OLD # into the Search Box and click the "Text" option.)

- What do the numerators and denominators mean in measures that are required to demonstrate meaningful use? ***New ID #2813***, ***Old ID #10095***
- Does an eligible hospital have to count patients admitted to both the inpatient and emergency departments in the denominator of meaningful use measures, or can they count only emergency department patients? ***New ID #3067***, ***Old ID #10468***
- If an eligible hospital or CAH has a rehabilitation unit or a psychiatric unit that is part of the inpatient department and that bills under Place of Service (POS) code 21, but that is excluded from the inpatient prospective payment system (IPPS), should patients from these units be included in the denominator for the measures of meaningful use objectives? ***New ID #3213***, ***Old ID #10591***
- How should patients in swing beds be counted in the denominators of meaningful use measures for eligible hospitals and CAHs? ***New ID #3259***, ***Old ID #10640***

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	
§170.306(f) - Exchange clinical information and	(1) *Electronically receive and display.* Electronically receive and display a patient's summary record from other providers and organizations including, at a minimum, diagnostic test results, problem list, medication list, medication allergy list, and procedures in accordance with the standard (and applicable implementation

patient summary record	specifications) specified in §170.205(a)(1) or §170.205(a)(2). Upon receipt of a patient summary record formatted according to the alternative standard, display it in human readable format.
	(2) *Electronically transmit.* Enable a user to electronically transmit a patient's summary record to other providers and organizations including, at a minimum, diagnostic results, problem list, medication list, medication allergy list, and procedures in accordance with: (i) The standard (and applicable implementation specifications) specified in §170.205(a)(1) or §170.205(a)(2); and (ii) For the following data elements the applicable standard must be used: (A) *Problems.* The standard specified in §170.207(a)(1) or, at a minimum, the version of the standard specified in §170.207(a)(2); (B) *Procedures.* The standard specified in §170.207(b)(1) or §170.207(b)(2); (C) *Laboratory test results.* At a minimum, the version of the standard specified in §170.207(c); and (D) *Medications.* The standard specified in §170.207(d).
§170.302(n) Automated measure calculation	For each meaningful use objective with a percentage-based measure, electronically record the numerator and denominator and generate a report including the numerator, denominator, and resulting percentage associated with each applicable meaningful use measure.

Standards Criteria	
Patient summary record	▪ §170.205(a)(1) - HL7 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.
Problems	▪ §170.207(a)(1) - The code set specified at 45 CFR 162.1002(a)(1) for the indicated conditions. ▪ §170.207(a)(2) - IHTSDO SNOMED CT® July 2009 version.
Procedures	▪ §170.207(b)(1) - The code set specified at 45 CFR 162.1002(a)(2). ▪ §170.207(b)(2) - The code set specified at 45 CFR 162.1002(a)(5).
Laboratory test results	▪ §170.207(c) - LOINC® version 2.27, when such codes were received within an electronic transaction from a laboratory.
Medication	▪ §170.207(d) - Any source vocabulary that is included in RxNorm, a standardized nomenclature for clinical drugs produced by the United States National Library of Medicine.

Related Certification FAQs

Click on the green numbers to view the answer to the FAQ.

- I've identified that I am using two different EHR technologies to meet a single certification criterion (my document management system receives and displays summary records (45 CFR 306(f)(1)) and my EHR technology from EHR technology developer XYZ transmits summary records (45 CFR 306(f)(2)). Do both EHR technologies need to be certified? ***9-10-011-1***
- Could an interface that transmits lab results in HL7 message format between a hospital laboratory system and a physician's EHR (presuming that the transmissions were occurring between two different legal entities) satisfy the certification criteria related to the exchange of key clinical information in 45 CFR 170.304(i) and 45 CFR 170.306(f)? If not, please specify the required data types and exchange characteristics that must be part of the required clinical information exchange. ***12-10-023-1***