

Stage 2

Eligible Hospital and Critical Access Hospital

Meaningful Use Core Measures

Measure 12 of 16

Last updated: November, 2014

Summary of Care	
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	<p>Measure 1:</p> <ul style="list-style-type: none"> 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. <p>Measure 2:</p> <ul style="list-style-type: none"> 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 10 percent of such transitions and referrals either (a) electronically transmitted using CEHRT to a recipient or (b) where the recipient receives the summary of care record via exchange facilitated by an organization that is a NwHIN Exchange participant or in a manner that is consistent with the governance mechanism ONC establishes for the nationwide health information network. <p>Measure 3:</p> <p>The eligible hospital or CAH must satisfy one of the two following criteria:</p> <ul style="list-style-type: none"> Conducts one or more successful electronic exchanges of a summary of care document, which is counted in "measure 2" (for eligible hospitals and CAHs the measure at §495.6(l)(11)(ii)(B)) with a recipient who has EHR technology that was designed by a different EHR technology developer than the sender's EHR technology certified to 45 CFR 170.314(b)(2); or Conducts one or more successful tests with the CMS designated test EHR during the EHR reporting period.
Exclusion	No exclusion.

Table of Contents

- Definition of Terms
- Attestation Requirements
- Additional Information
- 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 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 – A summary of care record must include the following elements:

- Patient name.
- Referring or transitioning provider's name and office contact information (EP only).
- 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
- Current problem list (Hospitals may also include historical problems at their discretion).
- Current medication list, and
- Current medication allergy list.

Problem lists – At a minimum a list of current, active and historical diagnoses. We do not limit the eligible hospital to just including diagnoses on the problem list.

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

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 provided.
- **THRESHOLD:** The percentage must be more than 50 percent in order for the eligible hospital or CAH to meet this measure.

MEASURE 2:

- **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 a) electronically transmitted using CEHRT to a recipient or b) where the recipient receives the summary of care record via exchange facilitated by an organization that is a NwHIN Exchange participant or in a manner that is consistent with the governance mechanism ONC establishes for the nationwide health information network. The organization can be a third-party or the sender's own organization.
- **THRESHOLD:** The percentage must be more than 10 percent in order for the eligible hospital or CAH to meet this measure.

MEASURE 3:

YES/NO

The eligible hospital or CAH attests YES to one of the two criteria:

1. Conducts one or more successful electronic exchanges of a summary of care document, which is counted in "measure 2" (for eligible hospitals and CAHs the measure at §495.6(l)(11)(ii)(B)) with a recipient who has EHR technology that was designed by a different EHR technology developer than the sender's EHR technology certified to 45 CFR 170.314(b)(2);

or

2. Conducts one or more successful tests with the CMS designated test EHR during the EHR reporting period.

Additional Information

- Only patients whose records are maintained using certified EHR technology must be included in the denominator for transitions of care.
- The transferring party must provide the summary care record to the receiving party.
- If the provider does not have the information available to populate one or more of the fields listed, either because they can be excluded from recording such information (for example, vital signs) or because there is no information to record (for example, laboratory tests), the provider may leave the field(s) blank. The only exception to this is the problem list, medication list, and medication allergy list.
- In the event that there are no current or active diagnoses for a patient, the patient is not currently taking any medications, or the patient has no known medication allergies, confirmation of no problems, no medications, or no medication allergies would satisfy the measure of this objective.
- In circumstances where there is no information available to populate one or more of the fields listed previously, 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 hospital must verify current problem list, current medication list, and current medication allergy list are not blank and include the most recent information known by the hospital as of the time of generating the summary of care document.
- The hospital 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 be expected to do so and meet Measure 1.
- To count in the numerator of measure 2, the summary of care record must be received by the provider to whom the sending provider is referring or transferring the patient.
- To count in the numerator of measure 2, one of the following three transmission approaches must be used:
 - Use of the transport standard capability required for certification. As required by ONC to meet the CEHRT definition, every EP, eligible hospital, and CAH, must have EHR technology that is capable of electronically transmitting a summary care record for transitions of care and referrals according to the primary Direct Project specification (the Applicability Statement for Secure Health Transport). Thus, EPs, eligible hospitals, or CAHs that electronically transmit summary care records using their CEHRT's "Direct" capability (natively or combined with an intermediary) would be able to count all such electronic transmissions in their numerator.
 - Use of the SOAP-based optional transport standard capability permitted for certification. As part of certification, ONC permits EHR technology developers to voluntarily seek certification for their EHR technology's capability to perform SOAP-based electronic transmissions. EHR technology developers who take this approach would enable their customers to also use this approach to meet the measure. Thus, EPs, eligible hospitals, or CAHs that electronically transmit summary care records using their CEHRT's "SOAP-based" capability (natively or combined with an intermediary) would be able to count all of those transmissions in their numerator.
 - Use of CEHRT to create a summary care record in accordance with the required standard (i.e., Consolidated CDA as specified in 45 CFR 170.314(b)(2)), and the electronic transmission is accomplished through the use of an eHealth Exchange participant who enables the electronic transmission of the summary care record to its intended recipient. Thus, EPs, eligible hospitals, or CAHs who create standardized summary care records using their CEHRT and then use an eHealth Exchange participant to electronically transmit the summary care record would be able to count all of those transmissions in their numerator. [See related FAQ.](#)
- In order to meet this objective and measure, the eligible hospital or CAH must use the capabilities and standards of CEHRT at 45 CFR 170.314(b)(2), (g)(1), (g)(2).

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	<ul style="list-style-type: none"> (i) Receive. EHR technology must be able to electronically receive transition of care/referral summaries in accordance with: <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> 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): <ul style="list-style-type: none"> ▪ 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	<ul style="list-style-type: none"> (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): <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> A. The standard specified in § 170.202(a).

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

**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 2014 Edition EHR Certification Criteria Grid Mapped to Meaningful Use Stage 2](#) 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 2014 Edition EHR Certification Criteria Grid Mapped to Meaningful Use Stage 2](#) for more information.

