Eligible Professional Meaningful Use Menu Set Measures Measure 7 of 9

Stage 1 (2014 Definition)
Last updated: May 2014

Transition of Care Summary	
Objective	The EP who 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 EP who 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	An EP who neither transfers a patient to another setting nor refers a patient to another provider during the EHR reporting period.

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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 / EXCLUSION

- DENOMINATOR: Number of transitions of care and referrals during the EHR reporting period for which the EP 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.
- EXCLUSION: If an EP does not transfer a patient to another setting or refer a patient to another provider during the EHR reporting period then they would be excluded from this requirement. EPs must select NO next to the appropriate exclusion, then click the APPLY button in order to attest to the exclusion.

The resulting percentage (Numerator ÷ Denominator) must be more than 50 percent in order for an EP 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 EP 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.

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): (1) Medications. At a minimum, the version of the standard specified in §170.207(d)(2); (2) Problems. At a minimum, the version of the standard specified in §170.207(a)(3); (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).

*Additional certification criteria may apply. Review the ONC 2014 Edition EHR Certification Criteria Grid Mapped to Meaningful Use Stage 1 for more information.

Standards Criteria*	
§170.202(a)	Applicability Statement for Secure Health Transport.
§170.202(b)	XDR and XDM for Direct Messaging Specification.
§170.202(c)	Transport and Security Specification.
§170.205(a)(1) *Implementation specifications*	HL7 CDA Release 2, CCD.: 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)	IHTSDO SNOMED CT® International Release, July 2012; and US Extension to SNOMED CT,® March 2012.
§170.207(d)(2)	RxNorm, August 6, 2012 Release.
§170.207(e)(2)	HL7 Standard Code Set CVX Vaccines Administered, updates through July 11, 2012.
§170.207(i)	The code set specified at 45 CFR 162.1002(c)(2) for the indicated conditions.

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