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» Stage 2 Data Sharing: **TIPSHEET FOR ELIGIBLE PROFESSIONALS**



Overview

Stage 2 of the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs includes several objectives that require information to be shared with another party. Three of these objectives—Clinical Summary, Patient Electronic Access, and Summary of Care—outline specific data elements needed to meet the objective. While some of the data elements are common between these three objectives, other data elements are individual to each objective.

The following is an explanation of what data must be included in order to meet the requirements for the Clinical Summary, Patient Electronic Access, and Summary of Care measures.



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Clinical Summary

A clinical summary of an office visit provides patients and their families with a record of the office visit and specific lab tests, follow-up actions, and treatment related to the visit. While this information is part of the patient's overall electronic health record, the clinical summary highlights information relevant to the patient's care at that particular moment. Because it is designed to be linked to a particular office visit and provided to the patient either at the conclusion of the visit or shortly thereafter, the information required for the clinical summary is limited to the information that is available in the EHR at the time the clinical summary is provided.

If an eligible professional (EP) has not yet entered specific data element into the EHR at the time the clinical summary is provided, that field can be left blank and the EP can still meet the objective. However, if listed information is available in the EHR at the time the clinical summary is provided, it must also be included in the clinical summary (except as described below).

What to Include

All information listed in the table below and available in the certified EHR at the time the clinical summary is provided must be part of the clinical summary provided to the patient. The clinical summary can be provided either online or on paper. However, the EP may withhold any information from the clinical summary if he or she believes that providing such information may result in significant harm. Additional details on the information listed below are available in the Frequently Asked Question available at <https://questions.cms.gov/faq.php?faqId=8237>.

Information Requirements for Clinical Summary Measure

- Patient name
- Provider's name and office contact information
- Date and location of the visit
- Reason for the office visit
- Current problem list
- Current medication list
- Current medication allergy list
- Procedures performed during the visit
- Immunizations or medications administered during the visit
- Vital signs taken during the visit (or other recent vital signs)
- Laboratory test results
- List of diagnostic tests pending
- Clinical instructions
- Future appointments
- Referrals to other providers
- Future scheduled tests
- Demographic information maintained within certified electronic health record technology (CEHRT) (sex, race, ethnicity, date of birth, preferred language)
- Smoking status
- Care plan field(s), including goals and instructions
- Recommended patient decision aids (if applicable to the visit)

Steps to Meeting Requirements

1

Enter information into the certified EHR technology at the time of the office visit

2

Withhold any information provider determines could cause possible harm

3

Provide modified information in clinical summary to patient (either online or on paper) within one (1) business day

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Patient Electronic Access

Online access allows patients easy access to their health information so that they can make informed decisions regarding their care and share their most recent clinical information with other health care providers and personal caregivers. The requirements for patient electronic access are similar to those for clinical summaries. The patient electronic access measure requires EPs to provide patients the ability to view online, download, and transmit their health information within four (4) business days of the information being available to the provider.

Unlike clinical summaries, which are tied to specific office visits, providing patient electronic access to information is an ongoing requirement. If a specific data field is not available to the EP at the time the information is sent to the patient portal, that information does not have to be made available online and the EP can still meet the objective. However, as new information for the specific items listed below becomes available to the provider, that information must be updated and made available to the patient online within four (4) business days.

What to Include

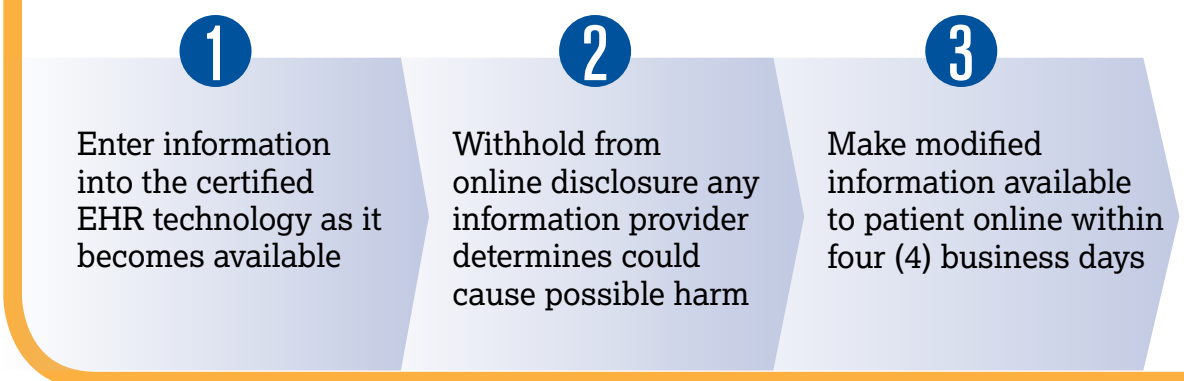
All information available at the time the information is sent to the patient portal must be made available to the patient online. However, the EP may withhold any information from online disclosure if he or she believes that providing such information may result in significant harm. In addition, the fields for problem list, medication list, and medication allergy list must either contain problems, medications, and medication allergies or a specific notation that the patient has none.

Information Requirements for Patient Electronic Access Measure

- Patient name
- Provider's name and office contact information
- Current and past problem list
- Procedures
- Laboratory test results
- Current medication list and medication history
- Current medication allergy list and medication allergy history
- Smoking status
- Vital signs (height, weight, blood pressure, BMI, growth charts)
- Demographic information (preferred language, sex, race, ethnicity, date of birth)
- Care plan field(s), including goals and instructions
- Any known care team members including the primary care provider (PCP) of record

Unless the information is not available in certified EHR technology (CEHRT), is restricted from disclosure due to any federal, state, or local law regarding the privacy of a person's health information, including variations due to the age of the patient, or the provider believes that substantial harm may arise from disclosing particular health information in this manner.

Steps to Meeting Requirements



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Summary of Care

EPs caring for the same patient who share information with one another can more effectively coordinate the care they provide. The purpose of a summary of care record is to ensure that the provider who transitions a patient to someone else's care gives the receiving provider the most up-to-date information available. When an EP transitions their patient to another setting or provider of care, or refers their patient to another provider, the EP should provide a summary of care record for the next provider of care.

Similar to the clinical summary and patient online access objectives, the information provided as part of the summary of care is generally limited to what is available to the EP and in the certified EHR technology at the time the summary of care is generated. Unlike clinical summary and patient online access objectives, the EP must verify that information was entered into the EHR for problem list, medication list, and medication allergy list prior to generating the summary of care. The problem list, medication list, and medication allergy list must either contain specific information or a notation that the patient has none of these items. Leaving the field blank would not allow the provider to meet the objective. If other data elements from the list below are not available in the EHR at the time the summary of care is generated, that information does not have to be made available in the summary of care.

What to Include

The fields for problem list, medication list, and medication allergy list must either contain problems, medications, and medication allergies, or a specific notation that the patient has none of these items.

Information Requirements for Summary of Care

- 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
- 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
- Demographic information (preferred language, sex, race, ethnicity, date of birth)
- Reason for referral
- Current problem list (EPs may also include historical problems at their discretion)**
- Current medication list**
- Current medication allergy list**

**** Required Fields**

Steps to Meeting Requirements

