Read this tip sheet to prepare to exchange information with other providers whom you refer to and achieve the CMS Promoting Interoperability (PI) program requirements.

OVERVIEW OF HEALTH INFORMATION EXCHANGE (HIE) REQUIREMENTS FOR MODIFIED STAGE 2

Objective #5	The eligible professional (EP) 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 of care record for each transition of care or referral.
Measure	The EP that transitions or refers their patient to another setting of care or provider of care must: (1) Use certified electronic health record technology (CEHRT) to create a summary of care records; and (2) Electronically transmit such summary to a receiving provider for more than 10 percent of transitions of care and referrals.

What do I do?
Create and send summary of care record that describes your patient and your reason for sending that patient for other care.

When?
When you send your patient to another provider or care setting.

How?
Use your EHR to create the summary of care record. Next, use your EHR or HIE interface to send the summary of care record.

How Often?
10% of all patients you send for care outside of your practice, during the reporting period.

CMS GUIDELINE FAQS

Topic	Quick Answer	Detailed Answer
Are there exclusions?	Yes, for providers who do not send many patients out of their practice.	• Yes, you do not have to meet this measure if you send fewer than 100 patients to other providers and care settings during the reporting period.
What does a transition of care (TOC) mean?	The change of care delivery for a patient (referrals received and made).	• CMS definition: "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 transitions of care and referrals that are ordered by the EP."
What is a summary of care?	The document your EHR (or HIE connection) sends and contains patient health information.	• It is also referred to as a "C-CDA." C-CDA is the term for the technical structure "underneath" the summary of care document. EHRs have the ability to "know" a summary of care document because of the C-CDA structure. • The document has fields designed to contain all the patient information that CMS requires (you can find the CMS required information on pages 1 and 2 of this CMS document).
Link to CMS Health Information Exchange Objective (Click here for access)		

EHR AND HIE FAQS

Topic	Quick Answer	Detailed Answer
Does CMS have requirements for my technology?	You can use 2014 or 2015 certified health IT.	• Certified health IT means that it has specific functionality to create, send, and incorporate summary of care records. Click here to access the CMS website that provides more information about certified health IT. • You have to make sure your EHR is certified for 2014 or 2015 requirements; these requirements ensure your health IT system has the functionality to send summary of care documents. Check with your vendor, if you are unsure.
Does my EHR "do" HIE?	Your EHR may have a built-in method to send and receive summary of care records. You can also use Direct Secure Messaging.	• Some EHRs have proprietary methods to exchange information with other providers who use the same EHR, even if they are not in your practice. For example, eClinicalWorks uses P2P, and Epic uses Care Everywhere. • If you don't have an EHR with its own solution, or if you want to communicate with providers who don't use the same EHR, you can use Direct Secure Messaging. See page 4 of tip sheet for more information.
What is Direct Secure Messaging?	Essentially, a specific kind of email for EHRs.	• Please see page 4 of this tip sheet for more information about Direct Secure Messaging (aka, Direct).
Do I have to pay anything?	You may.	• You don't have to pay to send or receive a summary of care document, but your vendor may have fees for the technology or the interfaces that allow you to communicate with other providers.
Link to CMS Health Information Exchange Objective (Click here for access)		

DIRECT SECURE MESSAGING FAQs

Topic	Quick Answer	Detailed Answer
What is Direct?	A technology developed to function like email and replace fax machines.	• Direct secure messaging is a form of "secure email" that is integrated within your EHR to facilitate the sending and receiving of electronic summary of care records from other providers' EHRs. Using Direct ensures that the sending and receiving providers know each other, information is transmitted securely, and a "confirmation" to the sender is sent when the message has been properly received by the receiving provider.
How do I get Direct?	Contact your EHR vendor.	• All 2015 certified health IT have Direct capabilities, but you may have to check with your vendor to make sure it is installed. Your EHR vendor may use a different term than "Direct" for secure email capabilities. • You can get a Direct address (for example, first.last@direct.abcmedical.org) from your vendor.
I have Direct. Now what?	Ask other providers for their Direct addresses and send summary of care records. Give others your address.	• Contact the providers or entities you want to send and receive summary of care records with and ask them for their Direct address; begin to build your address book. ○ DHCF is taking steps to create a provider-only resource that lists Direct addresses for those who wish to share them with other providers. • Within your EHR, you can enter a Direct address and send a summary of care record; ask your vendor for training modules and materials.
Where are my messages?	Delegate someone to check the Direct inbox and take appropriate action.	• Assign the individual(s) responsible for checking the Direct inbox (just as you would for a fax machine, fax inbox, or voicemail messages) and determine the appropriate follow-up steps, such as identifying where the summary of care record goes for the patient within the EHR. • Create a process to reply to messages received, as well.
I need more help.	We understand this is complicated.	• Contact your eHealthDC TA Specialist to discuss solutions.
Link to CMS Health Information Exchange Objective (Click here for access)		

SUMMARY OF CARE WORKFLOW FAQS

Topic	Quick Answer	Detailed Answer

Which patients do I send summary of care documents for?	For 10% of the patients you send for care by another provider or to a different location for care. In other words, for all transitions of care.	• Send summaries of care for the patients you transition during your reporting period.
		• Transition of care (TOC) examples include:
		  ○ Referrals to another provider or care setting (such as a hospital or nursing home), even when you maintain a treatment relationship with the patient; and
		  ○ Transitions of care to other providers or care settings, where the next provider performs ongoing monitoring or treatment.
		• See page 2 of this tip sheet for the CMS definition of a TOC

Do I have to send it right away?	No: Send the summary of care document within the reporting period.	• It is good practice to send the summary of care document at the time you transition the patient; however, you can send the summary care record anytime during the reporting period. • If your reporting period is 90 days, you must send the summary of care record before the last date of the calendar year that your reporting period occurred.
What do I put in a summary of care document?	You "tell" your EHR to automatically assemble the summary of care record from information you document in your patient's record.	• CMS requires specific information in a summary of care document (click on this document and review pages 1 and 2). The summary of care document must contain the information, if you know it, including care team members and a care plan with goals, health concerns, assessment and treatment plan. • Verify how your workflow collects this information and check that your EHR automatically inputs the CMS required information into the document when you tell it to create a summary of care record (your EHR may call it something else). Blank fields are OK if the patient has no applicable information, with the exception below.
I am ready to send. Should I check anything?	Yes: Problems, medications, and medication allergies.	• You must make sure the summary of care record contains the patient's most up-to-date problem list, medication list, and medication allergy list. If the patient has none, the summary of care should contain the applicable statement "no current problems/medications/medication allergies."
I sent the summary of care document. Now what?	Know whether your summary of care document was received by the person you sent it to.	• Work with your vendor to make sure your EHR "knows" that the summary of care record was sent. • It is a good idea to create a policy for everyone in your practice to follow that ensures summary of care records are sent in a consistent manner that gives you reasonable certainty that they are received.
What about sending labs?	Work with your vendor to determine the information to include.	• Certified EHR technology has the capability to send full lab reports in a summary of care document. • You can work with your vendor to learn how to set the parameters for a given patient and/or lab.