TIP SHEET

Transitions of Care Objective and Measures for Eligible Professionals – Stage 3

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

OVERVIEW OF HEALTH INFORMATION EXCHANGE (HIE) REQUIREMENTS FOR STAGE 3 OBJECTIVES AND MEASURES

Objective #7	The EP provides a summary of care record when transitioning or referring their patient to another setting of care, receives or retrieves a summary of care record upon the receipt of a transition or referral or upon the first patient encounter with a new patient, and incorporates summary of care information from other providers into their EHR using the functions of CEHRT.
Measure #1	For more than 50% of transitions of care and referrals, the EP that transitions or refers their patient to another setting of care or provider: 1) creates a summary of care record using CEHRT; and 2) electronically exchanges the summary of care record.
Measure #2	For more than 40% of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, the EP incorporates into the patient's EHR an electronic summary of care document.
Measure #3	For more than 80% of transitions or referrals received and patient encounters in which the provider has never before encountered patient, the EP performs clinical information reconciliation for medications, medication allergies, and current problems.

	What do I do?	When?	How?	How Often?
Measure #1	Create and send a summary of care record that describes your patient and your reason for sending that patient for other care.	When you send your patient to another provider or care setting.	Use your EHR to create the summary of care. Next, use Direct or your HIE interface to send the summary of care record. (See page 4 of this tip sheet for more information about Direct.)	50% of all patients you send for care outside of your practice, during the reporting period.
Measure #2	Find a patient's summary of care record and incorporate it into your EHR.	When you see a patient for the first time, and when you see a patient referred to you.	Before, during, or after the patient visit, you (or a staff member) use Direct or your HIE interface to find the patient's summary of care record. Next, use your EHR to incorporate the record into the patient's record.	40% of all referrals you receive + all new patients you have never seen before, during the reporting period.
Measure #3	Reconcile clinical information for your patient in your EHR.	When you see a patient for the first time, and when you see a patient referred to you.	Obtain the patient's summary of care record (see above) and use your EHR to review and select the information to reconcile, including medications, medication allergies, and problems.	80% of all referrals you receive + all new patients you have never seen before, during the reporting period.

CMS GUIDELINE FAQS

Topic	Quick Answer	Detailed Answer
When do I have to do the HIE measures?	During your reporting period.	• Within the reporting period, which is the 12-month time frame when you must meet the CMS requirements for HIE and other metrics. It is also referred to as the "EHR reporting period." • If your reporting period is less than a full calendar year, you have to perform the action in the calendar year of the reporting period.
Are there exclusions for these measures?	Yes, if you have fewer than 100 patients the measures apply to.	• Measure 1: Yes, if you send fewer than 100 patients to other providers and care settings during the reporting period. • Measures 2 and 3: Yes, if you receive fewer than 100 new patients and referrals during the reporting period.
How many measures do I have to meet?	2 of 3.	• You have to tell CMS (or attest) the percent thresholds for all 3 measures, but you only have to meet 2 of the 3 measure thresholds.
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 interface) sends (or receives) that contains patient health information.	• You can direct your EHR to create summary of care document for another provider or incorporate one from another provider into your EHR. ○ 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 CMS requires (click here and reference page 2 to find the CMS required information).
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 have to use 2015 certified health IT. This is different from 2014 certified health IT.	• Certified health IT means that it has specific functionality to create, send, and incorporate summary of care records. This CMS website provides more information about certified health IT. • You also have to make sure your EHR is certified to 2015 (not 2014) requirements. 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 the next page 4 of this 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).
What about the District's HIEs?	There are 3 HIE organizations in the District for exchanging information.	• CRISP (the Chesapeake Regional Information System for our Patients), Capital Partners in Care HIE, and the Children's IQ Network (CIQN) are health information exchange (HIE) organizations that operate in the District. Contact them and work with your TA specialist to determine which has the best services and network for your exchange needs.
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 EHR vendor or HIE interface 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 vendor or HIE.	• All 2015 certified health IT has 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 a 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)		

WORKFLOW: SENDING SUMMARY OF CARE RECORDS (MEASURE #1)

Topic	Quick Answer	Detailed Answer
Which patients do I send summary of care documents for?	For 50% 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. • You do not have to send a summary of care for patients who self-refer themselves to another provider. • 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 ○ TOCs to other providers or care settings for ongoing monitoring or treatment.
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 it any time during the reporting period (if your reporting period is less than a full year, send the summary of care document in the calendar year that the 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 here and reference page 2 to find the CMS required information). It 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 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 sends the required information in a C-CDA format every time (instead of, for example, a PDF). ○ C-CDA is the term for the summary of care document's technical structure. EHRs recognize, or "know," a summary of care document because of its C-CDA structure. • Also check with your EHR vendor or HIE connection representative to ensure reasonable certainty that the summary of care document was received. 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.
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.

WORKFLOW: INCORPORATING SUMMARY OF CARE RECORDS (MEASURE #2)

Topic	Quick Answer	Detailed Answer

For which patients do I incorporate a summary of care record?	For 40% of patients who are transitioned to you, including new patients, who have an electronic summary of care document.	• This measure applies to all new patients you see and all patients transitioned to you, during the reporting period, who have a summary of care record; CMS does not restrict this measure to the patients for whom you receive electronic referrals and transitions.
		• See page 2 of this tip sheet for the CMS definition of a transition of care (TOC).
		• Examples include:
		  ○ A new patient you have never seen before; and
		  ○ A follow-up visit after a hospital or emergency department discharge.

How do I find a patient's summary of care record?	Request them from the provider who sent you a patient, or "pull" the document from a HIE.	• You can use Direct to contact a provider who sent you a patient and ask for a summary of care record. • If you are connected to a HIE, contact your HIE to determine how to query, or "pull," a summary of care record from the HIE.
Do I have to track down the electronic summary of care record?	Yes	• You have to either reach out to the provider who sent you a patient and ask for the summary of care for that patient, OR query ("pull") the summary of care record from a HIE. • If you are unable to get the electronic summary of care document, you don't have to incorporate a summary of care record. In other words, that patient does not "count" for the measure.

When do I have to incorporate it?	Depends on your reporting period length.	• It's good practice to incorporate the summary of care record in connection with the patient's visit to you, however:
		  ○ If your reporting period is a full calendar year, you must obtain the summary care record and incorporate it before the end of the reporting period.
		  ○ If your reporting period is 90 days, you must complete these actions before the last date of the calendar year for your reporting period.

Link to CMS Health Information Exchange Objective (Click here for access)		

WORKFLOW: PERFORMING CLINICAL INFORMATION RECONCILIATION (MEASURE #3)

Topic	Quick Answer	Detailed Answer
For which patients do I reconcile information?	For 80% transitions of care and referrals to you.	• This measure applies to patients who are referred or transitioned to you, and new patients you see, during your reporting period. • See page 2 of this tip sheet for the CMS transition of care (TOC) definition and page 6 of this tip sheet for TOC examples.
Is CMS telling me how to do information reconciliation?	The CMS requirement is to use certified health IT to verify specific information is up to date. It is up to you how you perform the verification.	• CMS requires you to reconcile the patient's medication list, medication allergy list, and problem list. • CMS does not require to perform reconciliation in a specific way, but you must determine how your EHR "knows" that you have performed the action. • Work with your vendor to make sure your EHR configuration supports your workflow for information reconciliation (for example, manual or automatic) and that the summary of care record is incorporated in a manner that it can be accessible for use within the EHR.

When do I have to reconcile information?	Depends on your reporting period length.	• It is good practice to reconcile information in connection with the patient's visit to you, however:
		  ○ If your reporting period is a full calendar year, you must reconcile information before the end of the reporting period.
		  ○ If your reporting period is 90 days, you must reconcile information before the last date of the calendar year for your reporting period.

Can non-medical staff do this?	Yes.	• You can delegate another provider or credentialed medical staff you trust to review the information to reconcile and take appropriate follow-up action, including responding to any resulting clinical decision support.