HealthCare
Kentucky Regional Extension Center

KY REC Tip for the Kentucky Medicaid EHR Incentive Program (Promoting Interoperability)

Health Information Exchange

What does Stage 3 require for Health Information Exchange?

The eligible professional (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.

Providers must attest to all three measures and meet the threshold for two measures for this objective. If the EP meets the criteria for exclusion from two measures, they must meet the threshold for the one remaining measure. If they meet the criteria for exclusion from all three measures, they may be excluded from meeting this objective.

- **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 of care:
  - Creates a summary of care record using CEHRT; and
  - Electronically exchanges the summary of care record
- **Measure 2**: For more than 40% of transitions or referrals received and patient encounters in which the EP 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 EP has never before encountered the patient, the EP performs clinical information reconciliation on medication, medication allergy and current problem list

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Exclusions:

- **Measure 1**: Any EP who transfers a patient to another setting or refers a patient to another provider fewer than 100 times during the reporting period.
- **Measure 2**: Any EP for whom the total transitions or referrals received and patient encounters in which the provider has never before encountered the patient, is fewer than 100 during the reporting period.
- **Measure 3**: Any EP for whom the total transitions or referrals received and patient encounters in which the provider has never before encountered the patient, is fewer than 100 during the reporting period.

Additional Information:

- 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 transitions of care and referrals that are ordered by the EP.
- For Measure 1, the referring EP must have reasonable certainty of receipt by the receiving provider to count the action toward the measure. An EP must have a confirmation of receipt or that a query of the summary of care record has occurred in order to count the action in the numerator.
- In cases where the providers share access to an EHR, a transition or referral may still count toward the measure if the referring provider creates the summary of care document using CEHRT and sends the summary of care document electronically. If an EP chooses to include such transitions to providers where access to the EHR is shared, they must do so universally for all patients and all transitions or referrals.
- For Measure 1, the initiating EP must send a consolidated clinical document architecture (C–CDA) document that the receiving provider would be capable of electronically incorporating as a C–CDA on the receiving end.
- For the purposes of defining the cases in the denominator for Measure 2, we stated what constitutes “unavailable” and, therefore, may be excluded from the denominator, will be that an EP –
    - Requested an electronic summary of care record to be sent and did not receive an electronic summary of care document; and
    - The EP either:
        - Queried at least one external source via HIE functionality and did not locate a summary of care for the patient, or the provider does not have access to HIE functionality to support such a query, or
        - Confirmed that HIE functionality supporting query for summary of care documents was not operational in the provider’s geographic region and not available within the EP’s EHR network as of the start of the EHR reporting period.

- For Measure 2, a record cannot be considered to be incorporated if it is discarded without the reconciliation of clinical information or if it is stored in a manner that is not accessible for EP use within the EHR.
- For Measure 3, the process may include both automated and manual reconciliation to allow the receiving EP to work with both the electronic data provided with any necessary review, and to work directly with the patient to reconcile their health information.
- For Measure 3, if no update is necessary, the process of reconciliation may consist of simply verifying that fact or reviewing a record received on referral and determining that such information is merely duplicative of existing information in the patient record.
- Non-medical staff may conduct reconciliation under the direction of the provider so long as the EP or other credentialed medical staff is responsible and accountable for review of the information and for the assessment of and action on any relevant clinical decision support alert.

Direct Address:

Direct is a way to exchange health information between health care entities. It is similar to email, but contains additional security measures to ensure HIPAA compliance. Direct addresses look very similar to an email address, and can be issued to individuals, organizations, departments or devices. An example of a Direct address is b.wells@direct.aclinic.org. It is important to note that although this looks similar to an email address, traditional email accounts such as gmail and yahoo mail are NOT Direct addresses. Messages sent to and from traditional email accounts are not secure and will fail to send via Direct.

Direct addresses are available from EHR vendors, regional, local and state Health Information Exchange entities, as well as private service providers offering Direct exchange capabilities called Health Information Service Providers (HIPSs).

Best Practices:

- Include the word ‘direct’ when creating a new Direct Secure email address to help identify it.
- Create a list of your top referral partners and contact each office to obtain their Direct address. If they don’t have one, encourage them to sign up for Direct.
- List your Direct address in the Kentucky Direct Catalog, and also utilize the catalog to collect the Direct addresses of referral partners.
- Train staff and providers on how HIE works in your system.
- Ensure all referrals and transitions of care are documented in the EHR.
- Establish workflows for –
    - Requesting an electronic summary of care record and documenting when one was not received
    - Automated and/or manual clinical information reconciliation
- Determine office can query at least one external source via HIE functionality for summary of care document, or confirm the functionality does not exist or was not operational in your EHR during the reporting period.

- Check reports monthly to see how providers are doing to meet this objective and review the results and best practices in your monthly meetings.
- Keep a Summary of Care record in your binder, and ensure it contains the required criteria listed below:

Summary of Care record must include the following information if the provider knows it:

- Patient name
- Demographic information (preferred language, sex, race, ethnicity, date of birth)
- Smoking status
- Current problem list (providers may also include historical problems at their discretion)*
- Current medication list*
- Current medication allergy list*
- Laboratory test(s)
- Laboratory value(s)/result(s)
- Vital signs (height, weight, blood pressure, BMI)
- Procedures
- Care team member(s) (including the primary care provider of record and any additional known care team members beyond the referring or transitioning provider and the receiving provider)
- Immunizations
- Unique device identifier(s) for a patient's implantable device(s)
- Care plan, including goals, health concerns, and assessment and plan of treatment
- Referring or transitioning provider's name and office contact information
- Encounter diagnosis
- Functional status, including activities of daily living, cognitive and disability status
- Reason for referral

*An EP must verify that these three fields are not blank and include the most recent information known by the EP as of the time of generating the summary of care document or include a notation of no current problem, medication and/or medication allergies.

CMS EP Specification Sheet – HIE: https://www.cms.gov/files/document/medicaid-ep-2020-health-information-exchange-objective-7.pdf