



Eligible Hospital Tip Sheet for Meaningful Use Stage 2: Implementation Tips for Summary of Care Objective

Meaningful Use Stage 2 Objective 12 is related to Summary of Care. The objective states that an eligible hospital or CAH that transitions their patient to another setting of care or provider of care or refers their patient to another provider of care provides a summary care record for each transition of care or referral. There are three separate measures for the objective.

Measure 1: The eligible hospital or CAH that 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.

Measure 2: The eligible hospital or CAH that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 10 percent of such transitions and referrals either (a) electronically transmitted using CEHRT to a recipient or (b) where the recipient receives the summary of care record via exchange facilitated by an organization that is an [eHealth Exchange participant](#) or in a manner that is consistent with the governance mechanism ONC establishes for the nationwide health information network. eHealth Exchange was formally referred to as NWHIN in the Final Rule.

Measure 3:

The eligible hospital or CAH must satisfy one of the two following criteria:

- Conducts one or more successful electronic exchanges of a summary of care document, which is counted in "measure 2" (for eligible hospitals and CAHs the measure at §495.6(l)(11)(ii)(B)) with a recipient who has EHR technology that was designed by a different EHR technology developer than the sender's EHR technology certified to 45 CFR 170.314(b)(2); or
- Conducts one or more successful tests with the CMS designated test EHR during the EHR reporting period. Test conducted at the CMS/NIST EHR Randomizer, <https://ehr-randomizer.nist.gov>.

This tip sheet is designed to support eligible hospitals in their planning and implementation as they prepare to attest for Meaningful Use and successfully meet these measures. The steps include:

1. Creation of a Project Team
2. Creation of a Project Plan
3. Implementing 2014 Certified EHR Technology
4. Assessment of Referral Patterns
5. Discharge/Transition Workflow Analysis
6. Internal Communications Plan

7. External Communications Plan
8. Targeted Launch & Testing
9. Go-Live
10. Evaluation

Step 1: Creation of a Project Team

The exchange of relevant clinical data is essential when patients are transitioned from one care setting to another. This requires significant coordination both internally and externally with your community providers. The Summary of Care Objective is designed to measure both paper-based and electronic exchange of clinical data during a transition of care. The collection of data that is sent is called a summary of care record. The goal of the summary of care record is to help providers caring for the same patient to have access to better information and more effectively coordinate the care they provide. There are technical specifications and required information that must be contained within the Summary of Care record, which is often referred to by its name as a standard implementation guide, C-CDA, short for Consolidated-Clinical Document Architecture. For more information on technical requirements of a C-CDA, visit the CMS EHR Incentive Program [website](#). Alternatively, this [presentation](#) on Stage 2 Transitions of Care from CMS eHealth provides details as well.

Developing processes, policies and workflows that incorporate clinical, operational, and technical steps can be overwhelming and time consuming. By creating a project team focused on this effort, and a project plan outlining the tasks, you can ensure that the entire process has the tasks identified and owners assigned to those tasks, from start to finish. The team focused on Transitions of Care will likely be a sub-team of the larger Meaningful Use team. Some of the tasks for this step include:

- ✓ Identifying a Project Sponsor (a key person in the organization that can allocate resources for the project);
- ✓ Identifying a Project Manager knowledgeable in both clinical and operational areas of the organization (the person responsible for keeping track of the project plan, the tasks, identifying risks, acknowledging successes);
- ✓ Forming a Steering Committee (may be necessary in your organization to make important decisions, develop policies and procedures);
- ✓ Identifying an internal technical resource that understands the EHR and can assist with the necessary technical related tasks;
- ✓ Inclusion of the Meaningful Use resource in the organization;
- ✓ Identifying stakeholders (those individuals/organizations both inside and outside your organization that may be effected by this project).

Step 2: Creation of a Project Plan

While you are setting up your project team, it is likely that you will start on the creation of your project plan. This plan contains detailed listings of most, if not all of the tasks identified to successfully implement transitions of care. Along with tasks it is important to identify the owner of those tasks and any dependencies associated with them as well. This step includes:

- ✓ Creating a project plan, also referred to as a work plan (may be done in conjunction with EHR upgrade or provided by EHR vendor);
- ✓ Identifying any project dependencies or coordination points
- ✓ Agreeing on change/review/sign-off processes including how these items are documented
- ✓ Identifying tasks that may need to be performed by your EHR vendor or Health Information Service Provider (HISP)

Step 3: Certified EHR Technology to Support Transitions of Care

Your practice may have already implemented most if not all elements of the 2014 Certified version of your EHR. For 2014 EHR certification and Stage 2 Meaningful Use, electronic health record (EHR) vendors are required to either (a) certify their transitions-of-care modules or complete EHR product offerings to include Direct to meet certification requirements, or (b) work with a third party to provide Direct services. The third party vendor is referred to as a Health Information Service Provider, or HISP. The HISP manages the Direct accounts, and the technology backbone to send and receive messages.

Direct is a technical standard that allows a health care provider or office staff member to send encrypted health information directly to known, trusted recipients, such as other doctors and hospitals, over the Internet. It is very similar to the traditional email you use today, but its contents are encrypted for security. The Direct address looks much like a regular email address but often is integrated into the EHR technology and isn't necessarily accessed like a Microsoft Outlook or Gmail account. This address can be used to send and receive encrypted patient data to and from other doctors or hospitals. You can learn more about Direct by downloading the Direct Basics Guide from HealthIT.gov [here](#).

Some important things to consider when implementing transitions of care with your 2014 certified EHR include:

- ✓ Find out how your certified EHR product met the objective for Summary of Care and what the expectation is for how it should/could be implemented in your organization;
- ✓ Select and Contract with a HISP if necessary (may include the creation and management of a separate project plan); be prepared for the contracting process to take a significant amount of time depending on the processes of your practice;

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- Confirm with the HISP what information may be sent or received using HISP services and to whom;
- Become familiar with the security and identity assurance roles of your HISP, Certificate Authority (CA), and Registration Authority (RA);
- Discuss how to use Direct to connect with providers and patients who subscribe to *other* HISPs;
- Verify Direct Trust accreditation status (DTAAP) of the HISP through [EHNAC](#);
- ✓ Create policies and procedures related to who, what departments, and when records will be transmitted (this determines who in the organization receives Direct email addresses and how those accounts are managed);
- ✓ Identify and plan when all the technology, processes, workflows, policies and procedures will be in place to successfully start your reporting period.

Key Considerations for Numerators and Denominators

Make sure members of the project team agree upon and understand what counts as a transition of care for this measure, what is required to create a MU2-compliant summary of care record and how transitions will be tracked and measured. As stated in CMS FAQ #9690

If the receiving provider already has access to the CEHRT of the initiating provider of the transition or referral, simply accessing the patient's health information does not count toward meeting this objective. However, if the initiating provider also sends a summary of care document, this transition can be included in the denominator and the numerator as long as it is counted consistently across the organization and across both measures, if:

- *For Measure 1, a summary of care document is also provided by any means*
- *For Measure 2, a summary of care document is provided using the same technical standards used if the receiving provider did not have access to the CEHRT*

Review important items such as:

- ✓ What transitions or referrals will be tracked (e.g., transitions of care following an inpatient and/or emergency room visit)?
- ✓ How will these transitions be counted/measured? What transitions to providers cannot count toward the measure (i.e., providers who already have access to the patient's record using the same technology)?
- ✓ What minimum data must be included on the summary of care record to count?
- ✓ Is it clear to all that the hospital's certified EHR must create the summary of care record?
- ✓ What additional documentation will be required for MU2 audit purposes?

Step 4: Assessment of Referral Patterns

Once the technology is in place to support electronic exchange of summary of care records, your organization will have to do some work to identify the providers to whom you'll be sending documents. Start by assessing your current discharges/referrals to identify patterns: Whom do you most often transition or refer your patients to? How will your organization handle incoming documents? Often times, the assessment of referrals can be done while the EHR technology is being upgraded.

- ✓ You will need a mix that you can successfully send to electronically that will be at least 10% of your discharges during the reporting period, but should identify a higher percentage of discharges in advance to increase the likelihood you will meet the measure;
- ✓ As you perform your analysis, consider looking at a full year sample to account for any seasonal changes (e.g. influenza). This will also help prepare you for 2015, when your measurement period will be a full year;
- ✓ It may be necessary to contact the MU resource at provider organizations in your referral network to obtain their Direct addresses to build out your internal and external provider directory (be sure to coordinate these efforts with your HIE and/or HISP);
- ✓ If a significant portion of your transitions are to long-term care or other providers not eligible for the EHR incentive program, you may need to coordinate outreach to these organizations to assist them with obtaining HISP services and how it will benefit their organization;
- ✓ In some cases, it may be necessary for you to exchange provider directories with other organizations or have your vendors perform some additional work behind the scenes to ensure you are able to communicate with other providers. When in doubt, check with your vendor first.
- ✓ Some physician groups and small practices may not have yet implemented a Direct solution or are able to receive electronic transmissions of clinical data, it may be necessary to work with local Health Information Exchange organizations or vendors that offer a web-based secure Direct messaging service to these providers.

Your HISP can assist in determining the technology that is needed to support exchange with your trading partner's technology.

- ✓ Are they using or planning to use 2014-certified technology? If so, when will this be ready to use? You will want to plan your reporting period accordingly.
- ✓ Do they subscribe to services from an [eHealth Exchange Participant](#)? If so, work with your HIE or HISP to determine what options you may have, if you're considering this option.
- ✓ If not using a 2014-certified EHR, do they have Direct through some other means?
 - If not, encourage them to sign up for Direct services. [Find a contact in your state here.](#)

Step 5: Discharge/Transition Workflow Analysis

Implementing the Summary of Care objective for Stage 2 Meaningful Use has implications throughout your organization from registration to the emergency department, and discharge planning. It's crucial to understand how registration will request provider information from patients and their caregivers and how this information will be input into the hospital information system for access once the summary of care document needs to be transmitted.

Looking at both the current state and planning for the future state will allow your organization the opportunity to fully analyze what changes need to be made, how the changes may affect staff and providers and identify the workflows and processes needed to ensure a seamless transition to implementation of this measure. This step includes:

- ✓ Analyzing current state work flow
- ✓ Analyzing current state policies and procedures
- ✓ Reviewing ED Discharge documentation by end-users
- ✓ Reviewing Inpatient Discharge documentation by end-users
- ✓ Planning future state workflow for both outbound and inbound messages
- ✓ Identifying documentation components not currently captured for follow-up providers or facilities
- ✓ Updating training plans and documentation for new workflow(s)
- ✓ Training users

Step 6: Develop an Internal Communications Plan

Communicating the new workflows, processes, policies and procedures is essential to success.

Depending on your organization, you may find it necessary to use multiple avenues of communication as well as training methods. It may also be helpful to have ongoing communication throughout the project rollout so that all staff members have insight into the changes and the timing for when those changes go into effect. Important elements in your communications plan include:

- ✓ Timing of changes and who specifically it impacts
- ✓ How technology is used to support the process
- ✓ When and how training will be deployed
- ✓ Dashboards of work completed

Step 7: Develop an External Communications Plan

Having frequent communication with your external trading partners throughout the roll-out is fundamental to tracking success of your Summary of Care objective and the use of the EHR technology. Understanding the training needs of your external partners such as ambulatory providers and nursing homes, are vital because your success depends on them receiving the summary of care records sent by your organization.

Step 8: Targeted Launch and Testing

Prior to launching your entire ToC program, it may be helpful to identify one or two key partners with which to test the process. Tracking the MU Dashboard reports for accuracy in numerator and denominator counting as well as timely follow-up with organizations to ensure that documents were received are key tasks to a success launch. This is also a way to understand which EHR technology your partners are using on their end to support Measure 3 of the Summary of Care objective. This is also helpful to your organization to understand how your EHR technology will be used to receive documents from other providers and EHR systems.

Step 9: Go-Live

Once the technology is in place, the provider directory created, Direct addresses distributed, training is completed and all the workflows are in place, you are ready for go-live. For the 90-day reporting period in the first year of Stage 2, it may be necessary to launch electronic exchange with a few trading partners to start. This will provide opportunities to identify enhancements in both the technology and the process needed to streamline the electronic transmission of Summary of Care records to support Transitions of Care.

- ✓ Run and distribute Meaningful Use Dashboards frequently to track progress and ensure continued compliance with the measure;
- ✓ Keep the Steering Committee apprised of progress and remember to celebrate your successes;
- ✓ Create a community-wide group of hospitals and provider organizations that meets regularly to discuss transitions of care both inside and outside of meaningful use;
- ✓ Create a process for adding new trading partners as they are identified or able to send and receive messages – may be necessary to keep a small portion of the project team focused on this effort.

Step 10: Evaluation

Careful evaluation and tracking of transitions of care, sending of summary of care records and receipts of successful transmissions contributes to the success of meeting the measures within the Summary of Care objective in a timely fashion.

Closing Recommendations

Successful implementation of the Summary of care objective involves many steps and impacts many parts of the organization. Creating a team that includes people from across your organization is your first step to success. Ensure that multiple perspectives are included and that the process has been analyzed from the time of patient registration through patient discharge and final documentation. It may be necessary to organize community-wide events in your area to discuss transitions of care processes in an effort to create strong buy-in across a wide-variety of healthcare providers.