Eligible Professional Meaningful Use Core Measures Measure 14 of 15

Stage 1

Last Updated: March 9, 2012

Electronic Exchange of Clinical Information	
Objective	Capability to exchange key clinical information (for example, problem list, medication list, medication allergies, and diagnostic test results), among providers of care and patient authorized entities electronically.
Measure	Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information.
Exclusion	No exclusion.

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Definition of Terms

Diagnostic Test Results – All data needed to diagnose and treat disease. Examples include, but are not limited to, blood tests, microbiology, urinalysis, pathology tests, radiology, cardiac imaging, nuclear medicine tests, and pulmonary function tests.

Different Legal Entities – A separate legal entity is an entity that has its own separate legal existence. Indications that two entities are legally separate would include (1) they are each separately incorporated; (2) they have separate Boards of Directors; and (3) neither entity is owned or controlled by the other.

Distinct Certified EHR Technology – Each instance of certified EHR technology must be able to be certified and operate independently from all the others in order to be distinct. Separate instances of certified EHR technology that must link to a common database in order to gain certification would not be considered distinct. However, instances of certified EHR technology that link to a common, uncertified system or component would be considered distinct. Instances of certified EHR technology can be from the same vendor and still be considered distinct.

Exchange – Clinical information must be sent between different legal entities with distinct certified EHR technology and not between organizations that share a certified EHR technology. Distinct certified EHR technologies are those that can achieve certification and operate independently of other certified EHR

technologies. The exchange of information requires that the eligible professional must use the standards of certified EHR technology as specified by the Office of the National Coordinator for Health IT, not the capabilities of uncertified or other vendor-specific alternative methods for exchanging clinical information.

Patient Authorized Entities – Any individual or organization to which the patient has granted access to their clinical information. Examples would include an insurance company that covers the patient, an entity facilitating health information exchange among providers, or a personal health record vendor identified by the patient. A patient would have to affirmatively grant access to these entities.

Attestation Requirements

YES / NO

Eligible professionals (EPs) must attest YES to having performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information prior to the end of the EHR reporting period to meet this measure.

Additional Information

- The test of electronic exchange of key clinical information must involve the transfer of information to another provider of care with distinct certified EHR technology or other system capable of receiving the information. Simulated transfers of information are ***not*** acceptable to satisfy this objective.
- The transmission of actual patient information is ***not*** required for the purposes of a test. The use of test information about a fictional patient that would be identical in form to what would be sent about an actual patient would satisfy this objective.
- When the clinical information is available in a structured format it should be transferred in a structured format. However, if the information is unavailable in a structured format, the transmission of unstructured data is permissible.
- EPs can use their clinical judgment to identify what clinical information is considered key clinical information for purposes of exchanging clinical information about a patient at a particular time with other providers of care. A minimum set of information is identified in the HIT Standards and Criteria rule at 45 CFR 170.304(i), and is generally outlined in this objective as: problem list, medication list, medication allergies, and diagnostic test results. An EP's determination of key clinical information could include some or all of this information, as well as information not included here.
- An EP should test their ability to send the minimum information set in the HIT Standards and Criteria rule at 45 CFR 170.304(i). If the EP continues to exchange information beyond the initial test, then the provider may decide what information should be exchanged on a case-by-case basis.
- EPs must test their ability to electronically exchange key clinical information at least once prior to the end of the EHR reporting period. Testing may also occur prior to the beginning of the EHR reporting period. Every payment year requires its own, unique test. If multiple EPs are using the

same certified EHR technology in a shared physical setting, testing would only have to occur once for a given certified EHR technology.

- An unsuccessful test of electronic exchange of key clinical information will be considered valid for meeting the measure of this objective.

Related Meaningful Use FAQs

To see the FAQs, click the New ID # hyperlinks below, or visit the CMS FAQ web page at https://questions.cms.gov/ and enter the New ID # into the Search Box, clicking the "FAQ #" option to view the answer to the FAQ. (Or you can enter the OLD # into the Search Box and click the "Text" option.)

- For the meaningful use objective of "capability to exchange key clinical information," does exchange of electronic information using physical media, such as USB, CD-ROM, or other formats, meet the measure of this objective? ***New ID #3255***, ***Old ID #10638***
- For the meaningful use objective of "capability to exchange key clinical information," what forms of electronic transmission can be used to meet the measure of the objective? ***New ID #3359***, ***Old ID #10691***
- To meet the meaningful use objective "capability to exchange key clinical information," can different providers of care (e.g., physicians, hospitals, etc.) share EHR technology and successfully meet this objective? ***New ID #5985***, ***Old ID #10270***
- For meaningful use objectives that require a provider to test the transfer of data, can the EP, eligible hospital, or CAH conduct the test from a test environment or test domain of its certified EHR technology in order to satisfy the measures of these objectives? ***New ID #3817***, ***Old ID #10978***
- For meaningful use objectives that require a provider to test the transfer of data, if multiple EPs are using the same certified EHR technology across several physical locations, can a single test serve to meet the measures of these objectives? ***New ID #3819***, ***Old ID #10979***

Certification and Standards Criteria

Below is the corresponding certification and standards criteria for electronic health record technology that supports achieving the meaningful use of this objective.

Certification Criteria	
§170.304(i) Exchange clinical information and patient summary record	(1) *Electronically receive and display.* Electronically receive and display a patient's summary record, from other providers and organizations including, at a minimum, diagnostic tests results, problem list, medication list, and medication allergy list in accordance with the standard (and applicable implementation specifications) specified in §170.205(a)(1) or §170.205(a)(2). Upon receipt of a patient summary record formatted according to the alternative standard, display it in human readable format.

	(2) *Electronically transmit.* Enable a user to electronically transmit a patient summary record to other providers and organizations including, at a minimum, diagnostic test results, problem list, medication list, and medication allergy list in accordance with: (i) The standard (and applicable implementation specifications) specified in §170.205(a)(1) or §170.205(a)(2); and (ii) For the following data elements the applicable standard must be used: (A) *Problems*. The standard specified in §170.207(a)(1) or, at a minimum, the version of the standard specified in §170.207(a)(2); (B) *Laboratory test results*. At a minimum, the version of the standard specified in §170.207(c); and (C) *Medications.* The standard specified in §170.207(d).

Standards Criteria	
Patient summary record	• §170.205(a)(1) - HL7 CDA Release 2, CCD. Implementation specifications: HITSP Summary Documents Using HL7 CCD Component HITSP/C32. • §170.205(a)(2) - ASTM E2369 Standard Specification for Continuity of Care Record and Adjunct to ASTM E2369.
Problems	• §170.207(a)(1) - The code set specified at 45 CFR 162.1002(a)(1) for the indicated conditions. • §170.207(a)(2) - IHTSDO SNOMED CT® July 2009 version.
Laboratory test results	• §170.207(c) - LOINC® version 2.27, when such codes were received within an electronic transaction from a laboratory.
Medication	• §170.207(d) - Any source vocabulary that is included in RxNorm, a standardized nomenclature for clinical drugs produced by the United States National Library of Medicine.

Related Certification FAQs

Click on the green numbers to view the answer to the FAQ.

- I've identified that I am using two different EHR technologies to meet a single certification criterion (my document management system receives and displays summary records (45 CFR 306(f)(1)) and my EHR technology from EHR technology developer XYZ transmits summary records (45 CFR 306(f)(2)). Do both EHR technologies need to be certified? ***9-10-011-1***
- Could an interface that transmits lab results in HL7 message format between a hospital laboratory system and a physician's EHR (presuming that the transmissions were occurring between two different legal entities) satisfy the certification criteria related to the exchange of key clinical information in 45 CFR 170.304(i) and 45 CFR 170.306(f)? ***12-10-023-1***