

Support Electronic Referral Loops by Receiving and Incorporating Health Information



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The objective of this measure is to provide a summary of care record for each transition of care or referral when you transition your patient to another setting of care or healthcare clinician or when another healthcare clinician transitions or refers a patient to you.

Measure

For at least one electronic summary of care record received for patient encounters during the performance period for which a MIPS-eligible clinician was the receiving party of a transition of care or referral—or for patient encounters during the performance period in which the MIPS-eligible clinician has never before encountered the patient—the MIPS eligible clinician conducts clinical information reconciliation for medication, medication allergy, and current problem list.

Denominator

Number of electronic summary of care records received using a certified EHR for patient encounters during the performance period for which a MIPS-eligible clinician was the receiving party of a transition of care or referral, and for patient encounters during the performance period in which the MIPS-eligible clinician has never before encountered the patient.

Numerator

The number of electronic summary of care records in the denominator for which clinical information reconciliation is completed using a certified EHR for the following three clinical information sets:

- **Medication.** Review of the patient's medication, including the name, dosage, frequency, and route of each medication.
- **Medication allergy.** Review of the patient's known medication allergies.
- **Current problem list.** Review of the patient's current and active diagnoses.

Threshold

The numerator must be one or more.

Exclusion

Any MIPS-eligible clinician who is unable to implement the measure for a MIPS performance period in 2019 would be excluded from having to report this measure.

OR

Any MIPS-eligible clinician who receives fewer than 100 transitions of care or referrals or has fewer than 100 encounters with patients never before encountered during the performance period.

Scoring

This measure is required to achieve a promoting interoperability score. This measure is worth up to 20 points.

Eyefinity EHR Instructions

This objective of this measure is to encourage you to incorporate patient health information sent by other clinicians into the patient's record. You should, whenever possible, request that the summary of care (CCD) be sent electronically via direct mail .

This process requires two actions: receiving the summary of care and incorporating the data into the patient's record.

Receiving Summaries of Care

To complete this task, you will need a secure message with a summary of care (CCD) attached, and a preliminary visit with which to associate the CCD. When you receive a secure message containing a CCD file, perform the following steps:

1. In Eyefinity EHR, tap **Mail**.
2. Select the Direct Mail **Inbox**.
3. Tap the subject of the message.
4. In the Attachments section, locate the CCD and tap **Associate with Patient**.
The Document Management page opens.
5. Enter the name of the **Patient**, select the **Visit**, and ensure the **Category** displays CCD.
6. Tap **Save**.

Incorporating Summaries of Care into Patient Records

Once you've associated the summary of care with an exam, you'll need to incorporate the medication, medication allergy, and problem list data into the patient's record:

1. Open the preliminary visit.
2. Open the patient clipboard:
 - a. Tap **More**.
 - b. Select **Patient Clipboard**.
3. Tap **Edit**.
4. Reconcile any medications:
 - a. Tap the **Medications** tab.
 - b. Tap **Import**.
 - c. Select **Transition of Care (CCD)**.
 - d. Review the medications.
 - e. Tap **Select All** or tap to select individual medications manually, as needed, and tap **Accept**.

OR

Tap **Reject** to not incorporate any of the medications into the patient's record.

A summary page lists the patient's current medications and highlights the medications that will be imported from the CCD.

- f. Tap **Accept**.
 - g. Tap **Back** to exit medications and return to the patient clipboard.
5. Reconcile any medication allergies:

- a. Tap the **Allergies** tab.
- b. Tap **Reconcile**.
- c. Select **Transitions**.
- d. Review the allergies.

The left side of the screen displays the allergies currently in the patient record. The right side of the screen lists the allergies included in the CCD, including the date recorded, the author, reaction, and severity. You may need to swipe up to see additional allergies.

- e. Tap **Select All** or tap to select individual allergies manually, as needed, and tap **Accept**.

OR

Tap **Reject** to not incorporate any of the allergies into the patient's record.

A summary page lists the patient's current allergies and highlights the allergies that will be imported from the CCD.

- f. Tap **Accept**.
- g. Tap **Back** to exit allergies and return to the patient clipboard.

6. Reconcile the problem list:

- a. Tap the **Problem List** tab.
- b. Tap **Reconcile**.
- c. Select **Transitions**.
- d. Review the problems.

The left side of the screen displays the problems currently in the patient record. The right side of the screen lists the problems included in the CCD, including the date recorded and author. You may need to swipe up to see additional problems.

- e. Tap **Select All** or tap to select individual problems manually, as needed, and tap **Accept**.

OR

Tap **Reject** to not incorporate any of the problems into the patient's record.

A summary page lists the patient's current problems and highlights the problems that will be imported from the CCD.

- f. Tap **Accept**.
- g. Tap **Done** to exit medications and the patient clipboard.

The reconciliation is now complete. Continue documenting the exam.

Responsible Role

The following are suggested roles for completing this measure:

- Doctor
- Technician
- Scribe