Data Specifications Manual

Emergency Department Transfer Communication Measure

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Emergency Department Transfer Communication Measure Specifications

ED Transfer Communication Quality Measure

Numerator Statement: Number of patients transferred to another healthcare facility whose medical record documentation indicated that all the following relevant elements were documented and communicated to the receiving hospital in a timely manner:

- Home Medications
- Allergies and/or Reactions
- Medications Administered in ED
- ED Provider Note
- Mental Status/Orientation Assessment
- Reason for Transfer and/or Plan of Care
- Tests and/or Procedures Performed
- Tests and/or Procedures Results

Denominator Statement: Transfers from an ED to another healthcare facility.

Background of the Measure

In 2003, an expert panel convened by Stratis Health and the University of Minnesota Rural Health Research Center identified Emergency Department care as an important quality assessment measurement category for rural hospitals. Emergency care is particularly critical in rural hospitals where more limited scope of hospital services and geographic realities make organizing triage, stabilization, and transfer of patients an essential aspect of rural hospital care. Communication between hospitals and clinicians promotes continuity of care and may lead to improved patient outcomes. From 2005 to 2014, these measures were piloted by rural hospitals in Hawaii, Iowa, Maine, Minnesota, Missouri, Nebraska, Nevada, New York, Ohio, Oklahoma, Pennsylvania, Utah, Washington, West Virginia, Wisconsin, and Wyoming. Results of the pilot projects indicated room for improvement in ED care and transfer communication. Aggregate project results are available at http://www.flexmonitoring.org/wp-content/uploads/2014/02/ds8.pdf and http://www.flexmonitoring.org/publications/ds3/.

Communication problems are a major contributing factor to adverse events in hospitals, accounting for 65% of sentinel events tracked by The Joint Commission. In addition, research indicates that deficits exist in the transfer of patient information between hospitals and primary care physicians in the community, and between hospitals and long-term facilities. Transferred patients are excluded from the calculation of most national quality measures, such as those used in Hospital Compare. The Hospital Compare Web site was created to display rates of Process of Care measures using data that are voluntarily submitted by hospitals.

The Joint Commission has adopted National Patient Safety Goal 2, "Improve the Effectiveness of Communication Among Caregivers." This goal required all accredited hospitals to implement a standardized approach to hand- off communications, including nursing and physician handoffs from

the emergency department (ED) to inpatient units, other hospitals, and other types of health care facilities. The process must include a method of communicating up-to-date information regarding the patient's care, treatment, and services; condition, and any recent or anticipated changes. (Note: The National Patient Safety Goals are reviewed and modified periodically. In 2013 a communication goal focused on the communication of test results.) http://www.jointcommission.org/assets/1/6/HAP_NPSG_Chapter_2014.pdf

Limited attention has been paid to the development and implementation of quality measures specifically focused on patient transfers between EDs and other health care facilities. Examples are patients transferred between an ED and a skilled nursing facility with their often vulnerable and fragile populations. These measures are essential for all health care facilities, but especially so for small rural hospitals that transfer a higher proportion of ED patients.

While many aspects of hospital quality are similar for urban and rural hospitals (e.g., providing heart attack patients with aspirin), the urban/rural contextual differences result in differences in emphasis on quality measurement. Because of its role in linking residents to urban referral centers, important aspects of rural hospital quality include triage-and-transfer decision making about when to provide a particular type of care, transporting patients, and coordinating information flow to specialists beyond the community.

Emergency care is important in all hospitals, but it is particularly crucial in rural hospitals. Rural residents often need to travel greater distances than urban residents to get to a hospital initially. Because of their size, rural hospitals are less likely to have specialized staff and services such as cardiac catheterization or trauma surgery found in larger tertiary care centers, so high acuity patients are also more likely to be transferred. These size and geographic realities increase the importance of organizing triage, stabilization, and transfer in rural hospitals, which, in turn, suggest that measurement of these processes is an important issue for rural hospitals.

In 2018, as part of the Rural Quality Improvement Technical Assistance (RQITA) program, Stratis Health, in partnership with the University of Minnesota Rural Health Research Center, convened a Technical Expert Panel (TEP) to review, revise, and update the EDTC measures and the related specifications manual. The Panel members represented national experts in hospital ED physicians and nurses, quality measurement, electronic health records, and data analytics. The TEP met three times via conference call to review the measure specifications, and discussion was framed around three primary issues and challenges, including EDTC in a ""wired" world, appropriate population for transfers, and clinical relevance of specific data elements. The TEP recommended significant changes to help streamline and modernize the measure including reducing the total number of data elements from 27 to 8, updating the definition of 'sent' to better address communication via electronic health record (EHR) or health information exchange HIE, and clarifying specific definitions of individual data elements.

The ED Transfer Communication measure aims to provide a means of assessing how well key patient information is communicated from an ED to any healthcare facility. They apply to patients with a wide range of medical conditions (e.g., acute myocardial infarction, heart failure, pneumonia, respiratory compromise, and trauma) and are relevant for both internal quality improvement purposes and external reporting.

Selected References

Baldwin LM, MacLehose RF, Hart LG, Beaver SK, Every N, Chan L. Quality of care for acute myocardial infarction in rural and urban US hospitals. J Rural Health 2004 Spring;20(2):99-108.

Cortes TA, Wexler S, Fitzpatrick JJ. The transition of elderly patients between hospitals and nursing homes. Improving nurse-to-nurse communication. J Gerontol Nurs 2004 Jun;30(6):10-5; quiz 52-3. [5 references]

Ellerbeck EF, Bhimaraj A, Perpich D. Organization of care for acute myocardial infarction in rural and urban hospitals in Kansas. J Rural Health 2004 Fall;20(4):363-7.

Joint Commission on Accreditation of Healthcare Organizations. Sentinel events statistics. [Internet]. [Accessed 2007 Jul 18].

Klingner J, Moscovice I, Washington Rural Healthcare Quality Network and Stratis Health, Minnesota Quality Improvement Organization. Rural hospital emergency department quality measures: aggregate data report. Minneapolis (MN): University of Minnesota, Division of Health Services Research & Policy; 2007 Mar. 12 p. (Flex Monitoring Team data summary report; no. 3).

Klingner J, Moscovice I. Development and testing of emergency department patient transfer communication measures. J Rural Health 2012 Jan;28(1):44-53. [16 references]

Kripalani S, Lefevre F, Phillips CO, Williams MV, Basaviah P, Baker DW. Deficits in communication and information transfer between hospital-based and primary care physicians: implications for patient safety and continuity of care. JAMA 2007 Feb 28;297(8):831-41. [133 references]

Newgard CD, McConnell KJ, Hedges JR. Variability of trauma transfer practices among non-tertiary care hospital emergency departments. Acad Emerg Med 2006 Jul;13(7):746-54.

University of Minnesota Rural Health Research Center, Stratis Health (Minnesota's Quality Improvement Organization), HealthInsight (Nevada and Utah's Quality Improvement Organization). Refining and field testing a relevant set of quality measures for rural hospitals. Final report submitted to the Centers for Medicare & Medicaid Services under contract no. 500-02-MN01. Bloomington (MN): Stratis Health; 2005 Jun 30.

US Department of Health and Human Services. Hospital Compare Web site. [Web site]. [Accessed 2011 Feb 25].

Wakefield DS, Ward M, Miller T, Ohsfeldt R, Jaana M, Lei Y, Tracy R, Schneider J. Intensive care unit utilization and interhospital transfers as potential indicators of rural hospital quality. J Rural Health 2004 Fall;20(4):394-400.

Westfall JM, Van Vorst RF, McGloin J, Selker HP. Triage and diagnosis of chest pain in rural hospitals: implementation of the ACI-TIPI in the High Plains Research Network. Ann Fam Med 2006 Mar-Apr;4(2):153-8.

Population and Sampling

ED Transfer Communication (EDTC) Initial Patient Population
The population of the EDTC measure is defined by identifying those patients admitted to the emergency department who were then **discharged**, **transferred,** or **returned** to these facilities:

Inclusions:
- Acute Care Facility – Cancer Hospital or Children's Hospital – Including emergency department
- Acute Care Facility – Critical Access Hospital – Including emergency department
- Acute Care Facility – Department of Defense or Veteran's Administration – Including emergency department
- Acute Care Facility- General Inpatient Care – Including emergency department
- Hospice – healthcare facility
- **Other health care facility*, including discharge, transfer or return to:**
  - Extended or Intermediate Care Facility (ECF/ICF)
  - Long Term Acute Care Hospital (LTACH)
  - Long Term Care Facility
  - Nursing Home or Facility, including Veteran's Administration Nursing Facility
  - Psychiatric Hospital or Psychiatric Unit of a Hospital
  - Rehabilitation Facility, including Inpatient Rehabilitation Facility/Hospital or Rehabilitation Unit of a Hospital
  - Skilled Nursing Facility (SNF), Sub-Acute Care, or Swing Bed
  - Transitional Care Unit (TCU)

*Other health care facilities MUST be included in the population.

Exclusions:
- AMA (left against medical advice)
- Expired
- Home, including:
  - Assisted Living Facilities
  - Board and care, foster or residential care, group or personal care homes, and homeless shelters
  - Court/Law Enforcement – includes detention facilities, jails, and prison
  - Home with Home Health Services
  - Outpatient Services including outpatient procedures at another hospital, Outpatient Chemical Dependency Programs, and Partial Hospitalization
- Hospice-home
- Not Documented/Unable to determine
- Observation Status

Sample Size Requirements

Hospitals need to submit a **minimum of 45 cases** per quarter from the required population. A hospital may choose to sample and submit **more than** 45 cases. Hospitals that choose to sample have the option of sampling quarterly or sampling monthly. Hospitals whose initial patient population size is **less than** the minimum number of 45 cases per quarter for the measure cannot sample and should submit **all cases** for the quarter.

Hospital samples must be monitored to ensure that sampling procedures consistently produce statistically valid and useful data. Sample cases should be randomly selected in such a way that the individual cases in the population have an equal chance of being selected.

Measure Calculation

This measure is calculated using an all or none approach.

The overall EDTC Measure can be calculated as the percent of patients that met <u>all</u> the eight data elements.

Data elements not appropriate for an individual patient are scored as NA (not applicable), are counted in the measure as a positive, or 'yes' response, and the patient will meet that element criteria. The patient will either need to meet the criteria for all the data elements, or have an NA.

For quality improvement purposes, facilities are encouraged to review their information at the data element level to identify improvement opportunities in the transfer communication process.

Definition of *Sent* and Considerations for Electronic Transfer of Information

For ALL data elements, the definition of 'sent' includes the following documentation requirements:

- Hard copy sent directly with the patient, or
- Communicated via fax or phone within 60 minutes of patient departure, or
- Immediately available via shared EHR or HIE (see definition below)

For purposes of this measure, an EHR is defined as one where data entered into the system is **immediately** available at the receiving site. Facilities using the same EHR vendor or an HIE cannot assume immediate access by the receiving facility to the transferred patient's records.

Emergency Department Transfer Communication: All or None Composite Calculation

Measure Name: Emergency Department Transfer Communication
Measure ID: EDTC-All

Description: Patients who are transferred from an ED to another healthcare facility have all necessary communication made available to the receiving facility in a timely manner.

Rationale: Timely, accurate, and direct communication facilitates the handoff to the receiving facility provides continuity of care and avoids medical errors and redundant tests.

Type of Measure: Process

Improvement Noted As: An increase in the rate

Numerator Statement: Number of patients transferred to another healthcare facility whose medical record documentation indicated that all the following relevant elements were documented and communicated to the receiving hospital in a timely manner:

1. Home Medications
2. Allergies and/or Reactions
3. Medications Administered in ED
4. ED Provider Note
5. Mental Status/Orientation Assessment
6. Reason for Transfer and/or Plan of Care
7. Tests and/or Procedures Performed
8. Tests and/or Procedures Results

For ALL data elements, the definition of 'sent' includes the following documentation:
- Hard copy sent directly with the patient, or Communicated via fax or phone within 60 minutes of patient departure, or
- Immediately available via shared EHR or HIE

Denominator Statement: Transfers from an ED to another healthcare facility
Included Population: All transfers from an ED to another healthcare facility
Excluded Populations: None

Calculation:
   # of patients who have a Yes or NA for all elements
    All transfers from ED to another healthcare facility

Risk Adjustment: No

Data Collection Approach: Retrospective data sources for required data elements include administrative data and medical records.

Sampling: Yes, please refer to the measure specific sampling requirements (pg. 6)

Emergency Department Transfer Communication
Data Elements

1. Home Medications

For ALL data elements, the definition of 'sent' includes the following documentation requirements:
- Hard copy sent directly with the patient, or
- Communicated via fax or phone within 60 minutes of patient departure, or
- Immediately available via shared EHR or HIE

Suggested Data Collection Question: Does the medical record documentation indicate that the patient's current home medication list was sent to the receiving facility?

Allowable Values:
Y (Yes) Select this option if there is documentation that the patient's current home medication list was sent to the receiving facility.
N (No) Select this option if there is no documentation that the patient's current home medication list was sent to the receiving facility.

Notes for Abstraction:
- If documentation indicates patient is not on any home medications, select yes.
- If documentation is sent that home medications are unknown, select yes
- If patient is unable to respond, select yes.

Suggested Data Sources:
- Emergency Department record
- Transfer Summary

Inclusion Guidelines for Abstraction:
- Complimentary medications
- Over the counter (OTC) medications
- Prescription medications

Exclusion Guidelines for Abstraction: None

2. Allergies and/or Reactions

For ALL data elements, the definition of 'sent' includes the following documentation requirements:
- Hard copy sent directly with the patient, or
- Communicated via fax or phone within 60 minutes of patient departure, or
- Immediately available via shared EHR or HIE

Suggested Data Collection Question: Does the medical record documentation indicate that the patient's allergy history was sent to the receiving facility?

Allowable Values:
Y (Yes) Select this option if there is documentation that the patient's allergy information (or "unknown" if allergies not known) was sent to the receiving facility.
N (No) Select this option if there is no documentation that the patient's allergy information was sent to the receiving facility.

Notes for Abstraction:
- Allergy information can include:
  - Food allergies/reactions
  - Medication allergies/reactions
  - Other allergies/reactions
- If there is documentation of either an allergy or its reaction, select yes.
- If documentation that allergies are unknown, select yes.
- If documentation of "No Known Allergies", select yes.

Suggested Data Sources:
- Emergency Department record
- Transfer Summary

Inclusion Guidelines for Abstraction: None

Exclusion Guidelines for Abstraction: None

3. Medications Administered in ED

For ALL data elements, the definition of 'sent' includes the following documentation requirements:
- Hard copy sent directly with the patient, or
- Communicated via fax or phone within 60 minutes of patient departure, or
- Immediately available via shared EHR or HIE

Suggested Data Collection Question: Does the medical record documentation indicate that the list of medication(s) administered in the ED was sent to the receiving facility?

Allowable Values:
  Y (Yes) Select this option if there is documentation that the list of medications administered was sent to the receiving facility.
  N (No) Select this option if there is no documentation that the list of medications administered was sent to the receiving facility.
  NA (Not Applicable) Select this option if no medications were given.

Notes for Abstraction:
- Medication information documented anywhere in the ED record is acceptable.

Suggested Data Sources:
- Emergency Department record
- Medication Administration Record (MAR) if part of the ED documentation for the current encounter
- Transfer Summary document

Inclusion Guidelines for Abstraction: None

Exclusion Guidelines for Abstraction: None

4. ED Provider Note

For ALL data elements, the definition of 'sent' includes the following documentation requirements:
- Hard copy sent directly with the patient, or
- Communicated via fax or phone within 60 minutes of patient departure, or
- Immediately available via shared EHR or HIE

Suggested Data Collection Question: Does the medical record documentation indicate that an ED Provider Note was completed by the physician, advanced practice nurse (APN), or physician assistant (PA) and sent to the receiving facility?

Allowable Values:

Y (Yes) Select this option if there is documentation that an ED Provider Note was completed and sent to the receiving facility.

N (No) Select this option if there is no documentation that an ED Provider Note was completed and sent to the receiving facility.

Notes for Abstraction:

Provider note must include, at a minimum:
- Reason for the current ED encounter (medical complaint or injury)
- History of present illness or condition
- A focused physical exam
- Relevant chronic conditions, though chronic conditions may be excluded if the patient is neurologically impaired/altered

Suggested Data Sources:
- Emergency Department record
- Transfer Summary

Inclusion Guidelines for Abstraction: None

Exclusion Guidelines for Abstraction: None

5. Mental Status/Orientation Assessment

For ALL data elements, the definition of 'sent' includes the following documentation requirements:
- Hard copy sent directly with the patient, or
- Communicated via fax or phone within 60 minutes of patient departure, or
- Immediately available via shared EHR or HIE

Suggested Data Collection Question: Does the medical record documentation indicate that a Mental Status/Orientation Assessment was completed and sent to the receiving facility?

Allowable Values:
Y (Yes) Select this option if there is documentation that a mental status/orientation assessment was completed and sent to the receiving facility.
N (No) Select this option if there is no documentation that a mental status/orientation assessment for the condition was completed and sent to the receiving facility.

Notes for Abstraction:
Acceptable documentation includes but is not limited to:
- Alert
- Oriented
- Comatose
- Confused
- Demented
- Unresponsive
- Any Coma/Stroke Scale (e.g., Glasgow coma scale)
- Any mental status/orientation exam, scale, or assessment

Suggested Data Sources:
- Emergency Department record
- Transfer Summary document
- Glasgow coma scale
- Neuro flow sheets
- Vital Signs flow sheets

Inclusion Guidelines for Abstraction: None

Exclusion Guidelines for Abstraction: None

6. Reason for Transfer and/or Plan of Care

For ALL data elements, the definition of 'sent' includes the following documentation requirements:
- Hard copy sent directly with the patient, or
- Communicated via fax or phone within 60 minutes of patient departure, or
- Immediately available via shared EHR or HIE

Suggested Data Collection Question: Does the medical record documentation indicate that a reason for transfer and/or plan of care was identified by the physician, advanced practice nurse, or physician assistant (physician, APN, PA) and sent to the receiving facility?

Allowable Values:
Y (Yes) Select this option if there is documentation that a reason for transfer and/or plan of care was written and sent to the receiving facility.
N (No) Select this option if there is no documentation that a reason for transfer and/or plan of care was written and sent to the receiving facility.

Notes for Abstraction:
- May include suggestions for care to be received at the receiving facility.

Suggested Data Sources:
- Emergency Department record
- Transfer Summary
- EMTALA form

Inclusion Guidelines for Abstraction: None

Exclusion Guidelines for Abstraction: None

7. Tests and/or Procedures Performed

For ALL data elements, the definition of 'sent' includes the following documentation requirements:
- Hard copy sent directly with the patient, or
- Communicated via fax or phone within 60 minutes of patient departure, or
- Immediately available via shared EHR or HIE

Suggested Data Collection Question: Does the medical record documentation indicate that information was sent regarding any tests and procedures that were done in the ED?

Allowable Values:
   Y (Yes) Select this option if there is documentation that information on all tests and procedures that were done in the ED prior to transfer was sent to the receiving facility.
   N (No) Select this option if there is no documentation that information on all tests and procedures that were done in the ED prior to transfer was sent to the receiving facility.
   NA (Not Applicable) Select this option if no tests or procedures were done.

Notes for Abstraction:
- If no tests or procedures were done, select NA.

Suggested Data Sources:
- Emergency Department record
- Lab documentation
- Transfer Summary document

Inclusion Guidelines for Abstraction:
- Lab work ordered
- X-rays
- Procedures performed
- EKGs
- Cultures

Exclusion Guidelines for Abstraction: None

8. Tests and/or Procedure Results

For ALL data elements, the definition of 'sent' includes the following documentation requirements:
- Hard copy sent directly with the patient, or
- Communicated via fax or phone within 60 minutes of patient departure, or
- Immediately available via shared EHR or HIE

Suggested Data Collection Question: Does the medical record documentation indicate that results were sent from completed tests and procedures done in the ED?

Allowable Values:
   Y (Yes) Select this option if there is documentation of results being sent either with the patient or communicated to the receiving facility when available.
   N (No) Select this option if there is no documentation of results being sent either with the patient or communicated to the receiving facility when available.
   NA (Not Applicable) Select this option if no tests or procedures were done.

Notes for Abstraction:
- If facilities have a shared electronic health record, then tests and procedure results are considered sent, select yes.
- If results are not sent and facilities do not share electronic health records, then documentation must include a plan to communicate results to select yes.
- If no plan to communicate results, select no.

Suggested Data Sources:
- Emergency Department record
- Lab documentation
- Transfer Summary document

Inclusion Guidelines for Abstraction:
- Lab results
- X-ray results
- Procedure results
- EKG
- Cultures

Exclusion Guidelines for Abstraction: None

Appendix A: Emergency Department Transfer Communication Data Collection Tool

CMS Certified Number (CCN): _____

Name of State: _____

Patient Name: _____

Patient Medical Record Number: _____

Select Patient Discharged Disposition: (Select one option)

_____ Acute Care Facility – Cancer Hospital or Children's Hospital

_____ Acute Care Facility – Critical Access Hospital

_____ Acute Care Facility – Department of Defense or Veteran's Administration

_____ Acute Care Facility – General Inpatient Care

_____ Hospice – healthcare facility

_____ Other health care facility –

- Extended or Intermediate Care Facility (ECF/ICF)
- Long Term Acute Care Hospital (LTACH)
- Long Term Care Facility
- Nursing Home or Facility, including Veteran's Administration Nursing Facility
- Psychiatric Hospital or Psychiatric Unit of a Hospital
- Rehabilitation Facility, including Inpatient Rehabilitation Facility/Hospital or Rehabilitation Unit of a Hospital
- Skilled Nursing Facility (SNF), Sub-Acute Care, or Swing Bed
- Transitional Care Unit (TCU)

Date of Patient Encounter: _____/_____/_____
                                  (MM-DD-YYYY)

Date of Data Collection: _____/_____/_____
                                  (MM-DD-YYYY)

<mark>*NOTE: Prior to completing the data collection tool, please reference the Emergency Department Transfer Communication Measures Data Specifications Manual for detailed descriptions of each data element.*</mark>

For ALL data elements, the definition of 'sent' includes the following documentation requirements:

- Hard copy sent directly with the patient, or
- Communicated via fax or phone within 60 minutes of patient departure, or
- Immediately available via shared EHR or HIE

1. Home Medications:

_____Yes _____No

2. Allergies and/or Reactions:

_____Yes_____No

3. Medications Administered in ED:

_____Yes_____No_____N/A

4. ED Provider Note:

_____Yes_____No

5. Mental Status/Orientation Assessment

_____Yes_____No

6. Reason for Transfer and/or Plan of Care

_____Yes_____No

7. Tests and/or Procedures Performed:

_____Yes_____No_____N/A

8. Tests and/or Procedure Results:

_____Yes_____No_____N/A

Appendix B: EDTC Crosswalk with Promoting Interoperability Requirements

**Eligible Hospital and Critical Access Hospital Promoting Interoperability
2019 Objectives and Measures - Health Information Exchange**

Objective: The eligible hospital or critical access hospital (CAH) 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 electronic health record (EHR) using the functions of certified EHR technology (CEHRT).

The summary of care record must include the following elements:

Promoting Interoperability Programs standard	EDTC Aligned Data Element
Patient name	Not included
Procedures	7, 8
Encounter diagnosis	4
Immunizations	Not included
Laboratory test(s)	7
Laboratory test results	7, 8
Vital signs (height, weight, blood pressure, BMI)	Not included
Smoking status	Not included
Functional status, including activities of daily living, cognitive and disability status	5
Demographic information (preferred language, sex, race, ethnicity, date of birth)	Not included
Care plan field, including goals and instructions. Care Plan: The structure used to define the management actions for the various conditions, problems, or issues. A care plan must include at a minimum the following components: problem (the focus of the care plan), goal (the target outcome) and any instructions that the provider has given to the patient. A goal is a defined target or measure to be achieved in the process of patient care (an expected outcome)	6
Care team including the primary care provider of record and any additional known care team members beyond the referring or transitioning provider and the receiving provider	Not included
Discharge instructions	Not included
Current problem list (At a minimum a list of current and active diagnoses)	4
Current medication list (A list of medications that a given patient is currently taking)	1, 3
Current medication allergy list (A list of medications to which a given patient has known allergies)	2
Unique device identifiers for a patient's implantable device	Not included

Table by Jill M. Klingner. Updated by Stratis Health October 2019
References:
- https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/2019ProgramRequirementsMedicare.html
- https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/TableofContents_EH_Medicare_2019.pdf