Care Coordination and Care Transitions (CC)

The practice systematically tracks tests, referrals and care transitions to achieve high quality care coordination, lower costs, improve patient safety and ensure effective communication with specialists and other providers in the medical neighborhood.

Competency A: Diagnostic Test Tracking and Follow-Up. The practice effectively tracks and manages laboratory and imaging tests important for patient care and informs patients of the result.

CC 01 (Core) Lab and Imaging Test Management: The practice systematically manages lab and imaging tests by:

A. Tracking lab tests until results are available, flagging and following up on overdue results.
B. Tracking imaging tests until results are available, flagging and following up on overdue results.
C. Flagging abnormal lab results, bringing them to the attention of the clinician.
D. Flagging abnormal imaging results, bringing them to the attention of the clinician.
E. Notifying patients/families/caregivers of normal lab and imaging test results.
F. Notifying patients/families/caregivers of abnormal lab and imaging test results.

GUIDANCE	EVIDENCE
The practice demonstrates how it manages patient tests and test results (report, log, examples or electronic tracking system). If frequent lab tests are ordered for a patient, the practice provides the patient/family/caregiver (as appropriate) with all initial results, clear expectations for follow-up results and a plan for handling abnormal findings. Ineffective management of laboratory and imaging test results can result in less than optimal care, excess costs, and may compromise patient safety. Systematic monitoring helps ensure that needed tests are performed and that results are acted on, when necessary. **A, B.** The practice tracks lab and imaging tests from the time they are ordered until results are available, and flags test results that have not been made available. The flag may be an icon that automatically appears in the electronic system or a manual tracking system with a timely surveillance process. The practice follows up with the lab or diagnostic center (and the patient, if necessary) to determine why results are overdue, and documents follow-up efforts until reports are received. **C, D.** Abnormal results of lab or imaging tests are flagged and brought to the attention of the clinician, to ensure timely follow-up with the patient/family/caregiver. **E, F.** The practice provides timely notification to patients about test results (normal and abnormal). Filing in results in the medical record for discussion during a scheduled office visit does not meet the requirement.	• **Documented process** ***AND*** • **Evidence of implementation**

CC 02 (1 Credit) Newborn Screenings: Follows up with the inpatient facility about newborn hearing and blood-spot screening.	
GUIDANCE	**EVIDENCE**
The practice follows up with the hospital or state health department if it does not receive screening results. Most states mandate that birthing facilities perform a blood-spot test to screen for congenital conditions (based on recommendations by the American Academy of Pediatrics and the American College of Medical Genetics) and a hearing screening on all newborns. Early detection and treatment of congenital disorders can enhance health outcomes for newborns with positive (abnormal) screening results. Practices that do not see newborn patients are not eligible for this elective criterion.	• **Documented process** ***AND*** • **Evidence of implementation**
CC 03 (2 Credits) Appropriate Use for Labs and Imaging: Uses clinical protocols to determine when imaging and lab tests are necessary.	
GUIDANCE	**EVIDENCE**
The practice establishes clinical protocols based on evidence-based guidelines, to determine when imaging and lab tests are necessary. The practice may implement clinical decision supports to ensure that protocols are used (e.g., embedded in the order entry system). Inappropriate use of imaging or lab tests leads to unnecessary costs and risks and does not enhance patient outcomes.	• **Evidence of implementation**

Table of Contents

= Evidence shareable across practice sites

Competency B: Referrals to Specialists. The practice provides important information in referrals to specialists and tracks referrals until the report is received.

CC 04 (Core) Referral Management: The practice systematically manages referrals by:

A. Giving the consultant or specialist the clinical question, the required timing and the type of referral.

B. Giving the consultant or specialist pertinent demographic and clinical data, including test results and the current care plan.

C. Tracking referrals until the consultant or specialist's report is available, flagging and following up on overdue reports.

GUIDANCE	EVIDENCE
It is important that the practice track patient referrals and communicate patient information to specialists. Tracking and following up on referrals is a way to support patients who obtain services outside the practice. Poor referral communication and lack of follow-up (e.g., to see if a patient kept an appointment with a specialist, to learn about recommendations or test results) can lead to uncoordinated and fragmented care, which is unsafe for the patient and can cause duplication of care and services, as well as frustration for providers. Referrals may be tracked by the practice using a log or electronic system are determined by the clinician to be important to a patient's treatment, or as indicated by practice guidelines (e.g., referral to a surgeon for examination of a potentially malignant tumor; referral to a mental health specialist, for a patient with depression; referral to a pediatric cardiologist, for an infant with a ventricular septal defect). **A.** The referring clinician provides a reason for the referral, which may be stated as the **clinical question** to be answered by the specialist. The referring clinician indicates the type of referral, which may be a consultation or single visit; a request for shared- or co-management of the patient for an indefinite or a limited time, such as for treatment of a specific condition; or a request for temporary or long-term principal care (a transfer). The referring clinician clarifies the urgency of the referral and specifies the reasons for an urgent appointment. **B.** Referrals include relevant clinical information such as: • Current medications. • Diagnoses, including mental health, allergies, medical and family history, substance abuse and behaviors affecting health.	• **Documented process** ***AND*** • **Evidence of implementation**

Table of Contents

= Evidence shareable across practice sites

CC 04 (Core) Referral Management: *continued*	
GUIDANCE	**EVIDENCE**
• Clinical findings and current treatment. • Follow-up communication or information. Including the referring primary care clinician's care and treatment plan in the referral, in addition to test results and procedures, can reduce conflicts and duplicate services, tests and treatment. If the practice sends the primary care plan with the referral, the specialist can develop a corresponding specialty plan of care. Ideally, the primary care plan, developed in collaboration with the patient/family/caregiver, is coordinated with the specialty plan of care, created in collaboration with the patient/family/caregiver and primary care. **C.** A tracking process includes the date when a referral was initiated and the timing indicated for receiving the report. If the specialist does not send a report, the practice contacts the specialist's office and documents its effort to retrieve the report in a log or an electronic system.	• **Documented process** ***AND*** • **Evidence of implementation** 
CC 05 (2 Credits) Appropriate Referrals: Uses clinical protocols to determine when a referral to a specialist is necessary.	
GUIDANCE	**EVIDENCE**
The practice uses clinical protocols or decision-support tools to determine if a patient needs to be seen by a specialist or if care can be addressed or managed by the primary care clinician. Unnecessary referrals can lead to overuse of tests and services, increase patient dissatisfaction and reduce accessibility to specialists when needed.	• **Evidence of implementation** 

Table of Contents

 = Evidence shareable across practice sites

CC Competency B: Referrals to Specialists.

CC 06 (1 Credit) Commonly Used Specialists Identification: Identifies the specialists/specialty types frequently used by the practice.	
GUIDANCE	**EVIDENCE**
The practice monitors patient referrals to gain information about the referral specialists and specialty types it uses frequently. Specifying specialty type alone is not sufficient. This information may help identify areas where the practice can adopt guidelines or protocols to manage patient care in the primary care practice and identify trends in the patient population, and can help identify opportunities for improved coordination and patient experience when specialty care is needed.	• **Evidence of implementation**
CC 07 (2 Credits) Performance Information for Specialist Referrals: Considers available performance information on consultants/specialists when making referrals.	
GUIDANCE	**EVIDENCE**
It is important for the practice to make informed referrals to clinicians or practices that will provide timely, high-quality care. The practice consults available information about the performance of clinicians or practices to which it refers patients. The practice provides information or examples of the available performance data on the consultant/ specialist with the practice team. Information gathered in CC 11 may be useful in assessing consultants/specialists.	• **Data source** ***AND*** • **Examples** 
CC 08 (1 Credit) Specialist Referral Expectations: Works with nonbehavioral healthcare specialists to whom the practice frequently refers to set expectations for information sharing and patient care.	
GUIDANCE	**EVIDENCE**
Relationships between primary care practitioners and specialists support a coordinated, safe, high-quality care experience for patients. The practice has established relationships with nonbehavioral healthcare specialists through formal or informal agreements that establish expectations for exchange of information (e.g., frequency, timeliness, content).	• **Documented process** ***OR*** • **Agreement** 

Table of Contents

 = Evidence shareable across practice sites

CC Competency B: Referrals to Specialists.

CC 09 (2 Credits) Behavioral Health Referral Expectations: Works with behavioral healthcare providers to whom the practice frequently refers to set expectations for information sharing and patient care.	
GUIDANCE	**EVIDENCE**
Relationships between primary care practitioners and specialists support consistency of information shared across practices. The practice has established relationships with behavioral healthcare providers through formal or informal agreements that establish expectations for exchange of information (e.g., frequency, timeliness, content). A notification demonstrating legal inability to receive a report that includes confirmation a behavioral health visit occurred meets the content requirement. A practice needs an agreement if it shares the same facility or campus as behavioral healthcare professionals but has separate systems (basic onsite collaboration). The practice may present existing internal processes if there is partial integration of behavioral healthcare services.	• **Agreement** ***OR*** • **Documented process *and*** • ***E*vidence of implementation** 

CC 10 (2 Credits) Behavioral Health Integration: Integrates behavioral healthcare providers into the care delivery system of the practice site.	
GUIDANCE	**EVIDENCE**
Behavioral health integration includes care settings that have merged to provide behavioral health services and care coordination at a single practice setting. This is more involved than co-location of practices, because all providers work together to integrate patients' primary care and behavioral health needs, have shared accountability and collaborative treatment and workflow strategies.	• **Documented process** ***AND*** • **Evidence of implementation** 

Table of Contents

 = Evidence shareable across practice sites

CC Competency B: Referrals to Specialists.

CC 11 (1 Credit) Referral Monitoring: Monitors the timeliness and quality of the referral response.	
GUIDANCE	**EVIDENCE**
The practice assesses the response received from the consulting/specialty provider and evaluates whether the response was timely and provided appropriate information about the patient's diagnosis and treatment plan. The practice bases its definition of "timely" on patient need. Ongoing assessment and referral monitoring may be helpful in CC 07.	• **Documented process** ***AND*** • **Report**  ***Documented process only***
CC 12 (1 Credit) Co-Management Arrangements: Documents co-management arrangements in the patient's medical record.	
GUIDANCE	**EVIDENCE**
When a particular specialist regularly treats a patient, the primary care clinician and the specialist enter into an agreement that enables safe and efficient co-management of the patient's care. Under the agreement, the primary care clinician and specialist share changes in the treatment plan and patient health status, in addition to entering information in the medical record within an agreed-on time frame. The practice must provide three examples of such arrangements.	• **Evidence of implementation**
CC 13 (2 Credits) Treatment Options and Costs: Engages with patients regarding cost implications of treatment options.	
GUIDANCE	**EVIDENCE**
Cost can play a major role in a patient's drug and treatment adherence; the practice understands this and talks to patients about treatment costs (e.g., adds a financial question to the clinical intake screening [do you have trouble affording the care or prescriptions prescribed? Y/N], directs patients to resources such as copay and prescription assistance programs; the clinician asks about prescription drug coverage, tells patients which services are critical and should not be skipped, recommends less expensive options, if appropriate).	• **Documented process** ***AND*** • **Evidence of implementation**  ***Documented process only***

Table of Contents

 = Evidence shareable across practice sites

CC Competency C: Coordinating Care With Health Care Facilities.

Competency C: Coordinating Care With Health Care Facilities. The practice connects with health care facilities to support patient safety throughout care transitions. The practice receives and shares necessary patient treatment information to coordinate comprehensive patient care.

CC 14 (Core) Identifying Unplanned Hospital and ED Visits: Systematically identifies patients with unplanned hospital admissions and emergency department visits.	
GUIDANCE	**EVIDENCE**
The practice has a process for monitoring unplanned admissions and ED visits, including their frequency. The practice works with local hospitals, EDs and health plans to proactively identify patients with recent unplanned visits, and demonstrates how it systematically receives notifications from facilities with which the practice has established mechanisms for exchange. Receiving timely notification of patients with unplanned hospital admissions and ED visits allows practices to provide support and coordinate with the hospital or ED. Relying on notification of discharge alone would not meet the intent.	• **Documented process** ***AND*** • **Evidence of implementation**
CC 15 (Core) Sharing Clinical Information: Shares clinical information with admitting hospitals and emergency departments.	
GUIDANCE	**EVIDENCE**
The practice demonstrates timely sharing of information with admitting hospitals and EDs. The practice provides three examples as evidence of implementation. Shared information supports continuity in patient care across settings.	• **Documented process** ***AND*** • **Evidence of implementation**
CC 16 (Core) Post-Hospital/ED visit Follow-Up: Contacts patients/families/caregivers for follow-up care, if needed, within an appropriate period following a hospital admission or emergency department visit.	
GUIDANCE	**EVIDENCE**
The practice contacts patients to evaluate their status after discharge from an ED or hospital, and to make a follow-up appointment, if appropriate. The practice's policies define the appropriate contact period and systematically documents follow-up. Contact includes offering care to prevent worsening of a condition, clarify discharge instructions and encourage follow-up care, which may include, but is not limited to, physician counseling, referrals to community resources and disease or case management or self-management support programs.	• **Documented process** ***AND*** • **Evidence of implementation**

Table of Contents

= Evidence shareable across practice sites

CC 02 (1 Credit) Newborn Screenings: Follows up with the inpatient facility about newborn hearing and blood-spot screening.	
GUIDANCE	**EVIDENCE**
The practice follows up with the hospital or state health department if it does not receive screening results. Most states mandate that birthing facilities perform a blood-spot test to screen for congenital conditions (based on recommendations by the American Academy of Pediatrics and the American College of Medical Genetics) and a hearing screening on all newborns. Early detection and treatment of congenital disorders can enhance health outcomes for newborns with positive (abnormal) screening results. Practices that do not see newborn patients are not eligible for this elective criterion.	• **Documented process** ***AND*** • **Evidence of implementation**
CC 03 (2 Credits) Appropriate Use for Labs and Imaging: Uses clinical protocols to determine when imaging and lab tests are necessary.	
GUIDANCE	**EVIDENCE**
The practice establishes clinical protocols based on evidence-based guidelines, to determine when imaging and lab tests are necessary. The practice may implement clinical decision supports to ensure that protocols are used (e.g., embedded in the order entry system). Inappropriate use of imaging or lab tests leads to unnecessary costs and risks and does not enhance patient outcomes.	• **Evidence of implementation**

Table of Contents

= Evidence shareable across practice sites

Competency B: Referrals to Specialists. The practice provides important information in referrals to specialists and tracks referrals until the report is received.

CC 04 (Core) Referral Management: The practice systematically manages referrals by:

A. Giving the consultant or specialist the clinical question, the required timing and the type of referral.

B. Giving the consultant or specialist pertinent demographic and clinical data, including test results and the current care plan.

C. Tracking referrals until the consultant or specialist's report is available, flagging and following up on overdue reports.

GUIDANCE	EVIDENCE
It is important that the practice track patient referrals and communicate patient information to specialists. Tracking and following up on referrals is a way to support patients who obtain services outside the practice. Poor referral communication and lack of follow-up (e.g., to see if a patient kept an appointment with a specialist, to learn about recommendations or test results) can lead to uncoordinated and fragmented care, which is unsafe for the patient and can cause duplication of care and services, as well as frustration for providers. Referrals may be tracked by the practice using a log or electronic system are determined by the clinician to be important to a patient's treatment, or as indicated by practice guidelines (e.g., referral to a surgeon for examination of a potentially malignant tumor; referral to a mental health specialist, for a patient with depression; referral to a pediatric cardiologist, for an infant with a ventricular septal defect). **A.** The referring clinician provides a reason for the referral, which may be stated as the **clinical question** to be answered by the specialist. The referring clinician indicates the type of referral, which may be a consultation or single visit; a request for shared- or co-management of the patient for an indefinite or a limited time, such as for treatment of a specific condition; or a request for temporary or long-term principal care (a transfer). The referring clinician clarifies the urgency of the referral and specifies the reasons for an urgent appointment. **B.** Referrals include relevant clinical information such as: • Current medications. • Diagnoses, including mental health, allergies, medical and family history, substance abuse and behaviors affecting health.	• **Documented process** ***AND*** • **Evidence of implementation**

Table of Contents

= Evidence shareable across practice sites

CC 04 (Core) Referral Management: *continued*	
GUIDANCE	**EVIDENCE**
• Clinical findings and current treatment. • Follow-up communication or information. Including the referring primary care clinician's care and treatment plan in the referral, in addition to test results and procedures, can reduce conflicts and duplicate services, tests and treatment. If the practice sends the primary care plan with the referral, the specialist can develop a corresponding specialty plan of care. Ideally, the primary care plan, developed in collaboration with the patient/family/caregiver, is coordinated with the specialty plan of care, created in collaboration with the patient/family/caregiver and primary care. **C.** A tracking process includes the date when a referral was initiated and the timing indicated for receiving the report. If the specialist does not send a report, the practice contacts the specialist's office and documents its effort to retrieve the report in a log or an electronic system.	• **Documented process** ***AND*** • **Evidence of implementation** 
CC 05 (2 Credits) Appropriate Referrals: Uses clinical protocols to determine when a referral to a specialist is necessary.	
GUIDANCE	**EVIDENCE**
The practice uses clinical protocols or decision-support tools to determine if a patient needs to be seen by a specialist or if care can be addressed or managed by the primary care clinician. Unnecessary referrals can lead to overuse of tests and services, increase patient dissatisfaction and reduce accessibility to specialists when needed.	• **Evidence of implementation** 

Table of Contents

 = Evidence shareable across practice sites

CC Competency B: Referrals to Specialists.

CC 06 (1 Credit) Commonly Used Specialists Identification: Identifies the specialists/specialty types frequently used by the practice.	
GUIDANCE	**EVIDENCE**
The practice monitors patient referrals to gain information about the referral specialists and specialty types it uses frequently. Specifying specialty type alone is not sufficient. This information may help identify areas where the practice can adopt guidelines or protocols to manage patient care in the primary care practice and identify trends in the patient population, and can help identify opportunities for improved coordination and patient experience when specialty care is needed.	• **Evidence of implementation**
CC 07 (2 Credits) Performance Information for Specialist Referrals: Considers available performance information on consultants/specialists when making referrals.	
GUIDANCE	**EVIDENCE**
It is important for the practice to make informed referrals to clinicians or practices that will provide timely, high-quality care. The practice consults available information about the performance of clinicians or practices to which it refers patients. The practice provides information or examples of the available performance data on the consultant/ specialist with the practice team. Information gathered in CC 11 may be useful in assessing consultants/specialists.	• **Data source** ***AND*** • **Examples** 
CC 08 (1 Credit) Specialist Referral Expectations: Works with nonbehavioral healthcare specialists to whom the practice frequently refers to set expectations for information sharing and patient care.	
GUIDANCE	**EVIDENCE**
Relationships between primary care practitioners and specialists support a coordinated, safe, high-quality care experience for patients. The practice has established relationships with nonbehavioral healthcare specialists through formal or informal agreements that establish expectations for exchange of information (e.g., frequency, timeliness, content).	• **Documented process** ***OR*** • **Agreement** 

Table of Contents

 = Evidence shareable across practice sites

CC Competency B: Referrals to Specialists.

CC 09 (2 Credits) Behavioral Health Referral Expectations: Works with behavioral healthcare providers to whom the practice frequently refers to set expectations for information sharing and patient care.	
GUIDANCE	**EVIDENCE**
Relationships between primary care practitioners and specialists support consistency of information shared across practices. The practice has established relationships with behavioral healthcare providers through formal or informal agreements that establish expectations for exchange of information (e.g., frequency, timeliness, content). A notification demonstrating legal inability to receive a report that includes confirmation a behavioral health visit occurred meets the content requirement. A practice needs an agreement if it shares the same facility or campus as behavioral healthcare professionals but has separate systems (basic onsite collaboration). The practice may present existing internal processes if there is partial integration of behavioral healthcare services.	• **Agreement** ***OR*** • **Documented process *and*** • ***E*vidence of implementation** 

CC 10 (2 Credits) Behavioral Health Integration: Integrates behavioral healthcare providers into the care delivery system of the practice site.	
GUIDANCE	**EVIDENCE**
Behavioral health integration includes care settings that have merged to provide behavioral health services and care coordination at a single practice setting. This is more involved than co-location of practices, because all providers work together to integrate patients' primary care and behavioral health needs, have shared accountability and collaborative treatment and workflow strategies.	• **Documented process** ***AND*** • **Evidence of implementation** 

Table of Contents

 = Evidence shareable across practice sites

CC Competency B: Referrals to Specialists.

CC 11 (1 Credit) Referral Monitoring: Monitors the timeliness and quality of the referral response.	
GUIDANCE	**EVIDENCE**
The practice assesses the response received from the consulting/specialty provider and evaluates whether the response was timely and provided appropriate information about the patient's diagnosis and treatment plan. The practice bases its definition of "timely" on patient need. Ongoing assessment and referral monitoring may be helpful in CC 07.	• **Documented process** ***AND*** • **Report**  ***Documented process only***
CC 12 (1 Credit) Co-Management Arrangements: Documents co-management arrangements in the patient's medical record.	
GUIDANCE	**EVIDENCE**
When a particular specialist regularly treats a patient, the primary care clinician and the specialist enter into an agreement that enables safe and efficient co-management of the patient's care. Under the agreement, the primary care clinician and specialist share changes in the treatment plan and patient health status, in addition to entering information in the medical record within an agreed-on time frame. The practice must provide three examples of such arrangements.	• **Evidence of implementation**
CC 13 (2 Credits) Treatment Options and Costs: Engages with patients regarding cost implications of treatment options.	
GUIDANCE	**EVIDENCE**
Cost can play a major role in a patient's drug and treatment adherence; the practice understands this and talks to patients about treatment costs (e.g., adds a financial question to the clinical intake screening [do you have trouble affording the care or prescriptions prescribed? Y/N], directs patients to resources such as copay and prescription assistance programs; the clinician asks about prescription drug coverage, tells patients which services are critical and should not be skipped, recommends less expensive options, if appropriate).	• **Documented process** ***AND*** • **Evidence of implementation**  ***Documented process only***

Table of Contents

 = Evidence shareable across practice sites

CC Competency C: Coordinating Care With Health Care Facilities.

CC 17 (1 Credit) Acute Care After Hours Coordination: Systematic ability to coordinate with acute care settings after office hours through access to current patient information.	
GUIDANCE	**EVIDENCE**
The practice has a process to coordinate with acute care facilities when a patient is seen after the office is closed. Sharing patient information allows the facility to coordinate patient care based on current health needs and engage with practice staff.	• **Documented process** ***AND*** • **Evidence of implementation**  ***Documented process only***
CC 18 (1 Credit) Information Exchange during Hospitalization: Exchanges patient information with the hospital during a patient's hospitalization.	
GUIDANCE	**EVIDENCE**
The practice demonstrates that it can send and receive patient information during a patient's hospitalization. ***Note:*** *CC 15 assesses the practice's ability to share information, but the focus of CC 18 is two-way exchange of information.*	• **Documented process** ***AND*** • **Evidence of implementation** 
CC 19 (1 Credit) Patient Discharge Summaries: Implements a process to consistently obtain patient discharge summaries from the hospital and other facilities.	
GUIDANCE	**EVIDENCE**
The practice has a process for obtaining patient discharge summaries for patients following discharge from a hospital or other care facility. The practice shows that it obtains discharge summaries directly or demonstrates participation in a local admission, discharge, transfer (ADT) system. Actively gathering information about patient admissions, discharges or transfers from the hospital and other care facilities improves care coordination, safe handoffs and reduces readmissions.	• **Documented process** ***AND*** • **Evidence of implementation** 

Table of Contents

 = Evidence shareable across practice sites

CC 20 (1 Credit) Care Plan Collaboration for Practice Transitions: Collaborates with the patient/family/caregiver to develop/implement a written care plan for complex patients transitioning into/out of the practice (e.g., from pediatric care to adult care).	
GUIDANCE	**EVIDENCE**
The practice involves the patient/family/caregiver in the development or implementation of a written care plan for young adults and adolescent patients with complex needs transitioning to adult care. The written care plan may include: • A summary of medical information (e.g., history of hospitalizations, procedures, tests). • A list of providers, medical equipment and medications for patients with special health care needs. • Obstacles to transitioning to an adult care clinician. • Special care needs. • Information provided to the patient about the transition of care. • Arrangements for release and transfer of medical records to the adult care clinician. • Patient response to the transition. • Patient transition plan. **Internal medicine practices** receiving patients from pediatricians are expected to request/review the transition plan provided by pediatric practices, or to develop a plan, if one is not provided, to support a smooth and safe transition. **For family medicine practices** that do not transition patients from pediatric to adult care, should still educate patients and families about ways in which their care experience may change as the patient moves into adulthood. Sensitivity to privacy concerns should be incorporated into messaging.	• **Evidence of implementation**

Table of Contents

= Evidence shareable across practice sites

CC Competency C: Coordinating Care With Health Care Facilities.

CC 21 (*Maximum* 3 Credits) External Electronic Exchange of Information: Demonstrates electronic exchange of information with external entities, agencies and registries (may select one or more): **A. Regional health information organization or other health information exchange source that enhances the practice's ability to manage complex patients. (1 Credit)** **B. Immunization registries or immunization information systems. (1 Credit)** **C. Summary of care record to another provider or care facility for care transitions. (1 Credit)**	
GUIDANCE	**EVIDENCE**
The practice utilizes an electronic system to exchange patient health record data and other clinical information with external organizations. Exchange of data across organizations supports enhanced coordination of patient care. Practices can demonstrate this electronic exchange by: **A.** Exchanging patient medical record information to facilitate care management of patients with complex conditions or care needs. **B.** Submitting electronic data to immunization registries, to share immunization services provided to patients. **C.** Making the summary of care record accessible to another provider or care facility for care transitions. Practices may provide the required evidence for each criterion, for up to three credits. Each option is part of CC 21, but is listed separately in Q-PASS for scoring purposes.	• **Evidence of implementation**

Table of Contents

 = Evidence shareable across practice sites