

Summary of Care (Transition of Care Summary)

Measure 1: The EP 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% of transitions of care and referrals.

Measure 2: The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 10% of such transitions or referrals either electronically using certified CEHRT to a recipient **or** via exchange facilitated by an NwHIN compliant organization. *ONC has not yet established a governance mechanism for the nationwide health information network. Until ONC establishes such a governance mechanism, this specific option will not be available.*

Measure 3: An EP must satisfy one of the following criteria:

- Electronically exchange one or more summary of care documents with another EHR that was developed by a different EHR developer than the sender's EHR technology certified to 45 CFR 170.314(b)(2)
- Conducts one or more successful tests with the CMS designated test EHR during the EHR reporting period. **See page 3 for more details.**

How to meet this measure using ONCOCHART -

You can get credit for providing a summary record by using one of the following methods.

- **Measure 1** – After answering YES to the Transitioned question in the INI, FUE and EOT, answer **NO** to the pop-up. You'll also need to answer the *Released Explanation* question. If you choose to use this method, you will not be required to use the patient portal method or print the transition of care record for MU calculation purposes, **but you will be responsible for providing the patient with a transition of care summary.**

You can manually generate a summary of care record by going to *EMR > Continuity of Care > Clinical Document Architecture*

- You can decline printing the transition of care summary and not answer the *Released Explanation* question and still get credit in the MU calculator ***if the patient has authorized you to send health information to his/her patient portal or if you decide to print the summary at a later time.*** Contact ONCOCHART support for more information regarding the patient portal.
- Measure 2** – Sign up for the patient portal which gives you access to secure email capabilities.

After answering yes to the **Transitioned** question, click the Email option.

The screenshot shows the ONCOCHART interface with the 'Transition of Care Summary' section. The 'Transitioned?' dropdown is set to 'Yes', indicated by a red arrow. Below it are 'No release explanation' and 'Released explanation' dropdowns. A modal dialog titled 'ONCOCHART Message' is open, asking 'Would you like to email or print a Transfer of Care Summary Document to the requesting physician? This is required for Meaningful Use.' The dialog has three buttons: 'Print', 'Email' (indicated by a red arrow), and 'Cancel'.

Input the email address of the requesting physician. Click Send. The requesting physician **MUST have a Direct compatible email address**, or sending of the email will fail and not reach him/her.*

The screenshot shows the 'ONCOCHART Message' dialog with the text 'Enter the Direct compatible secure email address of the recipient:'. Below this is a text input field containing 'RequestingPhysicianEmail@email.com'. At the bottom are two buttons: 'Send' (with a green checkmark icon) and 'Cancel' (with a red X icon).

Exclusions for this measure.

Any EP who transfers a patient to another setting or refers a patient to another provider less than 100 times during the EHR reporting period is excluded from **all three measures**.

- **Measure 3** – Follow either step to satisfy this measure. (You'll need to be subscribed to the Patient Portal in order to meet this measure. Contact [ONCOCHART Support](#) for more information regarding the patient portal.)
 1. Exchange a summary of care with a provider or third party who has different CEHRT as the sending provider as part of the 10% threshold for measure #2 (allowing the provider to meet the criteria for measure #3 without the CMS Designated Test EHR), or
 2. If providers do not exchange summary of care documents with recipients using a different CEHRT in common practice, they may retain documentation on their circumstances and attest "Yes" to meeting measure #3 if they have and are using a certified EHR which meets the standards required to send a CCDA (§ 170.202).

This exchange may be conducted outside of the EHR reporting period timeframe, but must take place no earlier than the start of the year and no later than the end of the EHR reporting year or the attestation date, whichever occurs first.

For example, an eligible professional or eligible hospital that is reporting meaningful use for a 90-day EHR reporting period may conduct this exchange outside of this 90-day period as long as it is completed no earlier than the first day of the EHR reporting year and no later than the last day of the EHR reporting year.

For more information, please reference the [CMS FAQ](#).

*You can obtain your direct address by going to Administration > General Maintenance > Patient Portal