Health Information Exchange (Transition of Care Summary)

Measure 1: The EP, who transitions or refers their patient to another setting of care or provider of care, should provide a summary of care record for 100% of each transition of care or referral.

Measure 2: The EP, who transitions or refers their patient to another setting of care or provider of care, must electronically transmit such summary to a receiving provider for more than 10% of transitions of care or referrals.

How to meet this measure using ONCOCHART -

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

Measure 1

- **Option 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*

- **Option 2** - You can decline printing the transition of care summary and not answer the *Released Explanation* question an 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 in the INI, FUE or EOT and click the Email option.

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.*

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 **both measures**.

Notes

Summary of care record is also known as a Clinical Document Architecture (CDA).

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