SUMMARY OF CARE 1
(Part of Core Objective #15)

OBJECTIVE: The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care or referral.

MEASURES: EPs must satisfy both of the following measures in order to meet the objective.
Measure 1:
- 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 50 percent 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 percent of such transitions and referrals either (a) electronically transmitted using CEHRT to a recipient or (b) where the recipient receives the summary of care record via exchange facilitated by an organization that is a NwHIN Exchange participant or in a manner that is consistent with the governance mechanism ONC establishes for the NwHIN.
Measure 3:
An EP must satisfy one of the following criteria:
- Conducts one or more successful electronic exchanges of a summary of care document, as part of which is counted in "measure 2" (for EPs the measure at Â§495.6(j)(14)(ii)(B) with a recipient who has EHR technology that was developed designed by a different EHR technology 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.

EXCLUSION: 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.

NUMERATOR: (Patients Credited)
Matching transitions where a summary of care record was provided.

DENOMINATOR: (Patients Considered)
Total number of patient transitions of care by the provider to another setting or provider in the Reporting Period.

HOW TO:
Create a referral CCDA Summary of Care File for the Patient
01) From the a patient's SOAP Note screen, select the top toolbar "MU Central" option.
02) Click on "Refer Patient to Doctor or Facility".

03) Search and select the doctor you are referring the patient to.
04) Click the "Electronic Summary of Care" button, or the "Paper Summary of Care"
05) Click the red "Generate" button to create the CCDA Transition of Care File, then Exit.
06) If doing a Paper Summary, click the "Print CCDA" button, then the CCDA is displayed in a browser. Print the page.
(Most Browsers let you use the key combination "Ctrl P" to Print). You are done.
Send electronic CCDA Summary of Care File to the outside Doctor
07) Still on the SOAP Note Screen, from the top toolbar select "eScripts".
08) Click the Orange "CCDA's and/or Secure Messaging" button.
09) Click the blue "Compose" near the top of the screen.
10) Type in the "To:" field, the secure messaging address of the referred doctor.
If you do not know their address, the Name fields and search button can be used to look them up.
11) Type a Subject and a Message into the "Subject:" and "Message:" Fields
The Subject line is NOT encrypted, so should not have any health or other personal information!
12) Click the top left "Browse..." button
13) Use the file picker that opens to navigate to C:\Temp\ and select the CCDA that was just generated, and click the "Open" button.
The file will be named after the patient, like C:\Temp\CCDA_Patient_Name.XML
14) Click Send, then close eScripts.
15) Click "Summary of Care CCDA Uploaded" and you are done

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