Office of the National Coordinator for Health Information Technology

Health Data, Technology, and Interoperability:
Certification Program Updates, Algorithm Transparency, and Information Sharing
(HTI-1) Proposed Rule

ONC Health IT Certification Program Insights Condition

Updated April 2023

Measure ID and Version: Interop_Clinical Care_1_v1

Measure Title: Consolidated Clinical Document Architecture (C-CDA) Documents Obtained Using Certified Health IT by Exchange Mechanism

Measure Description

- *Regulatory Reference*: 42 CFR § 170.407(a)(2)
- *Associated Certification Criteria*: 42 CFR § 170.315(b)(2)
- This measure captures the volume of Consolidated Clinical Document Architecture (C-CDA) documents obtained using certified health IT by exchange mechanism relative to patient volume.

Denominator(s)

1. Number of encounters (see Definitions) during the reporting period.
2. Number of unique patients with an encounter during the reporting period.
3. Number of unique patients with an associated C-CDA document during the reporting period.
4. Number of unique C-CDA document obtained (see Definitions) using certified health IT during the reporting period.

Numerator(s)

1. Number of unique C-CDA documents obtained using certified health IT and Direct Messaging during the reporting period.
2. Number of unique C-CDA documents obtained using certified health IT and a local/regional health information exchange (HIE) or national health information network during the reporting period.
3. Number of unique C-CDA documents obtained using certified health IT and a developer-specific health information network (i.e., a network that facilitates exchange between entities using the same health IT developer's products) during the reporting period.
4. Number of unique C-CDA documents obtained using certified health IT and a method not listed above and not including electronic fax during the reporting period.

Stratifications

- None

Definitions

- **Encounter:** The definition of encounter codes follows HITAC recommendations:
  - Outpatient encounter codes = NCQA's Outpatient Value Set
  - Inpatient encounter codes = SNOMED codes 4525004, 183452005, 32485007, 8175000, and 48951000124107
- **C-CDA Documents Obtained**
  - C-CDA documents that have been sent or "pushed" by others and received using certified health IT OR
  - C-CDA documents that were found or "pulled" from a network or central repository using certified health IT (i.e., queried)
- **C-CDA Documents**
  - Only C-CDA documents that are Continuation of Care Document (CCD), referral note, and discharge summary document templates are counted in this measure. C-CDA aligns with 2015 Edition Certification requirement for CCD, referral note, and discharge summary document templates.

Supplemental Reporting Information

- **Required:** Measures shall be aggregated at the product level (across versions).
- **Required:** Documentation shall be provided related to the data sources and methodology used to generate these measures.
- **Optional:** Developers may also submit descriptive or qualitative information to provide context.

Notes

- Developers shall exclude duplicate C-CDAs from the numerator and denominator. Duplicate C-CDAs are those with the same document identifiers or otherwise contain substantially identical data as identified by developers of Certified Health IT, which may be obtained over multiple exchange mechanisms.
- Receipt of C-CDA documents is not limited to defined transitions of care or encounters with new patients.
- Obtaining a C-CDA without any data would not count as receipt.

Exclusions

- Products not certified to § 170.315(b)(2) would be excluded from reporting on this measure.

Measure Characteristics

- *Measure Scoring*: Proportion
- *Measure Area*: Clinical Care Information Exchange
- *Measure Category:* Interoperability

Expected Metrics

- The number of unique C-CDA documents obtained using a local/regional health information exchange (HIE) or national health information network divided by the number of unique C-CDA documents obtained using certified health IT within the reporting period.
- The number of unique C-CDA documents obtained using developer-specific networks divided by the number of unique C-CDA documents obtained using certified health IT within the reporting period.
- The number of unique C-CDA documents obtained using Direct Messaging divided by the number of unique C-CDA documents obtained using certified health IT within the reporting period.
- The number of unique C-CDA documents obtained using other means divided by the number of unique C-CDA documents obtained using certified health IT within the reporting period.
- The number of unique patients with associated C-CDA documents obtained within the reporting period divided by the number of unique patients with an encounter within the reporting period.
- The number of unique C-CDA documents obtained using certified health IT within the reporting period divided by the number of unique patients with an encounter during the reporting period.