ONC Health IT Certification Program Insights Condition

Updated April 2023

Measure ID and Version: Interop_Clinical Care_2_v1

Measure Title: Consolidated Clinical Document Architecture (C-CDA) Medications, Allergies, and Problems Reconciliation and Incorporation Using Certified Health IT

Measure Description

- *Regulatory Reference*: 42 CFR § 170.407(a)(3)
- *Associated Certification Criteria*: 42 CFR § 170.315(b)(2)
- This measure captures the number of Consolidated Clinical Document Architecture (C-CDA) documents that are reconciled and incorporated as part of a patient's record by clinicians or their delegates.

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 C-CDA documents of the Continuity of Care Document (CCD), Referral Note, Discharge Summary document types that are obtained and incorporated across all exchange mechanisms (see Definitions) supported by certified health IT 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.
- **Exchange Mechanisms**
  - Exchange mechanisms include, but are not limited to national networks, such as the Carequality framework and CommonWell, Direct Trust, and eHealth Exchange; Health IT Developer networks; EHR to EHR exchange; regional, local, and community HIE; Direct Secure Messaging.

Supplemental Reporting Information

- **Required:** Developers shall exclude duplicate C-CDA documents from the numerator and denominator. Duplicate C-CDA documents 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. If there are duplicate C-CDA documents obtained across multiple exchange mechanisms, the measure should indicate if at least one of the duplicates is viewed.
- **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

- The numerator would increment, or increase in number, upon completion of clinical information reconciliation of the C-CDA documents for medications, allergies and intolerances, and problems, as described in the certification criterion in § 170.315(b)(2).
- Reconciliation and incorporation shall involve an action by a human user, either a clinician or non-medical staff under the direction of a clinician.
  - If no update is necessary, the process of reconciliation may consist of simply verifying that fact or reviewing a record received and determining that such information is merely duplicative of existing information in the patient record.

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 total number of C-CDA documents (CCD, Referral Note, Discharge Summary) obtained and incorporated divided by the number of encounters during the reporting period.
- The total number of C-CDA documents (CCD, Referral Note, Discharge Summary) obtained and incorporated divided by the number of unique patients with an encounter during the reporting period.
- The total number of C-CDA documents (CCD, Referral Note, Discharge Summary) obtained and incorporated divided by the number of unique patients with an associated C-CDA document during the reporting period.