words, if a provider sends a C–CDA and the receiving provider converts the C–CDA into a pdf or a fax or some other format, the sending provider may still count the transition or referral in the numerator. If the sending provider converts the file to a format the receiving provider could not electronically receive and incorporate as a C–CDA, the initiating provider may not count the transition in their numerator.

- For the purposes of defining the cases in the denominator for Measure 2, we stated that what constitutes ''unavailable'' and, therefore, may be excluded from the denominator, will be that a provider—
    - Requested an electronic summary of care record to be sent and did not receive an electronic summary of care document; and
    - The provider either:
        - Queried at least one external source via HIE functionality and did not locate a summary of care for the patient, or the provider does not have access to HIE functionality to support such a query, or
        - Confirmed that HIE functionality supporting query for summary of care documents was not operational in the provider's geographic region and not available within the provider's HER network as of the start of the HER reporting period.
- For Measure 2, a record cannot be considered to be incorporated if it is discarded without the reconciliation of clinical information or if it is stored in a manner that is not accessible for provider use within the EHR.
- For Measure 3, the process may include both automated and manual reconciliation to allow the receiving provider to work with both the electronic data provided with any necessary review, and to work directly with the patient to reconcile their health information.
- For Measure 3, if no update is necessary, the process of reconciliation may consist of simply verifying that fact or reviewing a record received on referral and determining that such information is merely duplicative of existing information in the patient record.
- Non-medical staff may conduct reconciliation under the direction of the provider so long as the provider or other credentialed medical staff is responsible and accountable for review of the information and for the assessment of and action on any relevant CDS.

Regulatory References

- This objective may be found in Section 42 of the code of the federal register at 495.24 (d)(7)(i)(A) and (B). For further discussion please see 80 FR 62861.
- In order to meet this objective and measure, an EP must use the capabilities and standards of CEHRT at 45 CFR 170.315 (b)(1) through (b)(3) and (a)(6) through (a)(8).

Certification and Standards Criteria

Below is the corresponding certification and standards criteria for electronic health record technology that supports achieving the meaningful use of this objective.

Certification Criteria*	
§ 170.315(b)(1) Care Coordination	(1) Transitions of care—(i) Send and receive via edge protocol—(A) Send transition of care/referral summaries through a method that conforms to the standard specified in §170.202(d) and that leads to such summaries being processed by a service that has implemented the standard specified in §170.202(a)(2); and

(B) Receive transition of care/referral summaries through a method that conforms to the standard specified in §170.202(d) from a service that has implemented the standard specified in §170.202(a)(2).

(C) XDM processing. Receive and make available the contents of a XDM package formatted in accordance with the standard adopted in §170.205(p)(1) when the technology is also being certified using an SMTP-based edge protocol.

(ii) Validate and display—(A) Validate C-CDA conformance—system performance. Demonstrate the ability to detect valid and invalid transition of care/referral summaries received and formatted in accordance with the standards specified in §170.205(a)(3) and §170.205(a)(4) for the Continuity of Care Document, Referral Note, and (inpatient setting only) Discharge Summary document templates. This includes the ability to:

(1) Parse each of the document types.

(2) Detect errors in corresponding "document-templates," "section-templates," and "entry-templates," including invalid vocabulary standards and codes not specified in the standards adopted in §170.205(a)(3) and §170.205(a)(4).

(3) Identify valid document-templates and process the data elements required in the corresponding section-templates and entry-templates from the standards adopted in §170.205(a)(3) and §170.205(a)(4).

(4) Correctly interpret empty sections and null combinations.

(5) Record errors encountered and allow a user through at least one of the following ways to:

(i) Be notified of the errors produced.

(ii) Review the errors produced.

(B) Display. Display in human readable format the data included in transition of care/referral summaries received and formatted according to the standards specified in §170.205(a)(3) and §170.205(a)(4).

(C) Display section views. Allow for the individual display of each section (and the accompanying document header information) that is included in a transition of care/referral summary received and formatted in accordance with the standards adopted in §170.205(a)(3) and §170.205(a)(4) in a manner that enables the user to:

(1) Directly display only the data within a particular section;

(2) Set a preference for the display order of specific sections; and

	(3) Set the initial quantity of sections to be displayed. (iii) Create. Enable a user to create a transition of care/referral summary formatted in accordance with the standard specified in §170.205(a)(4) using the Continuity of Care Document, Referral Note, and (inpatient setting only) Discharge Summary document templates that includes, at a minimum: (A) The Common Clinical Data Set. (B) Encounter diagnoses. Formatted according to at least one of the following standards: (1) The standard specified in §170.207(i). (2) At a minimum, the version of the standard specified in §170.207(a)(4). (C) Cognitive status. (D) Functional status. (E) Ambulatory setting only. The reason for referral; and referring or transitioning provider's name and office contact information. (F) Inpatient setting only. Discharge instructions. (G) Patient matching data. First name, last name, previous name, middle name (including middle initial), suffix, date of birth, address, phone number, and sex. The following constraints apply: (1) Date of birth constraint—(i) The year, month and day of birth must be present for a date of birth. The technology must include a null value when the date of birth is unknown. (ii) Optional. When the hour, minute, and second are associated with a date of birth the technology must demonstrate that the correct time zone offset is included. (2) Phone number constraint. Represent phone number (home, business, cell) in accordance with the standards adopted in §170.207(q)(1). All phone numbers must be included when multiple phone numbers are present. (A) (3) Sex constraint. Represent sex in accordance with the standard adopted in §170.207(n)(1).
§ 170.315(b)(2) Care Coordination	(2) Clinical information reconciliation and incorporation—(i) General requirements. Paragraphs (b)(2)(ii) and (iii) of this section must be completed based on the receipt of a transition of care/referral summary formatted in accordance with the standards adopted in §170.205(a)(3) and §170.205(a)(4)

	using the Continuity of Care Document, Referral Note, and (inpatient setting only) Discharge Summary document templates. (ii) Correct patient. Upon receipt of a transition of care/referral summary formatted according to the standards adopted §170.205(a)(3) and §170.205(a)(4), technology must be able to demonstrate that the transition of care/referral summary received can be properly matched to the correct patient. (iii) Reconciliation. Enable a user to reconcile the data that represent a patient's active medication list, medication allergy list, and problem list as follows. For each list type: (A) Simultaneously display (i.e., in a single view) the data from at least two sources in a manner that allows a user to view the data and their attributes, which must include, at a minimum, the source and last modification date. (B) Enable a user to create a single reconciled list of each of the following: Medications; medication allergies; and problems. (C) Enable a user to review and validate the accuracy of a final set of data. (D) Upon a user's confirmation, automatically update the list, and incorporate the following data expressed according to the specified standard(s): (1) Medications. At a minimum, the version of the standard specified in §170.207(d)(3); (2) Medication allergies. At a minimum, the version of the standard specified in §170.207(d)(3); and
§ 170.315(b)(3) Care Coordination	(3) Problems. At a minimum, the version of the standard specified in §170.207(a)(4). (iv) System verification. Based on the data reconciled and incorporated, the technology must be able to create a file formatted according to the standard specified in §170.205(a)(4) using the Continuity of Care Document document template.
§ 170.315(a)(6) Problem list	Enable a user to record, change, and access a patient's active problem list: (i) Ambulatory setting only. Over multiple encounters in accordance with, at a minimum, the version of the standard specified in §170.207(a)(4). (ii) Inpatient setting only. For the duration of an entire hospitalization in accordance with, at a minimum, the version of the standard specified in §170.207(a)(4)
§ 170.315(a)(7) Medication list	Enable a user to record, change, and access a patient's active medication list as well as medication history: (i) Ambulatory setting only. Over multiple encounters.

	(ii) Inpatient setting only. For the duration of an entire hospitalization.
§ 170.315(a)(8) Medication Allergy List	Enable a user to record, change, and access a patient's active medication allergy list as well as medication allergy history: (i) Ambulatory setting only. Over multiple encounters. (ii) Inpatient setting only. For the duration of an entire hospitalization.

**Depending on the type of certification issued to the EHR technology, it will also have been certified to the certification criterion adopted at 45 CFR 170.314 (g)(1), (g)(2), or both, in order to assist in the calculation of this meaningful use measure.*

Standards Criteria	
§ 170.202(a) Transport standards	ONC Applicability Statement for Secure Health Transport, Version 1.0 (incorporated by reference in §170.299).
§ 170.202(2)(b) Transport standards	ONC Applicability Statement for Secure Health Transport, Version 1.2 (incorporated by reference in §170.299). (b) Standard. ONC XDR and XDM for Direct Messaging Specification (incorporated by reference in §170.299).
§ 170.202(2)(c) Transport standards	ONC Transport and Security Specification (incorporated by reference in §170.299).
§ 170.205(a)(1) Patient Summary Record	Health Level Seven Clinical Document Architecture (CDA) Release 2, Continuity of Care Document (CCD) (incorporated by reference in §170.299). Implementation specifications. The Healthcare Information Technology Standards Panel (HITSP) Summary Documents Using HL7 CCD Component HITSP/C32 (incorporated by reference in §170.299).

Additional certification criteria may apply. Review the ONC 2015 Edition Final Rule for more information.