Eligible Hospital and Critical Access Hospital Meaningful Use Core Measures
Measure 10 of 11

Stage 1 (2014 Definition)
Last updated: May 2014

Patient Electronic Access	
Objective	Provide patients the ability to view online, download, and transmit information about a hospital admission.
Measure	More than 50 percent of all unique patients discharged from the inpatient or emergency departments of the eligible hospital or CAH (POS 21 or 23) during the reporting period have their information available online, with the ability to view, download, and transmit to a third party information about a hospital admission, within 36 hours of discharge.
Exclusion	No exclusion.

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Definition of Terms

Access – When a patient possesses all of the necessary information needed to view, download, or transmit their information. This could include providing patients with instructions on how to access their health information, the website address they must visit for online access, a unique and registered username or password, instructions on how to create a login, or any other instructions, tools, or materials that patients need in order to view, download, or transmit their information.

Appropriate Technical Capabilities – A technical capability would be appropriate if it protected the electronic health information created or maintained by the certified EHR technology. All of these capabilities could be part of the certified EHR technology or outside systems and programs that support the privacy and security of certified EHR technology.

Transmission – Any means of electronic transmission according to any transport standard(s) (SMTP, FTP, REST, SOAP, etc.). However, the relocation of physical electronic media (for example, USB, CD) does not qualify as transmission although the movement of the information from online to the physical electronic media will be a download.

Diagnostic Test Results – All data needed to diagnose and treat disease. Examples include, but are not limited to, blood tests, microbiology, urinalysis, pathology tests, radiology, cardiac imaging, nuclear medicine tests, and pulmonary function tests.

Attestation Requirements

DENOMINATOR/ NUMERATOR

- DENOMINATOR: Number of unique patients discharged from an eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.
- NUMERATOR: The number of patients in the denominator whose information is available online, with the ability to view, download, and transmit to a third party information about a hospital admission, within 36 hours of discharge.

The resulting percentage (Numerator ÷ Denominator) must be more than 50 percent in order for an eligible hospital or CAH to meet this measure.

Additional Information

- The following information must be available to satisfy the objective and measure:
  - Patient name.
  - Admit and discharge date and location.
  - Reason for hospitalization.
  - Care team including the attending of record as well as other providers of care.
  - Procedures performed during admission.
  - Current and past problem list.
  - Current medication list and medication history.
  - Current medication allergy list and medication allergy history.
  - Vital signs at discharge.
  - Laboratory test results (available at time of discharge).
  - Summary of care record for transitions of care or referrals to another provider.
  - Care plan field(s), including goals and instructions.
  - Discharge instructions for patient.
  - Demographics maintained by hospital (sex, race, ethnicity, date of birth, preferred language).
  - Smoking status.
- As noted in the proposed rule, this is not intended to limit the information made available by the hospital. A hospital can make available additional information and still align with the objective.
- The measure for this objective must be met using CEHRT.
- In order to meet this objective and measure, an eligible hospital or CAH must use the capabilities and standards of CEHRT at 45 CFR 170.314(e)(1).

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*	
§170.314(e)(1) View, download, and transmit to third party	(i) EHR technology must provide patients (and their authorized representatives) with an online means to view, download, and transmit to a 3rd party the data specified below. Access to these capabilities must be through a secure channel that ensures all content is encrypted and integrity-protected in accordance with the standard for encryption and hashing algorithms specified at §170.210(f). (A) View. Electronically view in accordance with the standard adopted at §170.204(a), at a minimum, the following data: (1) The Common MU Data Set** (which should be in their English (i.e., non-coded) representation if they associate with a vocabulary/code set). (2) Ambulatory setting only. Provider's name and office contact information. (3) Inpatient setting only. Admission and discharge dates and locations; discharge instructions; and reason(s) for hospitalization. (B) Download. (1) Electronically download an ambulatory summary or inpatient summary (as applicable to the EHR technology setting for which certification is requested) in human readable format or formatted according to the standard adopted at §170.205(a)(3) that includes, at a minimum, the following data (which, for the human readable version, should be in their English representation if they associate with a vocabulary/code set): (i) Ambulatory setting only. All of the data specified in paragraph (e)(1)(i)(A)(*1*) and (e)(1)(i)(A)(*2*) of this section. (ii) Inpatient setting only. All of the data specified in paragraphs (e)(1)(i)(A)(*1*) and (e)(1)(i)(A)(*3*) of this section. (2) Inpatient setting only. Electronically download transition of care/referral summaries that were created as a result of a transition of care (pursuant to the capability expressed in the certification criterion adopted at paragraph (b)(2) of this section). (C) Transmit to third party. (1) Electronically transmit the ambulatory summary or inpatient summary (as applicable to the EHR technology setting for which certification is requested) created in paragraph (e)(1)(i)(B)(1) of this section in accordance with the standard specified in §170.202(a). (2) Inpatient setting only. Electronically transmit transition of care/referral summaries (as a result of a transition of care/referral) selected by the patient (or their authorized representative) in accordance with the standard specified in §170.202(a).

	(ii) Activity history log. (A) When electronic health information is viewed, downloaded, or transmitted to a third-party using the capabilities included in paragraphs (e)(1)(i)(A) through (C) of this section, the following information must be recorded and made accessible to the patient: (1) The action(s) (i.e., view, download, transmission) that occurred; (2) The date and time each action occurred in accordance with the standard specified at § 170.210(g); and (3) (3) The user who took the action (B) EHR technology presented for certification may demonstrate compliance with paragraph (e)(1)(ii)(A) of this section if it is also certified to the certification criterion adopted at §170.314(d)(2) and the information required to be recorded in paragraph (e)(1)(ii)(A) is accessible by the patient.

*Additional certification criteria may apply. Review the ONC 2014 Edition EHR Certification Criteria Grid Mapped to Meaningful Use Stage 1 for more information.

Standards Criteria*	
§170.210(f)	Any encryption and hashing algorithm identified by NIST as an approved security function of Annex A of the FIPS Publication 140-2.
§170.204(a)	Web Content Accessibility Guidelines (WCAG) 2.0, Level A Conformance.
§170.205(a)(3)	HL7 Implementation Guide for CDA Release 2: IHE Health Story Consolidation. The use of the “unstructured document” document-level template is prohibited.
§170.202(a)	Applicability Statement for Secure Health Transport.
§170.210(g)	The data and time recorded utilize a system clock that has been synchronized following (RFC 1305) Network Time Protocol, or (RFC 5905) Network Time Protocol Version 4.

*Additional standards criteria may apply. Review the ONC 2014 Edition EHR Certification Criteria Grid Mapped to Meaningful Use Stage 1 for more information.