Eligible Professional Meaningful Use Core Measures Measure 11 of 13

Stage 1 (2014 Definition)
Last updated: May 2014

Patient Electronic Access	
Objective	Provide patients the ability to view online, download and transmit their health information within four business days of the information being available to the EP.
Measure	More than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided timely (available to the patient within 4 business days after the information is available to the EP) online access to their health information, with the ability to view, download, and transmit to a third party.
Exclusion	Any EP who neither orders nor creates any of the information listed for inclusion, except for "Patient name" and "Provider's name and office contact information, may exclude the measure.

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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.

View – The patient (or authorized representative) accessing their health information online.

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.

Business Days – Business days are defined as Monday through Friday excluding federal or state holidays on which the EP or their respective administrative staffs are unavailable.

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/ EXCLUSION

- DENOMINATOR: Number of unique patients seen by the EP during the EHR reporting period.
- NUMERATOR: The number of patients in the denominator who have timely (within 4 business days after the information is available to the EP) online access to their health information to view, download, and transmit to a third party.
- EXCLUSION: Any EP who neither orders nor creates any of the information listed for inclusion, except for "Patient name" and "Provider's name and office contact information."

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

Additional Information

- The following information must be made available online: Patient name, provider's name and office contact information, current and past problem list, procedures. laboratory test results, current medication list and medication history, current medication allergy list and medication allergy history, vital signs (height, weight, blood pressure, BMI, growth charts), smoking status, demographic information (preferred language, sex, race, ethnicity, date of birth), care plan field(s), including goals and instructions, and any known care team members including the primary care provider (PCP) of record unless the information is not available in certified EHR technology (CEHRT), is restricted from disclosure due to any federal, state or local law regarding the privacy of a person's health information, including variations due to the age of the patient or the provider believes that substantial harm may arise from disclosing particular health information in this manner.
- Replaces the Stage 1 core objective for EPs of "Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies) upon request" and the Stage 1 menu objective for EPs of "Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, and allergies) within 4 business days of the information being available to the EP."
- This objective aligns with the Fair Information Practice Principles (FIPPs), in affording baseline privacy protections to individuals.
- The measure for this objective must be met using CEHRT.

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) 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.