Eligible Professional
EHR Incentive Program
Objectives and Measures for 2015
Objective 8 of 10

Date issued: October 6, 2015

Patient Electronic Access	
Objective	Provide patients the ability to view online, download, and transmit their health information within 4 business days of the information being available to the EP.
Measures	EPs must satisfy both measures in order to meet this objective: • Measure 1: More than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided timely access to view online, download, and transmit to a third party their health information subject to the EP's discretion to withhold certain information. • Measure 2: For an EHR reporting period in 2015, at least one patient seen by the EP during the EHR reporting period (or patient-authorized representative) views, downloads or transmits his or her health information to a third party during the EHR reporting period.
Exclusions	Measure 1: Any EP who: • Neither orders nor creates any of the information listed for inclusion as part of the measures except for "Patient Name" and "Provider's name and office contact information." Measure 2: Any EP who: • Neither orders nor creates any of the information listed for inclusion as part of the measures except for "Patient Name" and "Provider's name and office contact information;" or • Conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period.
Alternate Exclusion	Measure 2: Providers may claim an exclusion for the second measure if for an EHR reporting period in 2015 they were scheduled to demonstrate Stage 1, which does not have an equivalent measure.

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Definition of Terms

Provide 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.

Download – The movement of information from online to physical electronic media.
Transmission – This may be 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.

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/THRESHOLD/EXCLUSION/ALTERNATE EXCLUSION

MEASURE 1:

- DENOMINATOR: Number of unique patients seen by the EP during the EHR reporting period.
- NUMERATOR: The number of patients in the denominator who have access to view online, download and transmit their health information within 4 business days after the information is available to the EP.
- THRESHOLD: The resulting percentage must be more than 50 percent in order for an EP to meet this measure.
- EXCLUSION: Any EP who neither orders nor creates any of the information listed for inclusion as part of the measures except for "Patient Name" and "Provider's name and office contact information."

MEASURE 2:

- DENOMINATOR: Number of unique patients seen by the EP during the EHR reporting period.
- NUMERATOR: The number of patients in the denominator (or patient-authorized representative) who view, download, or transmit to a third party their health information.
- THRESHOLD: The numerator and denominator must be reported, and the numerator must be equal to or greater than 1.
- EXCLUSIONS: Any EP who— (a) Neither orders nor creates any of the information listed for inclusion as part of the measures except for "Patient Name" and "Provider's name and office contact information;" or (b) Conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period.
- ALTERNATE EXCLUSION: Provider may claim an exclusion for the second measure if for an EHR reporting period in 2015 they were scheduled to demonstrate Stage 1, which does not have an equivalent measure.

Additional Information

- In order to meet this objective, the following information must be made available to patients electronically within 4 business days of the information being made available to the EP:
    - 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
    - Any known care team members including the primary care provider (PCP) of record
- An EP can make available additional information and still align with the objective.
- In circumstances where there is no information available to populate one or more of the fields previously listed, either because the EP can be excluded from recording such information (for example, vital signs) or because there is no information to record (for example, no medication allergies or laboratory tests), the EP may have an indication that the information is not available and still meet the objective and its associated measure.
- The patient must be able to access this information on demand, such as through a patient portal or personal health record (PHR) or by other online electronic means. We note that while a covered entity may be able to fully satisfy a patient's request for information through VDT, the measure does not replace the covered entity's responsibilities to meet the broader requirements under HIPAA to provide an individual, upon request, with access to PHI in a designated record set.
- Providers should also be aware that while meaningful use is limited to the capabilities of CEHRT to provide online access there may be patients who cannot access their EHRs electronically because of a disability. Providers who are covered by civil rights laws must provide individuals with disabilities equal access to information and appropriate auxiliary aids and services as provided in the applicable statutes and regulations.
- For Measure 1, patient health information needs to be made available to each patient for view, download, and transmit within 4 business days of the information being available to the provider for each and every time that information is generated whether the patient has been "enrolled" for three months or for three years.
- A patient who has multiple encounters during the EHR reporting period, or even in subsequent EHR reporting periods in future years, needs to be provided access for each encounter where they are seen by the EP.
- If a patient elects to "opt out" of participation, that patient must still be included in the denominator.
- If a patient elects to “opt out” of participation, the provider may count that patient in the numerator if the patient is provided all of the necessary information to subsequently access their information, obtain access through a patient-authorized representative, or otherwise opt-back-in without further follow up action required by the provider.

- For Measure 2, the patient action may occur before, during or after the EHR reporting period but must take place no earlier than the start of the same calendar year as the EHR reporting period and no later than the date of attestation in order to count in the numerator.

Regulatory References

- This objective may be found in Section 42 of the code of the federal register at 495.22 (e)(8)(i). For further discussion please see 80 FR 62815.
- In order to meet this objective and measure, an EP 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) 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.

**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.*

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

Standards Criteria*	
§ 170.204(a)	Web Content Accessibility Guidelines (WCAG) 2.0, Level A Conformance (incorporated by reference in § 170.299).
§ 170.210(f)	Any encryption and hashing algorithm identified by the National Institute of Standards and Technology (NIST) as an approved security function in Annex A of the FIPS Publication 140-2 (incorporated by reference in § 170.299).
§ 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 2015 Edition Final Rule for more information.