Medicaid Eligible Hospital
EHR Incentive Program Modified Stage 2
Objectives and Measures for 2017
Objective 8 of 9

Updated: November 2016

Patient Electronic Access	
Objective	Provide patients the ability to view online, download, and transmit their health information within 36 hours of hospital discharge.
Measures	• Measure 1: More than 50 percent of all unique patients who are discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH are provided timely access to view online, download and transmit to a third party their health information. • Measure 2: For an EHR reporting period in 2017, more than 5 percent of unique patients discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH (or patient authorized representative) view, download or transmit to a third party their health information during the EHR reporting period.
Exclusion	Measure 2: Any eligible hospital or CAH that is located 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.

Table of Contents

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.

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.

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 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/THRESHOLD/EXCLUSION

MEASURE 1:

- 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 who have access to view, download, and transmit their health information within 36 hours after the information is available to the eligible hospital or CAH.
- THRESHOLD: The resulting percentage must be more than 50 percent in order for an eligible hospital or CAH to meet this measure.

MEASURE 2:

- DENOMINATOR: Number of unique patients discharged from the inpatient or emergency department (POS 21 or 23) of the eligible hospital or CAH during the EHR reporting period.
- NUMERATOR: The number of patients (or patient-authorized representative) in the denominator who view, download, or transmit to a third party their health information.
- THRESHOLD: The resulting percentage must be greater than 5 percent.
- EXCLUSION: Any eligible hospital or CAH that is located 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.

Additional Information

- In order to meet the objective, the following information must be available within 36 hours of hospital discharge:
    - 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
    - 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
- An eligible hospital 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 eligible hospital 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 eligible hospital 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.
- 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 discharged from the eligible hospital's inpatient or emergency department.
- 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 the 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.
- The provider must continue to update the information accessible to the patient each time new information is available.
- For Measure 2, the patient action may occur before, during, or after the EHR reporting period. However, in order to count in the numerator, it must occur within the EHR reporting period if that period is a full calendar year, or if it is less than a full calendar year, within the calendar year in which the EHR reporting period occurs.

Regulatory References

- This objective may be found in Section 42 of the code of the federal register at 495.22 (e)(8)(ii)(A). 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.