Consumer Workgroup Comments
Electronic Health Record Incentive Program- Stage 3 Proposed Rule
Objectives 5 and 6

The Consumer Work Group of the HIT Policy Committee is pleased to submit comments on Stage 3 Proposed Policy Regulation (CMS-3310-P) Objective 5: Patient Electronic Access to Health Information and Objective 6: Coordination of Care through Patient Engagement.

Objective 5: Patient Electronic Access to Health Information
The workgroup fully supports this objective to expand communication and engagement with patients, families and their care team through technology, which continues the momentum that started with the Stage 1 patient access objective.

Proposed Measure 1: *For more than 80 percent of all unique patients seen by the EP or discharged from the eligible hospital or CAH inpatient or emergency department (POS 21 or 23):*
1) to view online, download or transmit their health information OR 2) retrieve through an application interface program (API) within 24 hours of its availability

Comments:

- We agree with the proposal to provide access to 80% of patients to view and download their data within 24 hours of the data becoming available to the EP or EH. We support both the threshold and the timeline as proposed. Regarding the timeline, some work group members suggested that data availability should be in real time, not 24 hours after the data becomes available to the EP or EH.
- Our recommendation is that EPs and EHs under Meaningful Use should be required to offer and use both the View/Download option and potentially an ONC-certified API, with the caveats noted below. The workgroup believes APIs are a strong possible technical solution that could help break down silos in health care, and offer consumers more choice and better uses of their health information for self-care, care management and family caregiving. An API enabled by a provider could also allow patients to use their health information in apps that are suited to meet a wide range of unique needs.
- However, the workgroup also has concerns about APIs. While we recommend the use of both, we offer the recommendation pending the following:
    1. Adoption and implementation of the HITPC's Privacy & Security Workgroup's recommendations regarding addressing privacy and security risks for patients who choose to transmit their health information through APIs. These recommendations should be implemented in ways that enable use of APIs through ensuring appropriate privacy and security protections.
    2. Significant outreach to small practices and hospitals that need robust education about APIs and their privacy and security implications, so that they may appropriately educate patients per the August 16, 2011 HITPC Transmittal letter to ONC.
    3. Consideration of certifying additional functions such that the API may be used beyond solely download/transmit (for example, certifying inbound data functionalities). As proposed, APIs would only be certified for the download/transmit function, and not other functionality currently offered under MU such as secure messaging, patient-specific education resources and some forms of patient-generated health data (PGHD).

4. Clarification that APIs under Meaningful Use are required to be publicly available. An API-based approach should not lead to a proliferation of apps in cases where the patient has multiple providers, all of whom use proprietary APIs that feed into different apps and make it more complex for the patient to have one "home" (of their choosing) for their health information.

- This approach of requiring both options under Meaningful Use would give the marketplace time to determine which option or options are best suited to meet the needs of patients, caregivers and providers –again, assuming privacy, security and other concerns are being addressed as recommended by the Privacy & Security Workgroup.
- Further, at a minimum, maintaining View/Download is important because many patients are already using the functionality created in Stage 2 of MU, and these functions should continue to be available to patients until the intended and unintended impacts of using APIs are known. Functions such as secure messaging, online medication refills, appointment scheduling, etc. are part of many portals today, and allowing providers to discontinue these functions without a reasonable replacement may be highly disruptive for patients and families.
- Finally, just turning on the function is not adequate. Providers should be required to attest to active communication to patients (or patients' authorized representatives) about their ability to view and download their health information. The proposed rule appears only require the provider to fully enable the View/Download or API functionality.
- The workgroup also supports Measure 2: providing electronic access to clinically relevant patient specific educational resources for more than 35% of the patients seen by the EP or EH.

Exclusion Criteria:

Insufficient broadband: CMS asks about the current broadband exclusion. This exclusion would allow providers in a county that does not have 50 percent or more of its housing units with 4Mbps broadband available on the first day of the EHR reporting period to skip the VDT and API measures. We comment that the number of mobile users is increasing, and CMS should consider the extent to which consumers are using mobile apps via cellular data, which could be used in place of broadband to access health information. Individuals with limited broadband at home also may want to access their health information through libraries and churches. A broadband exclusion would mean patients in these counties would not always be offered electronic access. We recommend that instead of an exclusion, CMS consider requiring providers in low broadband counties to offer patients online access to their health information and promote it actively to patients, but allow these providers to be excluded from the requirement that a percentage of their patients actually logon and view, download or transmit their health information once in the reporting period.

Objective 6: Care Coordination through Patient Engagement

Proposed Objective: *Use communication functions of certified EHR technology to engage patients or their authorized representatives about patient care. Must meet 2 of 3 measures*

Proposed Measure 1: *> 25% of unique patients, view, download or transmit health information or use ONC-approved API to access information.*

Proposed Measure 2: *For 35% of unique patients, a secure message is sent to patient or in response to secure message sent by patient.*

Proposed Measure 3: *For 15% of unique patients, either patient-generated health data or data from a non-clinical setting is incorporated in the EHR.*

Comments:
The workgroup strongly supports patient engagement and care coordination, as two distinct concepts. Both are key components of new models of care, and essential to success in delivery system reform. However, the rule combines the concepts and does so in a way that would allow providers to potentially skip patient engagement altogether. By enabling providers to select just two of three proposed measures, they could select a) sending a secure message, and b) getting data from a "non-clinical" (e.g., non-MU eligible) provider. These are both essential to care coordination, but they have no meaningful role for the patient and thus do not constitute patient engagement.

Instead, we suggest that these concepts be separated. Below we provide options for doing so. The work group's preferred approach is Option B.

Option A: All three measures should be required, with one revision to Measure 1 (below) that will make it more achievable. Allowing EPs and EHs to attest to all three but not meet the threshold of performance for one measure means that measure is essentially optional. All three measures must be required if this is to count as "patient and family engagement" instead of just "care coordination:"

- Measure 1: 10% of patients view, download or transmit their health info through portal or API. The workgroup believes the proposed 25% threshold is not appropriate and could lead to providers gaming the system, with negative impacts on consumers. The Workgroup instead recommends the threshold be set at 10%, which represents a more achievable threshold yet still doubles the requirement over Stage 2. As CMS points out in the NPRM, the evidence from Stage 2 attestations thus far indicates this threshold is achievable.
- Measure 2: As proposed, a secure message was sent to more than 35% of all unique patients (or the patient's authorized representatives) using the electronic messaging function of CEHRT or in response to a secure message sent by the patient (or the patient's authorized representative).
- Measure 3: As proposed, patient-generated health data or data from a non-clinical setting is incorporated into the certified EHR technology for more than 15 percent of all unique patients for both EPs and EHs.
    - We note that, as an overall comment, PGHD should be "provider-requested." If PGHD is provider-requested, providers will build the appropriate workflows as a natural byproduct of succeeding on this measure. This eliminates concerns and questions about automating or validating data. If the provider requests it, they will plan the appropriate workflows and decide what kinds of data could be automatically incorporated into the EHR, which data will need review prior to incorporation, how to handle alerts for values that are out of range, etc.
    - We also note that some providers can use secure messaging to solicit PGHD.

Option B: All three measures are required, but the threshold for the VDT measure is reduced from 25% to 10% and the PGHD measure is revised:

- Measure 1: 10% of patients view, download or transmit their health info through portal or API
- Measure 2: As proposed, a secure message was sent to more than 35% of all unique patients (or the patient's authorized representatives) using the electronic messaging function of CEHRT or in response to a secure message sent by the patient (or the patient's authorized representative).
- Measure 3: Modification: Patient-generated health data is incorporated into the certified EHR technology for more than 10% of all unique patients. The modification is: moving "or data from a non-clinical setting" to the HIE objective.

Option C: Separate care coordination and patient and family engagement measures, and require 2 out of 3 revised measures to be met:

- Measure 1: 10% of patients view, download or transmit their health info through portal or API
- Measure 2: Move the proposed secure messaging requirement to the HIE Objective, and continue the Stage 2 Secure Messaging requirement in Objective 6 that 5% of patients send one secure message during the 12 month reporting period. This should apply to EPs only, as hospitals did not have a Stage 2 requirement. The HIE secure messaging option would apply to hospitals, and they should have this function available to patients (but not require a % threshold of patient use).
- Measure 3: Move the portion of the proposed PGHD measure that focuses on data from a "non-clinical" setting to the HIE Objective, and maintain the provider-requested PGHD measure in Objective 6 with a 10% threshold (as outlined in Option B above).

However, if secure messaging remains in this Objective as the NPRM proposed (meaning that the provider, not the patient, sends the message), then all three measures should be mandatory, per our Option B.

Under Option C, the HIE Objective would be revised as follows (strikethrough denotes deletions; italics and underline denotes additions):

Measure 1 (send summary of care): For more than 50 percent of transitions of care and referrals, the EP, eligible hospital or CAH that transitions or refers their patient to another setting of care or provider of care: (~~1) creates a summary of care record using CEHRT; and (2)~~ ***electronically exchanges*** the summary of care record.

- Must send summary of care/Common Clinical Data Set *OR receive clinical information from a non-MU eligible provider*
- Secure messaging may be used to fulfill this requirement to send either the CCDS or to communicate/solicit/receive clinical information from a non-MU eligible provider as long as the patient has the ability to view and participate in those messages.

(Note that the NPRM States: "For measure 2, we propose to include in the measure numerator situations where providers communicate with other care team members using the secure messaging function of certified EHR technology, and the patient is engaged in the message and has the ability to be an active participant in the conversation between care providers.")

Measure 2 (receive summary of care): For more than 40 percent of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, the EP, eligible hospital or CAH ***incorporates into the patient's EHR*** an electronic summary of care document from a source other than the provider's EHR system, *or clinical information from a non-MU eligible provider*.