# Consumer Workgroup Comments Electronic Health Record Incentive Program- Stage 3 Proposed RuleObjective 5 and 6

***WG Members – this draft is for discussion purposes only. We will add to, revise and finalize on our next call.***

# 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 InformationThe 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, download and transmit 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.

# In addition, just turning on the access function is not adequate. Providers should be required to attest to active communication to patients (or patients’ authorized representatives). The proposed guidelines only require the provider to fully enable the VDT or API functionality.

# We recommend the offer and use of both the VDT option and an ONC-certified API. This approach of both options will give the marketplace time to determine which option or options best are best suited to meet the needs of patients, caregivers and providers. Many patients are already using the functionality created in Stage 2 of MU, and this should still be available to patients along with an API until all of the intended and unintended consequences of a potential shift to APIs are known. Further, we note that since certification is proposed only for APIs to be able to download data, there are several functions proposed in the MU3 NPRM that will continue to require a portal, such as secure messaging, patient-specific education materials, and patient-generated health data.

* There are potential advantages to the API approach. From the provider perspective, an API option could potentially mean the provider would not be required to purchase or implement a separate mechanism to provide the ability to securely download or transmit health information to a third party. However, the API is only certified for the download function- as noted, it lacks other functionality currently offered under MU in a standardized way. So many providers would likely have to maintain a portal to succeed under other MU objectives. From the patient perspective, an API enabled by a provider could empower the patient to receive information from the provider in the manner that is most valuable to that particular patient – if the API works for the patient’s preferred app. Although it is unclear whether an API-based approach could lead to a proliferation of apps, particularly in cases where the patient has multiple providers, all of whom use different proprietary APIs that feed into different apps that, in the end, make it more complex for the patient to have one “home” (of their choosing) for their health information.
* As far as measurement is concerned, the API should be able to measure downloads in the same way as the current VDT/portal. It is not sufficient to measure API by ensuring that “at least one application which leverages the API is available to patients (or the patient-authorized representatives) to retrieve health information from the provider's certified EHR.” Downloads must be measured under Objective 6.
* ONC should consider whether more functions should be added to the API certification proposal. Functions such as secure messaging, online medication refills, appointment scheduling, etc. are part of many portals today, and allowing providers to discontinue these functions (largely for financial reasons) without a reasonable replacement may be highly disruptive for patients and families.

# Privacy and Security: There are continuing concerns about the privacy and security of patient health information accessed through VDT or API that must be addressed as we move forward. Specifically, we remain concerned about the privacy and security implications of patients who choose to download their data (via a portal or API) and up load it into an app of their choice. We strongly encourage ONC, OCR and CMS to collaborate on ways to both educate patients about their rights, as well as to examine policy options that improve privacy and security for patients using these methods to download their data and address the following:

* Once a patient pulls data into an app, the data is largely unprotected. Most apps are not under regulation by FTC, OCR or other federal authority.
* It is the patient’s, responsibility to understand the privacy security policies associated with the app or device, and yet they may assume that HIPAA still protects them.
* App/device may have poor privacy policies, weak security controls or policies that explicitly share data liberally with third parties or allow broad uses.
* Patients are largely uninformed about steps they should take to protect their data.

**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. An alternative would be to allow providers in low broadband counties to offer the access and promote it to patients, but allow them 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.

*EP with no office visit:* The workgroup also suggests that CMS consider whether the Office Visit or encounter is the right denominator. There may be providers who have no office visits, but who hold important data about patients that should be available to them. In addition, there are also providers (example: optometrists) with a far more limited data set who need a mechanism, perhaps through an API, to transfer data to a patient’s record. These providers should be able to attest that they have proactively provided the education and technology that allows patients to download their data, but does not require them to implement a portal, use secure messaging or provide electronic patient education materials.

To clarify: In Stage 2, Any EP who neither orders nor creates any of the information listed for inclusion as part of both measures, except for "Patient name" and "Provider's name and office contact information,” may exclude both measures (VDT and use). The measure set includes the following data:

* Patient name
* Sex
* Date of birth
* Race
* Ethnicity
* Preferred language
* Care team member(s)
* Medication Allergies
* Medications
* Care plan field(s) should include goals and instructions
* Problems
* Laboratory test(s)
* Laboratory value(s)/result(s)
* Procedures
* Smoking status
* Vital signs

CMS should consider whether providers who neither order nor create any of the above data below Care Team Members could be excluded from the workgroup’s proposal to require both API and VDT through a mechanism such as a portal, but still be required to make relevant data available through an API, without a patient use/download requirement.

**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 **skip patient engagement altogether.**  By enabling providers to select two of three 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 meaningful no role for the patient.

Instead, we suggest that these concepts be separated. Below we provide options for doing so. Our preferred option is *OPTION X (To Be Selected by WG in Next Call)…..*

Option A: All three measures should be required. Allowing people to attest to all three but not meet the threshold of performance means that one 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:”

* As proposed, 25% of patients view, download or transmit their health info through portal or API
* 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).
* 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 be required, but the PGHD measure is revised:

* As proposed, 25% of patients view, download or transmit their health info through portal or API
* 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).
* Modification: Patient-generated health data is incorporated into the certified EHR technology for more than 15 percent of all appropriate patients. The two modifications are: moving “or data from a non-clinical setting” to the HIE objective (outlined further below), as well as changing the denominator to all “appropriate” instead of “unique” patients. PGHD that is appropriate only to a small subset of patients should count.

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

* As proposed, 25% of patients view, download or transmit their health info through portal or API
* 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).
* 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

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.

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 asummary of care record using CEHRT; and ~~(2)~~ ***electronically exchanges*** the summary of care record.

* Must send Common Clinical Data Set (as defined in voluntary 2015 CEHRT NPRM) *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*.

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