# Office of the National Coordinator for Health IT Proposed Rule Public Comment Template

**2015 Edition Health Information Technology (Health IT) Certification Criteria, 2015 Edition Base Electronic Health Record (EHR) Definition, and ONC Health IT Certification Program Modifications**   
  
The Consumer Workgroup is charged with Policy focused review of VDT certification criteria in 2015 Certification NPRM. This section is an extract of the larger document that is available at:

<http://www.healthit.gov/policy-researchers-implementers/standards-and-certification-regulations>This document alone is not intended to provide a full and complete opportunity to comment on all of the provisions of the proposed rule. It only reflects those proposals included in the proposed rule related to the View, Download and Transmit certification criteria and modifications to the ONC Health IT Certification Program.

| § 170.315(e)(1) View, download, and transmit to a third party |
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| **Included in 2015 Edition Base EHR Definition?**  No |
| **Stage 3 MU Objectives**  The EP, eligible hospital, or CAH provides access for patients to view online, download, and transmit their health information, or retrieve their health information through an API, within 24 hours of its availability.  Use communications functions of certified EHR technology to engage with patients or their authorized representatives about the patient's care. |
| **2015 Edition Health IT Certification Criterion**   1. View, download, and transmit to 3rd party.    1. Patients (and their authorized representatives) must be able to use technology to view, download, and transmit their health information to a 3rd party in the manner specified below. Access to these capabilities must be online and 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).       1. View. Patients (and their authorized representatives) must be able to use health IT to view in accordance with the standard adopted at § 170.204(a)(1), at a minimum, the following data:          1. The Common Clinical 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.          4. Laboratory test report(s). Laboratory test report(s), including:             1. The information for a test report as specified all the data specified in 42 CFR 493.1291(c)(i) through (7);             2. The information related to reference intervals or normal values as specified in 42 CFR 493.1291(d); and             3. The information for corrected reports as specified in 42 CFR 493.1291(k)(2)          5. Diagnostic image report(s).       2. Download.          1. Patients (and their authorized representatives) must be able to use EHR technology to download an ambulatory summary or inpatient summary (as applicable to the health IT setting for which certification is requested) in only human readable format, in only the format specified in accordance to the standard adopted at § 170.205(a)(4), or in both formats. The use of the “unstructured document” document-level template is prohibited for compliance with the standard adopted at § 170.205(a)(4).          2. When downloaded according to the standard adopted at § 170.205(a)(4), the ambulatory summary or inpatient summary must include, 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):             1. Ambulatory setting only. All of the data specified in paragraph (e)(1)(i)(A)(1), (2), (4), and (5) of this section.             2. Inpatient setting only. All of the data specified in paragraphs (e)(1)(i)(A)(1), and (3) through (5) of this section.          3. Inpatient setting only. Patients (and their authorized representatives) must be able to 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)(1) of this section).       3. Transmit to third party. Patients (and their authorized representatives) must be able to:          1. Transmit the ambulatory summary or inpatient summary (as applicable to the health IT setting for which certification is requested) created in paragraph (e)(1)(i)(B)(2) of this section in accordance with at least one of the following.             1. The standard specified in § 170.202(a).             2. Through a method that conforms to the standard specified at § 170.202(d) and leads to such summary being processed by a service that has implemented the standard specified in § 170.202(a).          2. Inpatient setting only. 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 at least one of the following:             1. The standard specified in § 170.202(a).             2. Through a method that conforms to the standard specified at § 170.202(d) and leads to such summary being processed by a service that has implemented the standard specified in § 170.202(a).    2. Activity history log.   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 or when an application requests electronic health information using the capability specified at paragraph (e)(1)(iii) of this section, the following information must be recorded and made accessible to the patient:   * + - 1. The action(s) (i.e., view, download, transmission, API response) that occurred;       2. The date and time each action occurred in accordance with the standard specified at § 170.210(g);       3. The user who took the action; and       4. Where applicable, the addressee to whom an ambulatory summary or inpatient summary was transmitted.     1. 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 §170.315(d)(2) and the information required to be recorded in paragraph (e)(1)(ii)(A) is accessible by the patient. |
| **2015 Edition Health IT Certification Criterion, §170.315(e)(1) View, download, and transmit to 3rd party, continued**   * 1. Application access. Patients (and their authorized representatives) must be able to use an application that can interact with the following capabilities. Additionally, the following technical outcomes and conditions must be met through the demonstration of an application programming interface (API) that can respond to requests from other applications for data specified within the Common Clinical Data Set.      1. Security. The API must include a means to establish a trusted connection with the application requesting patient data, including a means for the requesting application to register with the data source, be authorized to request data, and log all interactions between the application and the data source.      2. Patient selection. The API must include a means for the application to query for an ID or other token of a patient’s record in order to subsequently execute data requests for that record in accordance with (e)(1)(iii)(C) of this section.      3. Data requests, response scope, and return format. The API must enable and support both of the following data request interactions:         1. Data-category request. The API must support syntax that allows it to respond to requests for each of the individual data categories specified in the Common Clinical Data Set and return the full set of data for that data category (according to the specified standards, where applicable) in either XML or JSON.         2. All-request. The API must support syntax that allows it to respond to a request for all of the data categories specified in the Common Clinical Data Set at one time and return such data (according to the specified standards, where applicable) in a summary record formatted according to the standard adopted at § 170.205(a)(4).      4. Documentation. The API must include accompanying documentation that contains, at a minimum:         1. API syntax, function names, required and optional parameters and their data types, return variables and their types/structures, exceptions and exception handling methods and their returns.         2. The software components and configurations that would be necessary for an application to implement in order to be able to successfully interact with the API and process its response(s).      5. Terms of use. The terms of use for the API must be provided, including, at a minimum, any associated developer policies and required developer agreements. |
| **Preamble FR Citation:** 80 FR 16848 **Specific questions in preamble?** *Yes* |
| **Public Comment Field:**  Click here to enter comments on § 170.315(e)(1) View, download, and transmit to a third party |