

# Measures Reporting for Eligible Hospitals

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*The fourth paper in this series reviewed the EHR certification requirements related to the notice of proposed rulemaking on meaningful use, published by the Centers for Medicare and Medicaid Services on January 13, 2010. This paper offers an overview of the health IT functionality measures for eligible hospitals. A companion paper (5a) provides an overview of the requirements for providers.*

Hospitals that intend to qualify early for the meaningful use EHR incentive program can first apply in the federal fiscal year 2011, which begins October 1, 2010, less than a year after the rules were first published. The qualification period in the first year is only 90 days.

While this is a short period, hospitals seeking to qualify should be determining their current capabilities to qualify and what related functionalities will be available from existing vendors in products to be offered or upgraded in the next year.

## **Criteria and Objectives**

To qualify as a meaningful user an eligible hospital must demonstrate that it meets all of the objectives and their associated measures (p. 1854). Except as otherwise indicated, each objective must be satisfied by an individual hospital as determined by unique CMS certification numbers. Within the NPRM CMS asks for public comment on whether hospitals might have difficulty meeting the proposed objectives.

The objectives proposed were guided by the recommendations presented by the Health IT Policy Committee, the advisory body also established under HITECH. The objectives are grouped under care goals, which are in turn grouped under health outcomes policy priorities.

The criteria for meaningful use are based on these objectives and their associated measures. Pages 1854–58 cover the five objectives and CMS’s rationale for choosing each, including those instances where they differ from the recommendations of the Health IT Policy Committee.

## **Health IT Functionality Measures**

CMS next discusses the functionality measures, stating: “In order for an...eligible hospital to demonstrate that it meets these proposed objectives, we believe a measure is necessary for each objective” (p. 1858). CMS then breaks the measures down into functionality and clinical quality measures (which will be the subject of the next paper).

CMS notes: “without a measure for each objective we believe that the definition of meaningful use becomes too ambiguous to fulfill its purpose. The use of measures also creates the flexibility to account for realities of current HIT products and infrastructure and the ability to account for future advances.”

The functionality measures describe either the eligible provider or eligible hospital requirement for each objective and the target compliance in order to meet the eligibility criteria. Many of these targets are percentages for which CMS provides a numerator, denominator, and the required percentage. In most instances the numerator is the number of activities or functions performed using an EHR, and the denominator being the full population.

It is this concept that is receiving considerable discussion, particularly a hospital's ability to record these numbers, especially the denominator, during a specified period (i.e., the EHR reporting period). Hospitals will have to take a careful look at how such numbers might be captured in order to meet the recording requirements and possible audit of such numbers.

This review should serve to both suggest comments hospitals might wish to make on the NPRM as well as specify requirements for hospital staff and vendors to discuss so that hospitals can take advantage of the program.

The list of functionality measures provides further rationale and detail on exactly what needs to be recorded and reported (pp. 1858–67). Not all of the measures require a reporting of a percentage. For instance, the requirement for implementation of drug-drug, drug-allergy, and drug-formulary checks merely requires affirmation that the eligible hospital has enabled the functionality.

The reason is partly due to the inability of CMS and some states to receive electronic reports of hospital quality as early as 2011. This requirement could change in 2012, when CMS expects to have the electronic capability.

Clinical decision support rules are another example of a measure that will require attestation, while certain capabilities such as exchange of electronic information requires attestation that the systems has been tested and not necessarily that an ongoing exchange is under way. As hospitals look to qualify as eligible facilities, they will have to develop audit trails of these attestations, as it is expected that audits will occur.

### **Privacy and Security Requirements**

The final requirement is to “protect electronic health information maintained using certified EHR technology through the implementation of appropriate technical capabilities.” The measure requires that the hospital complete a security risk analysis as prescribed under the HIPAA security rules. HIPAA requires that such risk assessments be made periodically.

In this case, such an assessment would not only include security as it relates to the EHR, EHR modules, and other technology, but also the full hospital system that is affected by the increase or introduction of EHR technology as required for meaningful use.

Hospitals should also be aware that there will be additional HIPAA requirements added or modified by HITECH. The proposal for these requirements should be published before February 18, 2010, and most of these requirements will likely be in effect before October 1, 2010.

The table beginning on the following page is developed from table 2 in the NPRM (pp. 1867–70). It collects the eligible hospital objectives, Stage 1 measures, numerators and denominators, as well as the

related technology requirements for the EHR technology required (the table appears in the full PDF version of this paper).

While the technology requirements are not part of the measures, and are described in a separate rule from the Office of the National Coordinator, this table provides a look at what certification and standards are necessary to meet a requirement.

Finally, under the functionality measurement section, CMS highlights its needs for public comment both on the measures presented for Stage 1 and future stages (p. 1870). CMS notes that it intends to build up health IT functionality measures, including:

- CPOE use to include not only the percentage of orders entered directly by providers but also the electronic transmission of those orders
- Extend incorporated clinical lab test results into EHR structured data to include “the full array of diagnostic test data used for the treatment and diagnosis of disease, where feasible”
- Capture measures in situations that currently allow provision and exchange of unstructured data where now there will be the requirement for the provision and exchange of electronic and structured data that currently require the performance of a capability tests and will require the actual submission of data.

*The next papers in this series will cover the reporting of clinical quality measures using EHRs.*

## References

Centers for Medicare and Medicaid Services. “Medicare and Medicaid Programs Electronic Health Record Incentive Program.” *Federal Register* 75, no. 8 (Jan. 13, 2010): 1844–2011. Available online at <http://edocket.access.gpo.gov/2010/pdf/E9-31217.pdf>.

Office of the National Coordinator for Health Information Technology, Department of Health and Human Services. “Health Information Technology: Initial Set of Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology.” *Federal Register* 75, no 8 (Jan. 13, 2010): 2014–47. Available online at <http://edocket.access.gpo.gov/2010/pdf/E9-31216.pdf>.

*(continued)*

## Objectives, Measures, and EHR Criteria for Eligible Hospitals

(sources: NPRM table 2, IFR, regulation text)

Objective	Measures	Numerator	Denominator	IFR Standards and Certification Criteria	Content Exchange Standard	Vocabulary Standard
Use CPOE	For eligible hospitals, CPOE is used for 10% of all orders	No. orders entered in IP facility/ department by an authorized provider using CPOE certified EHR technology	No. of all orders entered in an IP facility/ department.	Enable a user to electronically record, store, retrieve, and manage, at a minimum, the following order types: <ol style="list-style-type: none"> <li>1. Medications;</li> <li>2. Laboratory;</li> <li>3. Radiology/imaging;</li> <li>4. Blood bank;</li> <li>5. Physical therapy;</li> <li>6. Occupational therapy;</li> <li>7. Respiratory therapy;</li> <li>8. Rehabilitation therapy;</li> <li>9. Dialysis;</li> <li>10. Provider consults; and</li> <li>11. Discharge and transfer.</li> </ol>		
Implement drug-drug, drug-allergy, drug-formulary checks	The eligible hospital has enabled this functionality	None	None	<ol style="list-style-type: none"> <li>1. Automatically and electronically generate and indicate (e.g., pop-up message or sound) in real-time, alerts at the point of care for drug-drug and drug-allergy contraindications based on medication list, medication allergy list, age, and CPOE.</li> <li>2. Enable a user to electronically check if drugs are in a formulary or preferred drug list in accordance with the standard specified in Table 2A row 2.</li> <li>3. Provide certain users with administrator rights to deactivate, modify, and add rules for drug-drug and drug-allergy checking.</li> <li>4. Automatically and electronically track, record, and generate reports on the number of alerts responded</li> </ol>	Drug Formulary Check— Applicable Part D standard required by law (i.e., NCPDP Formulary and Benefits Standard 1.0).	

Objective	Measures	Numerator	Denominator	IFR Standards and Certification Criteria	Content Exchange Standard	Vocabulary Standard
				to by a user.		
Maintain an up-to-date problem list of current and active diagnoses based on ICD-9-CM or SNOMED CT	At least 80% of all unique patients seen admitted to the eligible hospital have at least one entry or an indication of "none" recorded as structured data	No. of unique patients with at least one entry.	No. of admissions.	Enable a user to electronically record, modify, and retrieve a patient's problem list for longitudinal care ( <i>i.e.</i> , over multiple office visits) in accordance with the applicable standards <sup>9</sup> specified in Table 2A row 1.		Problem List—Applicable HIPAA code set required by law ( <i>i.e.</i> , ICD-9-CM); or SNOMED CT <sup>®</sup> .
Maintain active medication list	At least 80% of all unique patients admitted to the eligible hospital have at least one entry (or an indication of "none" if the patient is not currently prescribed any medication) recorded as structured data	No. of unique patients with at least one entry.	No. of admissions.	Enable a user to electronically record, modify, and retrieve a patient's active medication list as well as medication history for longitudinal care ( <i>i.e.</i> , over multiple office visits) in accordance with the applicable standard specified in Table 2A row 1.		Medication List—Any code set by an RxNorm drug data source provider that is identified by the United States National Library of Medicine as being a complete data set integrated within RxNorm.
Maintain active medication allergy list	At least 80% of all unique patients admitted to the eligible hospital have at least one entry or (an indication of "none" if the patient has no medication allergies)	No. of unique patients with at least one entry.	No. of admissions.	Enable a user to electronically record, modify, and retrieve a patient's active medication allergy list as well as medication allergy history for longitudinal care ( <i>i.e.</i> , over multiple office visits).		

Objective	Measures	Numerator	Denominator	IFR Standards and Certification Criteria	Content Exchange Standard	Vocabulary Standard
	recorded as structured data					
Record demographics: <ul style="list-style-type: none"> <li>• preferred language</li> <li>• insurance type</li> <li>• gender</li> <li>• race</li> <li>• ethnicity</li> <li>• date of birth</li> <li>• date and cause of death in the event of mortality</li> </ul>	At least 80% of all unique patients admitted to the eligible hospital have demographics recorded as structured data	No. of unique admitted patients who have all required demographic elements recorded as structured data in their electronic record.	No. of unique admissions.	Enable a user to electronically record, modify, and retrieve patient demographic data including preferred language, insurance type, gender, race, ethnicity, date of birth, and date and cause of death in the event of mortality.		
Record and chart changes in vital signs: <ul style="list-style-type: none"> <li>• height</li> <li>• weight</li> <li>• blood pressure</li> </ul> Calculate and display: <ul style="list-style-type: none"> <li>• BMI</li> </ul> Plot and display growth charts for children 2–20 years, including BMI	For at least 80% of all unique patients age 2 and over admitted to eligible hospital, record blood pressure and BMI; additionally plot growth chart for children age 2–20	No. of unique patients admitted who have a record of their blood pressure and BMI (age 2–20) in their record.	No. of unique admissions 2 years old up to 20.	<ol style="list-style-type: none"> <li>1. Enable a user to electronically record, modify, and retrieve a patient's vital signs including, at a minimum, the height, weight, blood pressure, temperature, and pulse.</li> <li>2. Automatically calculate and display body mass index (BMI) based on a patient's height and weight.</li> <li>3. Plot and electronically display, upon request, growth charts (height, weight, and BMI) for patients 2–20 years old.</li> </ol>		
Record smoking status for patients 13 years old or older	At least 80% of all unique patients 13 years old or older admitted to the eligible	No. of unique patients 13 years or older with noted status.	No. of unique admissions 13 years old or older.	Enable a user to electronically record, modify, and retrieve the smoking status of a patient to: current smoker, former smoker, or never smoked.		

Objective	Measures	Numerator	Denominator	IFR Standards and Certification Criteria	Content Exchange Standard	Vocabulary Standard
	hospital have "smoking status" recorded					
Incorporate clinical lab test results into EHR as structured data	At least 50% of all clinical lab tests ordered whose results are in a positive/negative or numerical format are incorporated in certified EHR technology as structured data	No. of lab tests ordered during the EHR reporting period whose results are expressed in a positive or negative affirmation or as a number and are incorporated as structured data.	No. of lab tests ordered during the EHR reporting period for patients whose results are expressed in a positive or negative affirmation or as a number.	<ol style="list-style-type: none"> <li>1. Electronically receive clinical laboratory test results in a structured format and display such results in human readable format.</li> <li>2. Electronically display in human readable format any clinical laboratory tests that have been received with LOINC® codes.</li> <li>3. Electronically display all the information for a test report specified at 42 CFR 493.1291(c)(1) through (7).6</li> <li>4. Enable a user to electronically update a patient's record based upon received laboratory test results.</li> </ol>		
Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, and outreach.	Generate at least one report listing patients of the EP or eligible hospital with a specific condition	N/A	N/A	Enable a user to electronically select, sort, retrieve, and output a list of patients and patients' clinical information, based on user-defined demographic data, medication list, and specific conditions.		
Report hospital quality measures to CMS or the States	For 2011, provide aggregate numerator and denominator through attestation. For 2012, electronically submit the measures as	N/A	N/A	<ol style="list-style-type: none"> <li>1. Calculate and electronically display quality measure results as specified by CMS or states.</li> <li>2. Enable a user to electronically submit calculated quality measures in accordance with the standard specified in Table 2A row 5.</li> </ol>	Quality Reporting—CMS PQRI 2008 Registry XML Specification	

Objective	Measures	Numerator	Denominator	IFR Standards and Certification Criteria	Content Exchange Standard	Vocabulary Standard
	discussed in this proposed rule.					
Implement 5 clinical decision support rules related to a high priority hospital condition, including diagnostic test ordering, along with the ability to track compliance with those rules.	Implement 5 clinical decision support rules relevant to the clinical quality metrics the Eligible Hospital is responsible for as described.	N/A	N/A	<p>1. Implement automated, electronic clinical decision support rules (in addition to drug-drug and drug-allergy contraindication checking) according to a high priority hospital condition that use demographic data, specific patient diagnoses, conditions, diagnostic test results and/or patient medication list.</p> <p>2. Automatically and electronically generate and indicate (e.g., pop-up message or sound) in real-time, alerts and care suggestions based upon clinical decision support rules and evidence grade.</p> <p>3. Automatically and electronically track, record, and generate reports on the number of alerts responded to by a user.</p>		
Check insurance eligibility electronically from public and private payers.	Insurance eligibility checked electronically for at least 80% of all unique patients seen by the EP or admitted to the eligible hospital.	No. of unique patients whose eligibility was checked.	No. of unique admissions.	Enable a user to electronically record and display patients' insurance eligibility, and submit insurance eligibility queries to public or private payers and receive an eligibility response in accordance with the applicable standards specified in Table 2A row 4.	Administrative Transactions—Applicable HIPAA transaction standards required by law.	
Submit claims electronically to public and private payers.	At least 80% of all claims filed electronically by the EP or the eligible hospital.	No. of unique patients whose claims were submitted electronically.	No of unique admissions.	Enable a user to electronically submit claims to public or private payers in accordance with the applicable standards specified in Table 2A row 4.	Administrative Transactions—Applicable HIPAA transaction standards required by law.	

Objective	Measures	Numerator	Denominator	IFR Standards and Certification Criteria	Content Exchange Standard	Vocabulary Standard
<p>Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, allergies, discharge summary, procedures), upon request.</p>	<p>At least 80% of all patients who request an electronic copy of their health information are provided it within 48 hours.</p>	<p>No. of unique patients admitted that request an electronic copy of their health information and received it within 48 hours.</p>	<p>No. of unique patients admitted that request an electronic copy of their health information.</p>	<p>Enable a user to create an electronic copy of a patient's clinical information, including, at a minimum, diagnostic test results, problem list, medication list, medication allergy list, immunizations, discharge summary, and procedures in: (1) Human readable format; and (2) accordance with the standards<sup>%</sup> specified in Table 2A row 1 to provide to a patient on electronic media, or through some other electronic means.</p>	<p>Patient Summary Record—HL7 CDA R2 CCD Level 2 or ASTM CCR.</p>	<p>Problem List—Applicable HIPAA code set required by law (i.e., ICD-9-CM); or SNOMED CT<sup>®</sup>.</p> <p>Medication List—Any code set by an RxNorm drug data source provider that is identified by the United States National Library of Medicine as being a complete data set integrated within RxNorm.</p> <p>Medication Allergy List—No standard adopted at this time.</p> <p>Procedures—Applicable HIPAA code sets required by law (i.e., ICD-9-CM or CPT-4<sup>®</sup>).</p> <p>Lab Orders and Results—LOINC<sup>®</sup> when LOINC codes have been received from a</p>

Objective	Measures	Numerator	Denominator	IFR Standards and Certification Criteria	Content Exchange Standard	Vocabulary Standard
Provide patients with an electronic copy of their discharge instructions and procedures at time of discharge, upon request.	At least 80% of all patients who are discharged from an eligible hospital and who request an electronic copy of their discharge instructions and procedures are provided it.	No. of unique patients admitted that request an electronic copy of their discharge instruction and procedures and receive it.	No. of unique patients admitted that request an electronic copy of their discharge instructions and procedures.	Enable a user to create an electronic copy of the discharge instructions and procedures for a patient, in human readable format, at the time of discharge to provide to a patient on electronic media, or through some other electronic means.		laboratory.
Capability to exchange key clinical information (for example, discharge summary, procedures, problem list, medication list, allergies, diagnostic test results), among providers of care and patient authorized entities electronically	Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information.	N/A	N/A	<ol style="list-style-type: none"> <li>1. Electronically receive a patient summary record, from other providers and organizations including, at a minimum, discharge summary, diagnostic test results, problem list, medication list, medication allergy list, immunizations, and procedures and upon receipt of a patient summary record formatted in an alternative standard specified in Table 2A row 1, displaying it in human readable format.</li> <li>2. Enable a user to electronically transmit a patient summary record, to other providers and organizations including, at a minimum, discharge summary, diagnostic test results, problem list, medication list, medication allergy list, immunizations, and procedures in accordance with the standards% specified in Table 2A row 1.</li> </ol>	Patient Summary Record— HL7 CDA R2 CCD Level 2 or ASTM CCR.	<p>Problem List— Applicable HIPAA code set required by law (i.e., ICD-9-CM); or SNOMED CT®.</p> <p>Medication List— Any code set by an RxNorm drug data source provider that is identified by the United States National Library of Medicine as being a complete data set integrated within RxNorm.</p> <p>Medication Allergy List—No standard adopted at this time.</p>

Objective	Measures	Numerator	Denominator	IFR Standards and Certification Criteria	Content Exchange Standard	Vocabulary Standard
						<p>Procedures—Applicable HIPAA code sets required by law (i.e., ICD-9-CM or CPT-4<sup>®</sup>).</p> <p>Lab Orders and Results—LOINC<sup>®</sup> when LOINC codes have been received from a laboratory.</p>
Provide summary care record for each transition of care and referral	Provide summary of care record for at least 80% of transitions of care and referrals.	No. of transitions of care and referrals where the facility was the transferring or referring provider where an electronic summary of care records was provided as defined.	No. of transitions of care and referrals where the facility was the transferring or referring provider where a summary of care records was provided.	<p>1. Electronically receive a patient summary record, from other providers and organizations including, at a minimum, discharge summary, diagnostic test results, problem list, medication list, medication allergy list, immunizations, and procedures and upon receipt of a patient summary record formatted in an alternative standard specified in Table 2A row 1, displaying it in human readable format.</p> <p>2. Enable a user to electronically transmit a patient summary record, to other providers and organizations including, at a minimum, discharge summary, diagnostic test results, problem list, medication list, medication allergy list, immunizations, and procedures in accordance with the standards% specified in Table 2A row 1.</p>	Patient Summary Record—HL7 CDA R2 CCD Level 2 or ASTM CCR.	<p>Problem List—Applicable HIPAA code set required by law (i.e., ICD-9-CM); or SNOMED CT<sup>®</sup>.</p> <p>Medication List—Any code set by an RxNorm drug data source provider that is identified by the United States National Library of Medicine as being a complete data set integrated within RxNorm.</p> <p>Medication Allergy List—No standard adopted</p>

Objective	Measures	Numerator	Denominator	IFR Standards and Certification Criteria	Content Exchange Standard	Vocabulary Standard
						<p>at this time.</p> <p>Procedures—Applicable HIPAA code sets required by law (i.e., ICD-9-CM or CPT-4<sup>®</sup>).</p> <p>Lab Orders and Results—LOINC<sup>®</sup> when LOINC codes have been received from a laboratory.</p>
Perform medication reconciliation at relevant encounters and each transition of care	Perform medication reconciliation for at least 80% of relevant encounters and transitions of care	No. of relevant encounters and transitions of care for which the facility performed a medication reconciliation.	No. of relevant encounters and transitions of care.	Electronically complete medication reconciliation of two or more medication lists (compare and merge) into a single medication list that can be electronically displayed in real-time.		
Capability to submit electronic data to immunization registries and actual submission where required and accepted	Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries	N/A	N/A	Electronically record, retrieve, and transmit immunization information to immunization registries in accordance with the standards <sup>%</sup> specified in Table 2A row 8 or in accordance with the applicable state-designated standard format.	Submission to Immunization Registries—HL7 2.3.1 or HL7 2.5.1	Submission to Immunization Registries—CVX
Capability to provide	Performed at least one test of	N/A	N/A	Electronically record, retrieve, and transmit reportable clinical lab	Submission of Lab Results to	Submission of Lab Results to

Objective	Measures	Numerator	Denominator	IFR Standards and Certification Criteria	Content Exchange Standard	Vocabulary Standard
electronic submission of reportable lab results (as required by state or local law) to public health agencies and actual submission where it can be received	the EHR system's capacity to provide electronic submission of reportable lab results to public health agencies (unless none of the public health agencies to which eligible hospital submits such information have the capacity to receive the information electronically).			results to public health agencies in accordance with the standards% specified in Table 2A row 6.	Public Health Agencies—HL7 2.5.1	Public Health Agencies—LOINC® when LOINC codes have been received from a laboratory.
Capability to provide electronic syndromic surveillance data to public health agencies and actual transmission according to applicable law and practice	Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies (unless none of the public health agencies to which an EP or eligible hospital submits such information have the capacity to	N/A	N/A	Electronically record, retrieve, and transmit syndrome-based (e.g., influenza like illness) public health surveillance information to public health agencies in accordance with the standards specified in Table 2A row 7.	Submission to Public Health Agencies for Surveillance or Reporting (excluding adverse event reporting)—HL7 2.3.1 or HL7 2.5.1	Submission to Public Health Agencies for Surveillance or Reporting (excluding adverse event reporting)—According to applicable public health agency requirements.

Objective	Measures	Numerator	Denominator	IFR Standards and Certification Criteria	Content Exchange Standard	Vocabulary Standard
	receive the information electronically).					

<sup>%</sup> Instances where the version of an adopted standard (specified in the regulation text) will be “at a minimum” the version to which a Complete EHR or EHR Module must be tested and certified in order to be considered compliant with the adopted standard.

Objective	Measures	IFR Standards and Certification Criteria	Privacy and Security Standards
Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.	Conduct or review a security risk analysis per 45 CFR 164.308(a)(1) and implement security updates as necessary  <i>(no numerator or denominator provided)</i>	<ol style="list-style-type: none"> <li>1. Assign a unique name and/or number for identifying and tracking user identity and establish controls that permit only authorized users to access electronic health information.</li> <li>2. Permit authorized users (who are authorized for emergency situations) to access electronic health information during an emergency.</li> <li>3. Terminate an electronic session after a predetermined time of inactivity.</li> <li>4. Encrypt and decrypt electronic health information according to user-defined preferences (e.g., backups, removable media, at log-on/off) in accordance with the standard specified in Table 2B row 1.</li> <li>5. Encrypt and decrypt electronic health information when exchanged in accordance with the standard specified in Table 2B row 2.</li> <li>6. Record actions (e.g., deletion) related to electronic health information in accordance with the standard specified in Table 2B row 3 (i.e., audit log), provide alerts based on user-defined events, and electronically display and print all or a specified set of recorded information upon request or at a set period of time.</li> <li>7. Verify that electronic health information has not been altered in transit and detect the alteration and deletion of electronic health information and audit logs in accordance with the standard specified in Table 2B row 4.</li> </ol>	<p>General Encryption and Decryption of Electronic Health Information—A symmetric 128 bit fixed-block cipher algorithm capable of using a 128, 192, or 256 bit encryption key must be used (e.g., FIPS 197 Advanced Encryption Standard, (AES), Nov 2001).</p> <p>Encryption and Decryption of Electronic Health Information for Exchange—An encrypted and integrity protected link must be implemented (e.g., TLS, IPv6, IPv4 with IPsec).</p> <p>Record Actions Related to Electronic Health Information (i.e., audit log)—The date, time, patient identification (name or number), and user identification (name or number) must be recorded when electronic health information is created, modified, deleted, or printed. An indication of which action(s) occurred must also be recorded (e.g., modification).</p> <p>Verification that Electronic Health Information has not been Altered in Transit—A secure hashing algorithm must be used to verify that electronic health information has not been altered in transit. The secure hash algorithm used must be SHA-1 or higher (e.g., Federal Information Processing Standards (FIPS) Publication (PUB) Secure Hash Standard (SHS) FIPS PUB 180-3).</p> <p>Cross-Enterprise Authentication—Use of a cross-enterprise secure transaction that contains sufficient identity information such that the receiver can make access control decisions and produce detailed and</p>

		<p>8. Verify that a person or entity seeking access to electronic health information is the one claimed and is authorized to access such information.</p> <p>9. Verify that a person or entity seeking access to electronic health information across a network is the one claimed and is authorized to access such information in accordance with the standard specified in Table 2B row 5.</p> <p>10. Record disclosures made for treatment, payment, and health care operations in accordance with the standard specified in Table 2B row 6.</p>	<p>accurate security audit trails (e.g., IHE Cross Enterprise User Assertion (XUA) with SAML identity assertions).</p> <p>Record Treatment, Payment, and Health Care Operations Disclosures—The date, time, patient identification (name or number), user identification (name or number), and a description of the disclosure must be recorded.</p>
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