Most of those who presented testimony at the hearing felt that the proposed access report would neither be workable or useful for patients.

The proposed access report seems to rely on security audit logs that were designed for other purposes.  (Audit logs typically track by user, not necessarily by patient; logs may not distinguish between computer automated and human access, although at least one person commented that these two types of access could be logged separately; not all health information in "designated record sets" is tracked through audit logs, since the HIPAA Security Rule does not require this; and not all access to a record will be picked up in an audit log (e.g., Paul's surgeon example).)

The proposed access report also would not be useful for patients because it results in a deluge of information that would be impossible to understand. Due to the volume of information produced in such a report, it could actually obscure rather than highlight potential inappropriate accesses.  Covered entities (and business associates operating on their behalf) should be required to investigate patient complaints of inappropriate access, and could use audit trail functionalities to support this investigation (but a report to the patient would not be required). Patients should have recourse to file a compliant with OCR if they do not believe their complaints have been properly investigated.

Questions were raised about what patients really want. While some of the patient advocates supported access reports, they did not provide clear testimony on how they could be implemented. Testimony from providers indicated that patients do not generally request these reports.

We did not hear evidence that any organization was currently producing an access report for patients.

HITECH calls for an accounting of "disclosures" that includes disclosure for treatment, payment and operations. There were concerns expressed that it is difficult (and, perhaps impossible) to distinguish between and “access” and a “disclosure” as those terms are currently defined. Using current definitions, it might not be possible to produce an accounting of “disclosures” without producing an access report.   HITECH both references current HIPAA definitions – but also requires HHS to implement the new requirement in a way that “takes into account the interests of the individuals in learning the circumstances under which their protected health information is being disclosed and takes into account the administrative burden of accounting for such disclosures.”

Potentially worth exploring: The possibility of narrowing the definitions of “disclosures” that must be part of a report to the patient so that it encompasses only those external to the organization or OHCA, and/or only those involving deliberate [human] access vs. disclosures through interfaces or aggregate reports. Also, a number of comments were made about identifying machines (devices) that access the data on these reports.    Any discussion about the definition of the term “disclosure” needs to address which devices are included.

We will also need to decide what we think Congress meant by "disclosures through an EHR." (language from HITECH) Suggestions were made to limit this to just Certified EHR Technology, which could be a first step to a step-wise implementation of HITECH. Others testified that payers and non-clinicians were not intended by Congress to be covered by the HITECH provisions. HITECH defines “EHR” as an electronic record “created, gathered, managed, and consulted by authorized health care clinicians and staff;” however, the Tiger Team will need to consider whether there should be similar transparency rights for other entities covered by HIPAA.

We will need to determine what type of information should be included in an accounting of disclosures. Many who testified raised concerns about releasing the names of individuals who have accessed a patient’s record to the patient. In addition, requiring a report to include the “purpose” of a disclosure would require manual entry by providers and probably not be doable given current health care workflows; it also is not always possible to know the recipient of the data, even with respect to an external disclosure.

Previous recommendations of the Tiger Team (all adopted by the Policy Committee) may provide a foundation upon which to build. We have put before the Policy Committee (and secured adoption of) recommendations regarding patient rights to an accounting of queries of their health record, and potentially also of access to a patient's view, download and transmit account.  Are there also aspects of sharing patient records using Direct that technology could track in an accounting?  Are they recommending accounting for blue button automatic push and pull?  Also, we received a lot of testimony that receiving reports of routine (and arguably expected) uses and disclosures would not be of interest to patients. Consequently, can we also build on our rhetoric re: meaningful consent and the patient not being surprised as the basis for focusing on disclosures that might not be expected by the patient, or that might be out of the decision-making control of the patient's trusted physician/health care provider?    Should we instead ask ONC to pilot some options in order to better determine what patients would want?

As for business associates, perhaps it makes sense to first define the scope of what is expected of covered entities; then, to the extent a business associate is performing one of those functions for a covered entity, then the covered entity could ask the business associate to account for those disclosures (or the covered entity could decide that it wants to handle disclosing business associate disclosures to the patient).