Intermountain Healthcare's Concerns with
Expanded Accounting of Disclosures Requirements

Section 13405(c) of the HITECH Act (P.L. 111-5) would newly require that covered entities with electronic health records have the capacity to produce an accounting of disclosures of protected health information through an electronic health record for treatment, payment and health care operations over a three-year period.

For the reasons outlined below, this new requirement would be both operationally overwhelming and technologically not feasible even with Intermountain's extensive and advanced electronic medical record capabilities. Our preliminary estimate for programming, storage, infrastructure, and personnel costs for moving toward compliance with the new accounting for disclosures requirement is approximately $250 million over a three-year development period. Note that even with an expenditure of $250 million, Intermountain would - as described below - still be unable to fully comply with the new requirement.

Intermountain Healthcare is a not-for-profit, community-based integrated delivery system headquartered in Salt Lake City, Utah that operates 23 hospitals, over 140 clinics, and other healthcare services. Intermountain has approximately 31,000 employees and provides clinical services in about six million patient visits each year while Select Health, our health insurance company, covers more than 500,000 individuals. Intermountain employs approximately 800 physicians and has contractual arrangements with more than 3,000 additional physicians. We have over 500 HIPAA business associates.

Intermountain was part of developing some of the earliest electronic medical records, beginning in the 1970s. Electronic medical records and other computer systems are a key component in our efforts to achieve our mission to provide the best possible health care at the lowest appropriate cost. Intermountain uses its computer systems to identify and eliminate inappropriate variation in the delivery of health care. This actually allows Intermountain to provide better quality health care at a lower cost. The Dartmouth Atlas Project found that Medicare could have realized $40 billion in savings if all U.S. hospitals used the high-quality/low-cost standard for care of patients with severe chronic illness set by the Salt Lake City region.

Intermountain has approximately one hundred enterprise information systems, databases, and applications with electronic protected health information. In addition, Intermountain has more than 2,500 smaller departmental systems, databases, or applications where electronic protected health information may be stored or accessed. Some examples of our databases include the radiology system for images, the lab system for lab reports, a hospital admitting and billing system, several large clinical data systems used within our hospitals and clinics, the system that transcribes notes from a physician's dictation, the retail pharmacy system that tracks and bills for prescriptions, as well as specialized department systems such as the labor and delivery system which makes prenatal care information readily available to the hospital staff when a patient comes in to deliver her baby. Importantly, the majority of our systems, databases, and applications lack the

capacity to track access to individual patient records when that access is made only to read or print the protected health information.

Further, not all of these electronic systems interface with each other. We do not have access to all of our information on a single patient with a click of a mouse, or even with many clicks of a mouse. Extensive professional staff time is currently required to develop an accounting of disclosures report under the existing Privacy Rule provisions. It took approximately thirty hours of professional time to comply with a recent request for an accounting of disclosures made during a specified one-year period. While the report produced included just one definitive disclosure, which was made to the Utah Health Department for a required reporting to the state trauma registry, the report also included, as required by HIPAA, a listing of all the research projects undertaken during the time-period that could possibly have included protected health information about the patient. This listing and description of research projects extended for 45 pages.

In the more than six years since the Privacy Rule took effect, we have received only ten requests for an accounting of disclosures. Four of those ten requestors called our Privacy Office to complain that the accounting of disclosures reports that had been produced pursuant to their requests did not produce the information they sought. One requestor was seeking information on whether her ex-husband had received any copies of their child's records. Other requestors wanted information on all employees of the covered entity who had accessed their records. Importantly, neither of these types of requests would be satisfied under the new requirements.

The new accounting for disclosures requirement in the HITECH Act would require an ability to account for all non-oral disclosures of protected health information for a three-year period, including disclosures made for treatment, payment and health care operations. This means, for example, that access to protected health information in the hospital's medical record systems by an affiliated health care provider (separate covered entity under HIPAA) would have to be trackable for three years. Intermountain does not presently have the storage capacity or the technology to comply with this requirement.

To illustrate the magnitude of this task, consider that non-affiliated providers (separate covered entity under HIPAA) working in Intermountain hospitals or remotely from their offices access patient information over 1 million times each month in just one of Intermountain's primary electronic medical record systems (multiple access to a single patient record on the same day by the same provider is counted only once). Each month, approximately 260,000 hospital claims, 290,000 outpatient clinic claims and 500 home care claims are sent from Intermountain hospitals and clinics to payers. Similarly, transmittal of lab and dictated reports to affiliated providers would have to be trackable for three years. Intermountain estimates that 60,000 lab reports and 210,000 dictated reports per month are sent to affiliated providers via automated fax from multiple systems.

As noted above, our hospitals maintain many different databases and systems with patient information -- systems for radiology images, systems for lab work, systems for clinical

care in the hospital setting which are often different from the systems for clinical care in clinics and home care settings, systems for patient admitting, systems for patient billing, etc. Not all of these systems have the ability to maintain or track disclosures for three years. While most systems currently track additions to a patient record by a user, many disclosures that would newly be required to be trackable result from simply viewing the record, which as noted above tends not to be trackable. Additionally, nurses often access the electronic medical record to print out information – such as lab results – at the request of a physician. No record of the physician's request for a paper copy of the lab report is reflected in the electronic medical record.

Electronic access events in which additions are made to the patient record are noted on some of our systems but the data is only maintained for 12-24 months due to storage capacity issues and maintenance costs. Note that the majority of our systems with this capability are systems that have been built or customized by Intermountain. Many of the specialized systems we have purchased from outside vendors lack this type of auditing capability. It is important to note that audit trail capacity does not equate to capacity to produce an accounting of disclosures report. There is significant variability in the level of detail captured in audit trails. Typically, audit trails capture the user ID of the credential accessing the data (which, despite our best efforts, does not always match up with the person actually accessing the data because, for example, where multiple clinicians use the same computer at a nursing station, should a clinician forget to log off then the next user could unintentionally be accessing records under the previous user's ID), the medical record number/account number of the patient whose information is being accessed, and a date/time stamp. The amount of variability comes in the level of detail with respect to what information is being accessed. Some audit trails can tell us which screen, report, or subpart of the record was accessed but this information is not available on all of our audit trails and, when it is available, it is not always fully reliable. Further, an audit trail does not distinguish between a use and a disclosure and none of our audit trails have the capacity to capture all of the information needed for an accounting of disclosures report nor do they have storage capacity to maintain this information for three years.

Our best estimate of the time and cost required to develop the capacity to move toward compliance with the new accounting for disclosures requirement is in the three-year/$250 million range. Programming and other set-up costs for adding data capture functionality to support the audit logs would be approximately $26,400 per information system with the total cost approaching $68 million. Storage costs for maintaining a rolling period of three years of audit data would be approximately $30,000 per information system for the first three years with a total estimated cost approaching $78 million. Infrastructure development and maintenance costs, including personnel for managing the audit data, would cost approximately $40,800 per information system in the first three years with a total cost approaching $106 million.

Further, the Privacy Rule currently requires that an accounting for disclosures must include the date of the disclosure; the name of the entity or person who received the protected health information and, if known, the address of such entity or person; a brief

description of the protected health information disclosed; and a brief statement of the purpose of the disclosure that reasonably informs the individual of the basis for the disclosure or, in lieu of such statement, a copy of a written request for a disclosure. While the implementation/compliance costs detailed above would allow us to track "who" accessed "what" piece of the protected health information, we still would be UNABLE to capture the "why" information was accessed piece. Having the ability to track the justification for each access could require "pop-ups" to appear that would require physicians and others who access protected health information to provide a justification for the disclosure of the protected health information. This would involve additional costs, have a high hassle factor for users of our systems, and could adversely affect patient care because each and every non-oral disclosure of protected health information for treatment, payment and health care operations would have to be justified.

Even if we were to develop the capacity to develop and store non-oral disclosures of protected health information used in treatment, payment, and healthcare operations, compiling an accounting of disclosures from all these systems over a three-year period could NOT be accomplished with the click of a mouse. Instead, it would require extensive professional time (probably in the 80 - 100 hour range) to access each of the many systems and review any information that might be relevant.

In sum, the new requirement that covered entities with electronic medical records have the capacity to produce an accounting of disclosures for treatment, payment and health care operations over a three-year period is both operationally overwhelming and technologically not feasible even with Intermountain's extensive and advanced electronic medical record capabilities. We have estimated that altering our systems to allow us to move toward compliance would be a three-year, approximately $250 million endeavor.

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Intermountain Healthcare is a not-for-profit integrated health care delivery system of 23 hospitals, more than 140 clinics and related services based in Salt Lake City, Utah. Intermountain's team includes approximately 31,000 employees, providing care in nearly six million patient visits every year. SelectHealth, a not-for-profit insurance company, is also owned by Intermountain and provides benefits for more than 500,000 people. Intermountain has over 500 business associate agreements. A pioneer in the use of information technology, Intermountain has used electronic medical records since the 1970s to implement best practices and clinical protocols – resulting in higher quality care that costs less. Medicare spending could be reduced by a third, with improved quality, if the nation provided care the way care is provided at Intermountain, according to research from Dartmouth Medical School. See intermountainhealthcare.org

For more information, contact Intermountain Healthcare Washington Counsel Karen Scalander at McDermott Will & Emery LLP (kscalander@mwe.com 202.756.8024 (work) 202.321.3172 (cell) 202.547.9547 (home)).