



Standard Specification for Audit and Disclosure Logs for Use in Health Information Systems¹

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1. Scope

1.1 This specification is for the development and implementation of security audit/disclosure logs for health information. It specifies how to design an access audit log to record all access to patient identifiable information maintained in computer systems and includes principles for developing policies, procedures, and functions of health information logs to document all disclosure of health information to external users for use in manual and computer systems. The process of information disclosure and auditing should conform, where relevant, with the Privacy Act of 1974 (1).²

1.2 The first purpose of this specification is to define the nature, role, and function of system access audit logs and their use in health information systems as a technical and procedural tool to help provide security oversight. In concert with organizational confidentiality and security policies and procedures, permanent audit logs can clearly identify all system application users who access patient identifiable information, record the nature of the patient information accessed, and maintain a permanent record of actions taken by the user. By providing a precise method for an organization to monitor and review who has accessed patient data, audit logs have the potential for more effective security oversight than traditional paper record environments. This specification will identify functionality needed for audit log management, the data to be recorded, and the use of audit logs as security and management tools by organizational managers.

1.3 In the absence of computerized logs, audit log principles can be implemented manually in the paper patient record environment with respect to permanently monitoring paper patient record access. Where the paper patient record and the

computer-based patient record coexist in parallel, security oversight and access management should address both environments.

1.4 The second purpose of this specification is to identify principles for establishing a permanent record of disclosure of health information to external users and the data to be recorded in maintaining it. Security management of health information requires a comprehensive framework that incorporates mandates and criteria for disclosing patient health information found in federal and state laws, rules and regulations and ethical statements of professional conduct. Accountability for such a framework should be established through a set of standard principles that are applicable to all health care settings and health information systems.

1.5 Logs used to audit and oversee health information access and disclosure are the responsibility of each health care organization, data intermediary, data warehouse, clinical data repository, third party payer, agency, organization or corporation that maintains or provides, or has access to individually-identifiable data. Such logs are specified in and support policy on information access monitoring and are tied to disciplinary sanctions that satisfy legal, regulatory, accreditation and institutional mandates.

1.6 Organizations need to prescribe access requirements for aggregate data and to approve query tools that allow auditing capability, or design data repositories that limit inclusion of data that provide potential keys to identifiable data. Inferencing patient identifiable data through analysis of aggregate data that contains limited identifying data elements such as birth date, birth location, and family name, is possible using software that matches data elements across data bases. This allows a consistent approach to linking records into longitudinal cases for research purposes. Audit trails can be designed to work with applications which use these techniques if the query functions are part of a defined retrieval application but often standard query tools are not easily audited. This specification applies to the disclosure or transfer of health information (records) individually or in batches.

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² The boldface numbers in parentheses refer to the list of references at the end of this standard.

1.7 This specification responds to the need for a standard addressing privacy and confidentiality as noted in Public Law 104–191 (2), or the Health Insurance Portability and Accountability Act of 1996 (3).

2. Referenced Documents

2.1 *ASTM Standards:*³

E1384 Practice for Content and Structure of the Electronic Health Record (EHR)

E1633 Specification for Coded Values Used in the Electronic Health Record

E1762 Guide for Electronic Authentication of Health Care Information

E1869 Guide for Confidentiality, Privacy, Access, and Data Security Principles for Health Information Including Electronic Health Records

E1902 Specification for Management of the Confidentiality and Security of Dictation, Transcription, and Transcribed Health Records (Withdrawn 2011)⁴

E1986 Guide for Information Access Privileges to Health Information

2.2 *Other Health Informatics Standards:*

Health Level Seven (HL7) Version 2.2⁵

ANSI ASC X12 Version 3, Release 3⁶

ISO/TEC 15408

3. Terminology

3.1 *Definitions:*

3.1.1 *access, n*—the provision of an opportunity to approach, inspect, review, retrieve, store, communicate with, or make use of health information resources (for example, hardware, software, systems or structure) or patient identifiable data and information, or both. **(E1869)**

3.1.2 *audit log, n*—a record of actions, for example, creation, queries, views, additions, deletions, and changes performed on data.

3.1.3 *audit trail, n*—a record of users that is documentary evidence of monitoring each operation of individuals on health information. Audit trails may be comprehensive or specific to the individual and information (4). For example, an audit trail may be a record of all actions taken by anyone on a particularly sensitive file (5).

3.1.4 *authentication, n*—the provision of assurance of the claimed identity of an entity, receiver or object.

(E1762, E1869, CPRI)

3.1.5 *authorize, v*—the granting to a user the right of access to specified data and information, a program, a terminal or a process. **(E1869)**

3.1.6 *authorization, n*—the mechanism for obtaining consent for the use and disclosure of health information.

(CPRI, AHIMA)

3.1.7 *certificate, n*—certificate means that a Certificate Authority (CA) states a given correlation or given properties of persons or IT-systems as true. If the certificate is used to confirm that a key belongs to its owner, it is called key certificate. If the certificate is used to confirm roles (qualifications), it is called authentication certificate.

3.1.8 *confidential, n*—status accorded to data or information indicating that it is sensitive for some reason, and therefore, it needs to be protected against theft, disclosure, or improper use, and must be disseminated only to authorized individuals or organizations with an approved need to know. Private information, which is entrusted to another with the confidence that unauthorized disclosure which would be prejudicial to the individual will not occur (6).

(E1869; CPRI)

3.1.9 *database, n*—a collection of data organized for rapid search and retrieval.

(Webster’s, 1993)

3.1.10 *database security, n*—refers to the ability of the system to enforce security policy governing access, creation, modification, or destruction of information. Unauthorized creation of information is an important threat.

3.1.11 *disclosure, n*—to access, release, transfer, or otherwise divulge health information to any internal or external user or entity other than the individual who is the subject of such information. **(E1869)**

3.1.12 *health information, n*—any information, whether oral or recorded in any form or medium that is created or received by a health care provider, a health plan, health, researcher, public health authority, instructor, employer, school or university, health information, service or other entity that creates, receives, obtains, maintains, uses or transmits health information; a health oversight agency, a health information service organization; or, that relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present or future payments for the provision of health care to a protected individual; and, that identifies the individual with respect to which there is a reasonable basis to believe that the information can be used to identify the individual (3).

3.1.13 *information, n*—data to which meaning is assigned, according to context and assumed conventions. **(E1869)**

3.1.14 *transaction log, n*—a record of changes to data, especially to a data base, that can be used to reconstruct the data if there is a failure after the transaction occurs, in other words, a means of ensuring data integrity and availability.

3.1.15 *user, n*—a person authorized to use the information contained in an information system as specified by their job function. The patient may be designated an authorized user by statute or institutional policy. A user also may refer to internal and external systems that draw data from an application.

3.1.16 *user identification (user ID), n*—the combination name/number biometric assigned and maintained in security procedures for identifying and tracking individual user activity.

³ For referenced ASTM standards, visit the ASTM website, www.astm.org, or contact ASTM Customer Service at service@astm.org. For *Annual Book of ASTM Standards* volume information, refer to the standard’s Document Summary page on the ASTM website.

⁴ The last approved version of this historical standard is referenced on www.astm.org.

⁵ Available from HL7, Mark McDougall, Executive Director, 900 Victors Way, Suite 122, Ann Arbor, MI 48108.

⁶ Available from American National Standards Institute (ANSI), 25 W. 43rd St., 4th Floor, New York, NY 10036, <http://www.ansi.org>.

3.1.17 *view*—a designated configuration for data/information extracted from information system(s) and presented through a workstation.

4. Significance and Use

4.1 Data that document health services in health care organizations are business records and must be archived to a secondary but retrievable medium. Audit logs should be retained, at a minimum, according to the statute governing medical records in the geographic area.

4.2 The purpose of audit access and disclosure logs is to document and maintain a permanent record of all authorized and unauthorized access to and disclosure of confidential health care information in order that health care providers, organizations, and patients and others can retrieve evidence of that access to meet multiple needs. Examples are clinical, organizational, risk management, and patient rights' needs.

4.3 Audit logs designed for system access provide a precise capability for organizations to see who has accessed patient information. Due to the significant risk in computing environments by authorized and unauthorized users, the audit log is an important management tool to monitor, access retrospectively. In addition, the access and disclosure log becomes a powerful support document for disciplinary action. Audit logs are essential components to comprehensive security programs in health care.

4.4 Organizations are accountable for managing the disclosure of health information in a way that meets legal, regulatory, accreditation and licensing requirements and growing patient expectations for accountable privacy practices. Basic audit trail procedures should be applied, manually if necessary, in paper patient record systems to the extent feasible. Security in health information systems is an essential component to making progress in building and linking patient information. Successful implementation of large scale systems, the use of networks to transmit data, growing technical capability to address security issues and concerns about the confidentiality, and security provisions of patient information drive the focus on this topic. (See Guide E1384.)

4.5 Consumer fears about confidentiality of health information and legal initiatives underscore disclosure practices. Patients and health care providers want assurance that their information is protected. Technology exists to incorporate audit functions in health information systems. Advances in security audit expert systems can be applied to the health care industry. Emerging off-the-shelf products will be able to use audit logs to enable the detection of inappropriate use of health information. Institutions are accountable for implementing comprehensive confidentiality and security programs that combine social elements, management, and technology.

5. Audit Functions in Health Information Systems

5.1 An audit log is a record of actions (queries, views, additions, deletions, changes) performed on data by users. Actions should be recorded at the time they occur. These actions include user authentication, user or system-directed

signoff, health record access to view, and receipt of patient health record content from external provider/practitioner.

5.1.1 Health record content (transformation/translation via interfaces, interface engines, gateways between heterogeneous applications) should be maintained in the “before” and “after” form. For example, laboratory reports/data translated from laboratory forwarded to clinical repository storage.

5.2 Other database tables are needed to link the items in 5.1 and 5.1.1 to satisfy inquiries and to produce useful reports. Including unique user identification, for example, number, user name, work location, and employee status (permanent, contract, temporary) provides essential user information. While the audit log is a complete entity, data may be extracted from other systems for use in the audit log application.

5.3 The following functions should be performed when auditing:

5.3.1 Audits should identify and track individual users' access, including authentication and signoff, to a specific patient's or provider's data. This function should be done in real time and captured in audit logs. In the paper patient record, at a minimum, keep a permanent charge copy of all external releases. For example, an audit can be authorized by the patient or guardian, provided by law, or granted in an emergency. This may be a computer file.

5.3.2 Record or report type of access (authentication, signoff, queries, views, additions, deletions, changes). Complete records of the type of access and all actions performed on the data should be maintained. All changes to an individual patient's or provider's computer based health information should be retrievable. Changes, additions, and deletions to a patient's health information should be reported to the guardian/custodian/steward of patient/health information/medical records.

5.3.3 Record and maintain breach access flag. Flags should notify a security administrator and the guardian/custodian/steward of patient/health information/medical records that potential breaches may be occurring or have occurred. Organizations should be able to tailor flags to meet their requirements. For example, restricted health data may be flagged in one organization, high profile individuals' (that is, celebrity, employees, VIPs, providers) data may be flagged in another.

5.3.4 Maintain user identification data. Doing so should include a user identification code, full name, and employment status and the access authorization based on role and job function that is assigned by the organization.

5.3.5 Allow cross-reference to user employment, work location, or contract status with authorized access code.

5.3.6 Allow easy retrieval. Audit log queries must be efficient to operate and provide easy, on demand reporting within a reasonable time frame.

5.3.7 Provide search capability by user and patient identification, date range, type of data accessed, type of access (queries, views, additions, deletions, change). Doing so allows the capability to query access patterns to identify exceptions and allows programs to be written to generate exception reports related to known access patterns.