Corporate Policy
Title Page

POLICY NAME: Patient Privacy	
POLICY NUMBER: 00175	**Date of latest revision:** June 14, 2017
ORIGINATING DEPARTMENT: Legal Services//Information and Privacy Office	**Responsible VP:** Nyranne Martin, General Counsel

☐ **New Policy**
☑ **Revised Policy**

Policy Background or Rationale: (Is there a story, incident or legislation driving this policy?)

Given legislative and regulatory changes to the Personal Health Information Protection Act (PHIPA) resulting from the Health Information Protection Act (HIPA) in 2016, the launch of the MyChart patient portal, and additional requirements relating to the ConnectingOntario ClinicalViewer, revisions to the policy were required.

Scope of Policy: (who will it impact most)

This policy applies to all TOH Staff, all TOH hospital sites, and to all TOH Agents. TOH is committed to protecting the privacy of our patients and safeguarding the personal health information (PHI) with which we are entrusted. This policy establishes rules for the collection, use, and disclosure of PHI held at TOH in order to protect patient privacy and to ensure the delivery of safe and effective healthcare services.

Key Messages for Staff: (top points managers need to tell staff now)

The purpose of the revisions to the 2016 version are to clearly communicate to staff that:

- MyChart is a method for patients to get access to their personal health information (PHI);
- "Use" includes "viewing" of PHI;
- The eHealth ClinicalViewer may be accessed for the provision of patient care only;
- Authorized users are not permitted to access their own PHI or that of others unless they are providing care as part of their duties;
- The Hospital has mandatory privacy breach reporting to the Information and Privacy Commissioner of Ontario (IPC) and relevant regulatory colleges;
- Staff and agents may be subject to fines and penalties as well as prosecution by the Attorney General of Ontario;
- Staff may only override a consent directive with patient consent or for authorized purposes;
- Authorized users are not permitted to print PHI collected by consent directive override for later use when using eHealth Ontario's shared electronic health record systems; and
- The Digital Health Drug Repository is part of eHealth Ontario's systems.

Once finalized, the Information and Privacy Office (IPO) will include summaries of the new policy in various communications channels to further increase staff awareness of the policy and of their obligations under the legislation.

Contact for Questions or Inquiries

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ISSUED BY: General Counsel & Chief Privacy Officer

APPROVED BY: Senior Management Team

CATEGORY: Administration

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POLICY STATEMENT:

The Ottawa Hospital (TOH or the Hospital) is committed to protecting the privacy of our patients and safeguarding the personal health information (PHI) with which we are entrusted. This policy establishes rules for the collection, use, and disclosure of PHI held at TOH in order to protect patient privacy and to ensure the delivery of safe and effective healthcare services.

DEFINITION(S):

1. "**Agent**": any person authorized by TOH to act on its behalf in respect of PHI for TOH's purposes, and not the agent's own purposes, whether or not the agent has the authority to bind the custodian, is employed by the custodian, or is being remunerated;

2. "**Circle of Care**": A group that includes any person who is involved in the care or treatment of a given patient and who may rely on implied consent for the collection, use, and disclosure of information for the purposes of providing that patient with care;

3. "**Collect**": to gather, acquire, receive, or obtain PHI by any means from any source;

4. "**Consent**": A patient or substitute decision maker's (SDM) agreement, whether express (explicit statement from the patient or SDM or implied (concluded from the surrounding circumstances), written or oral, to the collection, use, or disclosure of their PHI;

5. "**Consent Directive**": a patient or SDM's instruction to withhold or withdraw, in whole or in part, consent to the collection, use, or disclosure of PHI to one or more individuals (also known as a 'lock-box');

6. "**Disclose**": to make the information available or to release it to any other person;

7. "**Healthcare**": any observation, examination, assessment, care, service, or procedure that is done for a health-related purpose;

8. "**Health Information Custodian**": A person or organization described in section 3 of the *Personal Health Information Protection Act* (PHIPA) and who has custody or control of PHI. For the purposes of this policy, this includes TOH;

9. "**Patient Photography"**: any recording of a patient's likeness, whether identifiable or not, through visual means including still photography, videotaping, and digital imaging, but excluding radiographic or ultrasonic images (e.g. X-rays, echocardiography, macro / micro photography of pathological specimens, ophthalmic or endoscopic images);

10. "**Personal Health Information (PHI)**": information about an individual, whether in oral or recorded form, that identifies the individual or could enable such identification and that relates to: the person's health, medical history or past or future medical treatment (e.g. a patient's physical or mental health or personal or family health history; the provision of healthcare to a patient; the identity of a patient's healthcare provider or SDM; payments or eligibility for healthcare or healthcare coverage; donation by any individual of any body part or bodily substance; a patient's health number);

11. "**Privacy Breach**": any intentional or unintentional unauthorized collection, use, or disclosure of PHI, including the loss of or failure to protect such information;

12. "**Secondary Use**": Any use of information beyond that for which the information was collected;

13. "**Staff**": All permanent or temporary, full-time, part-time, casual or contract employees, trainees and volunteers, including but not limited to physicians, residents, interns, researchers and students;

14. "**Substitute Decision-Maker (SDM)**": a person who is authorized under PHIPA to consent on behalf of a patient to the collection, use, or disclosure of that patient's PHI; and

15. "**Use**": to view, handle or otherwise deal with PHI.

ALERTS: N/A

POLICY

Accountability:

1. TOH staff and agents ("we") are responsible for protecting patient privacy. All known or suspected privacy breaches must be reported to TOH's Information and Privacy Office (IPO) as soon as reasonably possible.

2. We must cooperate with the IPO to ensure that privacy breaches are properly contained and investigated and that further privacy breaches are prevented.

3. We must ensure successful completion of privacy training as required by the IPO. TOH privacy training involves, at a minimum, completion of the Electronic Learning Module (ELM) training on an annual basis. Individuals may be required to complete additional training at the direction of the IPO. Regulated health professionals must meet all training requirements set out by their respective regulatory colleges.

4. We are responsible for complying with the rules relayed in privacy training, including those on collection, use, and disclosure of information in the various information systems used at TOH. In particular, we should be aware that the ConnectingOntario ClinicalViewer may only be accessed for the purpose of providing or assisting in care and may not be accessed for research, quality assurance, or other purposes.

5. TOH will undertake regular audits to evaluate the appropriateness of the collection, use, and disclosure of PHI by its staff and agents.

6. We do not have the authority to access our own PHI. We may get authorized access by registering for MyChart, a secure patient portal, or through Health Records Department processes.

7. We do not have the authority to access the PHI of family, friends, neighbours, or high-profile patients using any and all clinical information systems unless we are providing care to the patient as part of our authorized duties. This remains the case even if verbal consent is obtained. MyChart is an appropriate vehicle for patients to access and delegate access to their PHI.

8. Any violation of this policy is grounds for disciplinary action up to and including dismissal or termination of hospital privileges. Under PHIPA, TOH also has mandatory privacy breach reporting requirements to the Information and Privacy Commissioner of Ontario (IPC) as well as to relevant regulatory colleges.

9. We are subject to the fines and penalties set out in PHIPA. We may also be subject to prosecution by the Attorney General of Ontario.

10. We are responsible for safeguarding the PHI we collect, use, and disclose in the course of our authorized duties through the use of physical, administrative, technical, and electronic safeguards described in Corporate Policy 00271 (Information Systems and Technology Security).

11. Under the direction of the IPO, patients or their SDMs will be informed of the loss, theft, or inappropriate access, use or disclosure of their PHI as soon as reasonably possible, as may be required by PHIPA. We must cooperate with the IPO to ensure that patients are properly notified of breaches relating to their PHI.

Openness:

12. Upon request, patients will be informed of:
    (i) TOH's privacy statement, which describes TOH's privacy and information practices and is posted in high-traffic areas throughout the Hospital as well as on TOH's website;
    (ii) Their right to forward an inquiry or make a complaint to TOH's IPO and/or to the IPC; and
    (iii) Their right to obtain access to and/or to request a correction of a record of their PHI.

Consent:

13. We may rely on a patient's or SDM's implied consent for the collection, use, and disclosure of PHI if the information is required for the purposes of providing healthcare to the patient.

14. Before using PHI for any secondary purpose, we will seek express consent from patients or their SDMs except where the information:
    (i) Is needed to prevent serious bodily harm or reduce a significant risk of harm to any person;
    (ii) Is being collected for the purpose of educating TOH staff or agents on the provision of healthcare;
    (iii) Is being used to manage risks and errors or to improve the quality of healthcare services;
    (iv) Is being used and disclosed as part of a research study that has been approved by the Ottawa Health Sciences Network Research Ethics Board (the REB) or other contractually assigned Board of record as approved by TOH; or
    (v) Must be disclosed by law.

15. When obtaining consent from patients or SDMs, TOH staff and agents must make reasonable efforts to ensure that patients or their SDMs are advised of the purpose for which their information is being collected.

16. Patients or their SDMs are entitled to withdraw consent to the use and disclosure of their PHI stored in TOH's electronic health record system by applying a consent directive **(See Appendix A)**.

17. We may only override a consent directive with patient consent or for authorized purposes **(See Appendix A)**.

18. TOH investigates all overrides of consent directives to ensure the access was appropriate and authorized.

Collection, Use, and Disclosure:

19. We may only collect, use, and/or disclose PHI to the extent necessary for legitimate purposes prescribed by TOH and in the course of our duties. The purpose for collection must be clear at the time of collection and may include:
    (i) Delivery of patient care;
    (ii) Hospital administration (e.g. billing and invoicing);
    (iii) Support for and promotion of education and research that has been approved by the REB or other contractually assigned Board of record as approved by TOH;
    (iv) Risk Management, Error Management and Quality of Care;
    (v) Quality assurance;
    (vi) Documentation of patterns of illness to support prevention programs and early disease detection;
    (vii) Fundraising, provided express consent has been obtained or with implied consent where the information consists only of the patient's name and contact information; and
    (viii) Meeting TOH's legal and regulatory requirements.

19. We may only collect PHI through photography or videography if done in accordance with **Appendix B**.

20. No patient will be contacted for research purposes unless express consent for such contact has been previously obtained and recorded in the patient's record.

21. We may rely on implicit consent for the disclosure of PHI to others within a patient's circle of care.

22. PHI may be disclosed through shared electronic health records systems for use by external healthcare providers who are involved in the care of the

person to whom the information relates and who have signed an agreement with TOH to enable access to the information.

23. Patients or their SDMs have the right to apply a Privacy Level Code to limit the disclosure of information relating to the patient's admission status at TOH. When responding to public inquiries about a patient's admission status, we must observe any Privacy Level Code that has been applied at the request of the patient or SDM in SMS **(see Appendix C).**

24. We will not disclose PHI on any personally-run social media outlet. All uses of social media by TOH staff and agents must comply with Corporate Policy 00672 (Social Media).

Accuracy, Access and Correction:

25. We will take reasonable steps to ensure that information about patients is accurate, complete, and up-to-date.

26. We must record PHI when it is collected or as soon as reasonably possible afterward. Whenever possible, the individual who collects the PHI should be the one recording the PHI.

27. When disclosing PHI for any purpose, we will set out for the recipient any known limitations on the accuracy and/or completeness of the information.

28. Upon request and verification of identity, patients or their SDMs will be informed of the existence, use, and disclosure of their PHI and given access to that information unless a specific exception applies **(see Appendix D).**

29. When an individual demonstrates the inaccuracy or incompleteness of their PHI held by TOH, we will take steps to amend the information **(see Appendix E)**. Where appropriate, the amended information will be transmitted to third parties having access to the information in question.

Retention:

30. TOH has established information retention guidelines to ensure consistency in retention time for PHI (see Corporate Policy 00204 (Retention and Destruction of Corporate Record).

Exceptions:

31. Any exceptions to this policy must be approved by the Chief Privacy Officer the IPO or the Privacy and Information Security Steering Committee.

Inquiries:

32. Any inquiries relating to this policy may be directed to the IPO at infoprivacyoffice@toh.ca or (613) 739-6668.

REFERENCES:

Personal Health Information Protection Act, 2004, SO 2004, c.3 Sch. A

University Health Network Policy & Procedure Manual, Administrative – Privacy

eHealth Ontario, "Electronic Health Record Privacy Policies"

Information and Privacy Commissioner of Ontario, "Detecting and Deterring Unauthorized Access to Personal Health Information" (Toronto: ON, 2015)

Information and Privacy Commissioner of Ontario, Order HO-014

Information and Privacy Commissioner of Ontario, PHIPA Order HO-010

Information and Privacy Commissioner of Ontario, PHIPA Order HO-002

RELATED POLICIES:

Corporate Policy 00271 (Information Systems and Technology Security)

Corporate Policy 00186 (Media Relations)

Corporate Policy 00672 (Social Media)

Corporate Policy 00204 (Retention and Destruction of Corporate Record)

Corporate Policy 00313 (Police & Coroner Investigations)

APPENDIX A: CONSENT DIRECTIVES ("Lock-Box")

What to do when you receive a request to apply a Consent Directive:

1. Determine the relevant information system in which the patient or SDM wishes to apply the Consent Directive and follow the procedures outlined below in this Appendix for:

    (i) TOH's OACIS System; and

    (ii) eHealth Ontario's shared electronic health record (EHR) Systems (i.e. ConnectingOntario, Diagnostic Imaging Common Services (DI-CS), Digital Health Drug Repository (DHDR), Ontario Laboratory Information System (OLIS)).

2. Inform the patient or SDM that a Consent Directive may have negative consequences, including delays in the delivery of healthcare, decisions that are based on incomplete or inaccurate information, or other negative impacts.

3. Inform the patient or SDM that demographic information (first name, last name, gender, date of birth, primary address, health care number, MRN) cannot be made subject to a Consent Directive because this information may be required to:

    (i) Uniquely identify the individual in TOH information systems and other shared systems for the purpose of managing privacy procedures related to the individual; and

    (ii) To ensure the accuracy of the PHI in the systems.

4. Inform the patient or SDM that he or she may apply, modify, or withdraw a Consent Directive at any time.

5. Inform the patient or SDM that a Consent Directive may be overridden if:

    (i) Consent is obtained from the patient or SDM;

    (ii) It is reasonably believed that the information is needed to eliminate or reduce a risk of serious bodily harm to the patient and it is not possible to obtain consent in a timely manner;

    (iii) It is reasonably believed that the information is needed to eliminate or reduce a risk of serious bodily harm to someone other than the patient; or

(iv) For any purpose authorized by Corporate Policy 00313 (Police and Coroner Investigations), or by law.

6. Inform the patient or SDM that he or she will be notified if a Consent Directive is inappropriately overridden.

TOH's OACIS System:

If a patient or SDM wishes to apply a Consent Directive in OACIS, he or she must complete a Lock-Box Request form, which can be obtained from the Health Records Department and must be returned to the Health Records Department in person or by mail.

eHealth Ontario's Shared EHR Systems:

PHI that was collected following a Consent Directive override in the eHealth Ontario shared EHR systems listed below may only be viewed for the purpose for which the Consent Directive was overridden and for the time required to fulfill that purpose.

We may not print PHI that was collected following a Consent Directive override for later use. It can only be used at the time the override is conducted and for the purpose of the override.

A. ConnectingOntario, Diagnostic Imaging Common Services (DI-CS)

If a patient or SDM wishes to apply a Consent Directive in the ConnectingOntario or DI-CS system, he or she should be directed to TOH's external Privacy webpage for further information. Patients may also contact the IPO directly.

B. OLIS:

If a patient or SDM wishes to apply a Consent Directive in OLIS, he or she must contact Service Ontario at 1 (800) 291-1405.

C. Digital Health Drug Repository (DHDR):

If a patient or SDM wishes to apply a Consent Directive in DHDR, he or she must contact Service Ontario at 1-800-291-1405 or visit the Ministry of Health and Long-Term Care's webpage at www.ontario.ca/mydruginfo.

APPENDIX B: PATIENT PHOTOGRAPHY

1. We may only collect PHI through photography or videography if:

    (i) The information is being collected for the purposes of documenting patient care or findings, medical education, or staff teaching;

    (ii) To the extent possible, express consent has been obtained from the patient or SDM in advance of collection. Such consent must be documented through a notation or inclusion of a completed consent form in the patient's health record (Consent / Authorization Related to Patient Photography, Videotaping and Other Imaging Form, which can be obtained from Printing Services); and

    (iii) Images are de-identified to the extent reasonably possible.

2. In cases where the patient is incapable of providing consent and obtaining consent from the SDM is impracticable, photos or video may be taken and used for treatment purposes. The patient or SDM must be informed of the circumstances and asked to complete a consent form at the first reasonable opportunity.

3. Photography or Videography done for research purposes must be approved by the REB;

4. Express consent must be obtained from the patient or SDM for the disclosure of identifiable patient images outside TOH (including to practitioners / students who are not agents of TOH).

Note: patient photography for media purposes is governed by Corporate Policy 00186 (Media Relations).

APPENDIX C: PRIVACY LEVEL CODES

A patient or SDM may request that a Privacy Level Code be applied to his or her health record in TOH's Information Systems in order to limit the disclosure of information relating to the patient's admission status at TOH. The following codes may be applied by the Admitting Department or by a Ward Clerk after admission:

O= Open – no restrictions

N= No Calls – Yes visits

F= Family Members only (calls and visits)

S= No visits – Yes calls

D= Patient here – No other information

C= Confidential – Patient not here

U = Unknown – Refer to Nursing Unit

APPENDIX D: ACCESS TO MEDICAL RECORDS

TOH's OACIS System

Access to medical records held by TOH is subject to the following:

1. Patients or SDMs can request access to patient medical records by filling out a Request / Consent for Release / Disclosure of Patient Health Information form.

2. Patient access to PHI may be withheld if the information:

   (i) Is prohibitively costly to provide;

   (ii) Contains references to other individuals;

   (iii) Cannot be disclosed for legal, security, or commercial proprietary reasons;

   (iv) Is subject to solicitor-client litigation privilege.

3. If information is withheld for any of the above reasons or for any other reason, the reason will be communicated to the patient or SDM.

4. TOH will respond to a patient or SDM's request for access to a medical record within 30 days. We may notify the individual that an additional 30 days is required to respond to the request if:

   (i) Responding within 30 days would interfere with patient care because finding or compiling the medical record is very complex; or

   (ii) More time is needed to confirm whether some of the medical record should be withheld.

5. TOH may charge reasonable costs for individual access to information based on IPC guidance and directives.

6. Patients or SDMs may get access to their PHI by registering for MyChart, a secure online patient portal. Patients will only be able to view documents that are finalized on or after October 1, 2016, and not all documents are available on MyChart. For more information on MyChart, please contact mychart@toh.ca.

eHealth Ontario's Shared EHR Systems:

A. ConnectingOntario, Diagnostic Imaging Common Services (DI-CS):

If a patient or SDM requests access to information in the ConnectingOntario, or DI-CS system and the information has been created and contributed by TOH, the record can be provided to the individual in accordance with TOH's internal procedures. If the information requested was created and contributed to the system by another HIC or by multiple HICs, the individual must contact eHealth Ontario directly and may visit TOH's external Privacy webpage for further information.

B. OLIS:

If a patient or SDM wishes to access a record in OLIS, he or she must contact Service Ontario at 1 (800) 291-1405.

C. Digital Health Drug Repository (DHDR):

If a patient or SDM wishes to access their PHI in DHDR, he or she must contact Service Ontario at 1 (800) 291-1405 or visit the Ministry of Health and Long-Term Care's webpage at www.ontario.ca/mydruginfo.

APPENDIX E: CORRECTION TO MEDICAL RECORDS

Correction to medical records held by TOH is subject to the following:

1. A patient or SDM can request a correction to a patient's medical record by filling out a Request for Correction to Personal Health Record form, which can be obtained from the Health Records Department.

2. TOH may decline a request to make a correction to a medical record if:

   (i) The information was received from another organization and TOH does not have enough information to know whether it should be corrected;

   (ii) The correction is frivolous, vexatious, or requested in bad faith;

   (iii) The medical record is not incorrect or incomplete; or

   (iv) The information represents a clinical opinion that was made in good faith.

3. When a challenge relating to the accuracy of a medical record is not resolved to the satisfaction of the patient or SDM, the individual may write a statement of disagreement. Health Records will record the substance of the unresolved challenge and include the written statement from the individual in the patient's health record.

A. eHealth Ontario's Shared EHR Systems:

ConnectingOntario, Diagnostic Imaging Common Services (DI-CS):

If a patient or SDM requests that a correction be made to information in the ConnectingOntario or DI-CS system and the information has been created and contributed by TOH, TOH must determine whether the correction should be made in accordance with the procedures outlined in this Appendix. Where a request for correction is granted and the correction is medically relevant (i.e. not a minor correction such as an update to a patient's contact information), the most responsible staff must contact eHealth Ontario at: privacy.operations@ehealthontario.on.ca or 1 (416) 946-4767.

If the request relates to information that has been contributed by another HIC or by multiple HICs, staff must notify the individual that the information is not within the custody or control of TOH and direct the individual to contact

eHealth Ontario directly at privacy@ehealthontario.on.ca or 1 (866) 250-1554.

B. OLIS:

If a patient or SDM wishes to request a correction to their information in OLIS, he or she must speak to the HIC who ordered the test or to the laboratory that performed the test.

C. Digital Health Drug Repository (DHDR):

If a patient or SDM wishes to request a correction to their PHI in DHDR, he or she must contact Service Ontario at 1-800-291-1405.