Information and Privacy Commissioner,
Ontario, Canada

Commissaire à l'information et à la protection de la vie privée,
Ontario, Canada

PHIPA DECISION 63

HA16-8

Community Care Access Centre - Hamilton

December 7, 2017

Summary: The complainant submitted a number of correction requests to the CCAC under the *Personal Health Information Protection Act*. The custodian made some corrections, addressed other concerns by making the entries "inactive," and attached a statement of disagreement provided by the complainant. Only one correction request remained outstanding at the end of the mediation stage. The adjudicator upholds the CCAC's decision that the complainant has not demonstrated that the records are inaccurate or incomplete for the purpose for which the custodian uses the information, as required by section 55(8) of *PHIPA*. No order is issued.

Statutes considered: *Personal Health Information Protection Act, 2004*, sections 55(1), (8), (10), (11).

Decisions considered: PHIPA Decisions 36, 37 and 49.

BACKGROUND:

[1] This decision addresses the remaining issues regarding an individual's request to her local Community Care Access Centre (the CCAC)[1] to have certain corrections made to her personal health information (PHI) in the CCAC's electronic database.

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[1] The full name of the CCAC here is the Hamilton Niagara Haldimand Brant (HNHB) Community Care Access Centre.

[2] The individual listed four diagnostic or risk codes in her health record that she believed to be incorrect and which she sought to have "expunged." The CCAC issued several decision letters that explained the corrections or amendments that it agreed to make to the health record. One of the risk codes was amended, three other codes were removed from the individual's active electronic health record, and a statement of disagreement was added to reflect that the individual disagreed with those items. Finally, the CCAC advised that it could not "expunge" items from the health record.

[3] The individual was not satisfied by the CCAC's response to the correction request and she filed a complaint with this office, which resulted in a complaint file being opened. During the mediation stage, the mediator discussed section 55(10) of *PHIPA* with the complainant because it requires the custodian to retain information in a health record that is altered in response to a correction request. The explanation that this provision formed the basis of the CCAC's inability to have the objectionable entries "expunged" resolved this aspect of the complaint.[2]

[4] Mediation satisfactorily resolved the complainant's concerns around the risk and diagnostic codes generally, but she remained concerned about the item identifying a psychiatric diagnosis. It was not possible to resolve this aspect of the complaint through further mediation and the complaint was transferred to the review stage of the complaint process. The adjudicator began her review by sending a Notice of Review to the CCAC to seek representations on the facts and issues, which the CCAC provided. In turn, the adjudicator provided a non-confidential copy of the CCAC's representations to the complainant and invited her to respond to the issues set out in a Notice of Review. She did so. The complaint was then moved to the decision stage and was subsequently transferred to me.

[5] In this decision, I find that there is insufficient evidence to establish that the diagnosis code in question is inaccurate or incomplete for the purpose to which the CCAC uses the information. The custodian is not required to make the requested correction and no order is issued.

RECORDS:

[6] The only correction request remaining at issue is to the following entry in the CCAC's electronic health record for the complainant:

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[2] Section 55(10)(a) states that upon granting a request for a correction, the health information custodian shall make the requested correction by recording the correct information in the record and striking out the incorrect information in a manner that does not obliterate the record. The complainant was advised that there is no right in *PHIPA* to have incorrect information in a record removed, replaced, or amended in such a manner that it is completely obliterated - it must remain legible.

> Diagnostic Code 3004: Neurotic Depression (CC) Depression – Long Standing Psychiatric History – Personality Disorder

DISCUSSION:

[7] There is no dispute that the HNHB-CCAC is a "health information custodian" under section 3(1) of *PHIPA*[3] and that the records at issue are the complainant's personal health information under section 4(1) of *PHIPA*.

Does the CCAC have a duty to make the requested correction under section 55 of PHIPA?

[8] Section 55(1) of the *Act* permits an individual who has received access to her personal health information to request that a custodian correct a record "if the individual believes that the record is inaccurate or incomplete for the purposes for which the custodian has collected, uses or has used the information . . .".

[9] Section 55(8) sets out the right of correction to records of personal health information, as follows:

> The health information custodian shall grant a request for a correction under subsection (1) if the individual demonstrates, to the satisfaction of the custodian, that the record is incomplete or inaccurate for the purposes for which the custodian uses the information and gives the custodian the information necessary to enable the custodian to correct the record.

[10] Section 55(9) of *PHIPA* sets out two exceptions to the obligation to correct records. If the PHI was not originally created by the custodian and the custodian does not have sufficient knowledge, expertise and authority to correct the record or if it consists of a professional opinion or observation that a custodian has made in good faith about the individual, the custodian is not required to correct it.

[11] In all cases where a complaint regarding a custodian's refusal to correct records of PHI is filed with this office, the individual seeking the correction has the onus of establishing that the "record is incomplete or inaccurate for the purposes for which the custodian uses the information" for the purpose of section 55(8).

[12] Section 55(8) requires the individual asking for correction to satisfy two conditions: first, the individual must demonstrate, to the satisfaction of the custodian, that the record is incomplete or inaccurate for the purposes for which the custodian uses the information; and, second, give the custodian the information necessary to

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[3] Specifically, pursuant to clause 3 of section 3(1), as a community care access corporation within the meaning of the *Community Care Access Corporations Act, 2001.*

enable the custodian to correct the record. If the conditions are established, the question becomes whether or not any of the exceptions that are set out in section 55(9) apply. In this case, the CCAC cites both sections 55(9)(a) and 55(9)(b) of the *Act*.

[13] Depending on the circumstances of the correction request, the information that the individual is seeking corrected and the reasons for the custodian's refusal to correct the records, this office may approach the analysis initially under section 55(8) or under section 55(9) of *PHIPA*.[4] In this complaint, my review focusses on section 55(8).

The submissions of the parties

[14] The CCAC describes the context in which it provides services to its clients, noting that many of the services that are coordinated under its auspices are provided by third party service provider agencies. To coordinate these services, the CCAC gathers information from the referring source, which in this case was the complainant's primary care physician, to develop a care plan to meet the client's needs. The CCAC submits that it has standardized the information that is shared with its service providers, who rely on the information to inform their care plans and to assign staff with the appropriate skill set. This information necessarily includes diagnoses and any updates. According to the CCAC, the complainant's care coordinator[5] received the diagnosis that is the subject of this review from the complainant's primary care physician in 2010.

[15] The CCAC acknowledges its duty to correct a record of personal health information if satisfied that it is incomplete or incorrect for the purpose for which it is used. However, the CCAC maintains that in this case, the complainant has not provided the necessary information to support her allegation that the diagnosis code to which she objects is incomplete or inaccurate. The CCAC submits that it consulted with the complainant's primary care physician during its review of the correction request and he affirmed the accuracy of the clinical information on which the diagnosis code is based. Given this affirmation, the CCAC argues, the complainant's disagreement with the diagnosis and her view that it is wrong is not sufficient to enable it to correct the record.

[16] The CCAC observes that even if it were to accept that the information at issue triggered its duty to correct under section 55(8) of *PHIPA*, the entry consists of PHI that fits within both of the section 55(9) exceptions to the duty to correct. The CCAC states that as a health information custodian, it has maintained the complainant's record of PHI based on information received and documented in good faith for the purpose of working with the complainant, her health care providers and the CCAC's service provider agencies to deliver the home care services for which she is eligible.

[17] The CCAC confirms that the entry of concern to the complainant has been made

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[4] PHIPA Decision 37.

[5] According to the CCAC, this individual was the complainant's care coordinator from 2008 to 2015.

"inactive" in the system and the complainant's statement of disagreement is attached. This means that the entry is not part of the CCAC's active electronic health record for the complainant.[6] Service providers can only view active risk codes and, further, while authorized CCAC staff are able to access the omitted information in the historical record, the complainant's statement of disagreement applicable to that information is also part of the record.

[18] The complainant explains the basis of her belief that the diagnosis code is inaccurate by noting that her family physician "has never made referrals to psychiatrist, professional nor psychologist has absolutely no reports from psychiatrist" and has no "professional evidence" of such a diagnosis. The complainant describes several encounters she had with her physician in 2016 where she brought up the diagnosis code and he responded by telling her about situations where her behaviour supposedly reflected the validity of the diagnosis; however, she contends, "there were no facts of such allegations he had mentioned." The complainant submits that not getting along with personal support workers does not mean she has the alleged diagnosis. Further, she suggests that conflating the two suggests that the incorrect diagnosis was also not made in good faith. Rather, the diagnosis is "nothing but [a] bad assumption." In support of her assertion that the diagnosis code is incorrect, the complainant provided a September 2014 consult letter from a physician at a sleep medicine clinic where, under "Psychiatric History," she submits it says she has no psychiatric history.

[19] Further, the complainant disputes the CCAC's position that the diagnosis was based on assessments that include descriptions of her self-reported affect, claiming that these submissions are based on "horribly incorrect" information. She provided copies of her medication list (revised August 2013) and problem list (November 2015) prepared by her family physician and she points out that neither list contains the medication for, or reference to, the disputed diagnosis, even though these were previously part of her medical record at his office. In the complainant's view, the CCAC's submissions about the legitimacy of this diagnosis are evidence enough of bad faith, as well as a disregard for the seriously insulting and possibly defamatory effect of the incorrect diagnosis on her.

[20] Other portions of the complainant's submissions focus on her concerns about the CCAC, identified CCAC care coordinators, her family physician and personal support services, including her views about various interactions and health care provided to her or her family members over the years. Related to these matters, the complainant provided attachments that include articles, blog posts and a health regulatory college committee decision. Since the matters addressed by these portions of her representations are unrelated to the accuracy or completeness of the specific PHI that

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[6] With its representations, the CCAC included a printout of the complainant's active electronic health record and this was shared with the complainant. Additionally, at the complainant's request, the CCAC wrote to her (on December 7, 2015) to clarify "what is viewable to authorized staff and service providers directly involved in your care." This letter forms part of the complaint file.

is being reviewed under section 55(8) of *PHIPA*, they are not set out further.

Analysis and findings

[21] This office's approach to the interpretation of section 55(8) of *PHIPA* was established by PHIPA Decision 36, in which Adjudicator Jennifer James stated:

> There is no question that the accuracy of records containing personal health information is essential to the effective provision of health care. However, the correction provisions of *PHIPA* are limited by the requirement that the individual requesting the correction demonstrate to the satisfaction of the custodian that the record is incomplete or inaccurate for the purposes for which the custodian uses the information. The accuracy of the information that is requested to be corrected is therefore connected to the purposes for which the information is used.
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> In interpreting these provisions of the *PHIPA*, I find it helpful to have regard to section 11(1) which requires health information custodians that use PHI about an individual to take reasonable steps to ensure that the information is accurate, complete and up-to-date as is necessary for the purposes for which it uses the information. The duty to use accurate information under section 11(1) can be viewed as the corollary to the duty to correct inaccurate information under section 55(8). In both, the purpose for which the information is used is key to understanding the scope of the duty.

[22] Adjudicator James' approach has been adopted in subsequent decisions,[7] and I do so here.

[23] In the circumstances of this complaint, I find that the CCAC is not required to make any correction to the CCAC's electronic record of the complainant's PHI because she has not demonstrated that the record is incomplete or inaccurate for the purposes for which CCAC uses the information. In the context of this review under *PHIPA*, the complainant's disagreement with the diagnosis and her view that it is wrong or unjustified is not sufficient to establish the requirements of section 55(8). The complainant's representations and attachments do not provide a sufficient basis upon which to interfere with CCAC's refusal to correct the diagnosis code in her electronic record of PHI in the manner she has requested. Some of the attachments, as mentioned, are general to a field of study or health issue, not specific to the complainant. The letter from the sleep clinic physician does not support her position that the CCAC's diagnosis code is incorrect – what is recorded does not match the complainant's claim in her representations; moreover, the history consists of information self-reported by the complainant. The complainant's medication and

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[7] PHIPA Decisions 41, 59 and others.

problem lists, which omit the disputed diagnosis and a related medication, do not persuade me that the CCAC diagnosis code is inaccurate or incomplete, given the CCAC's evidence of the complainant's physician affirming it when asked and the complainant's own evidence of the physician discussing the diagnosis with her.

[24] I also note that the CCAC has made the disputed diagnosis code "inactive" on the system and that the complainant's statement of disagreement is attached to it. Although authorized CCAC staff may view the omitted information in her historical record of PHI, the complainant's statement of disagreement now forms part of the complainant's electronic record. This meets the requirements of section 55(10). It also reflects the complainant's exercise of her entitlement under section 55(11) of *PHIPA* to require the CCAC to attach her statement of disagreement setting out the corrections that the CCAC refused to make. I am satisfied that making the disputed entry inactive in the complainant's electronic health record and attaching a statement of disagreement meets the CCAC's obligations under *PHIPA.*

[25] As I stated above, the complainant bore the onus of establishing the criteria for changing the record. Under the circumstances, I conclude that the complainant has not demonstrated that the identified diagnosis code in the CCAC's electronic record is incomplete or inaccurate for the purposes for which the custodian uses the information, as section 55(8) requires. As the requirements of section 55(8) have not been met in this complaint, it is not necessary for me to consider the exceptions in section 55(9) of *PHIPA.*

[26] Accordingly, I will not order the CCAC to make the requested change.

NO ORDER:

For the foregoing reasons, no order is issued.

Original Signed by: December 7, 2017

Daphne Loukidelis
Adjudicator