RNAO Submission on Bill 119: *Health Information Protection Act, 2015*

Submission to the Standing Committee on Justice Policy

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The Registered Nurses' Association of Ontario (RNAO) is the professional association representing registered nurses (RN), nurse practitioners (NP), and nursing students in Ontario. RNAO advocates for healthy public policy and we welcome this opportunity to provide input to the Standing Committee on Justice Policy regarding Bill 119, the *Health Information Protection Act, 2015*.

SCHEDULE 1

Schedule 1 proposes several amendments to the *Personal Health Information Protection Act (PHIPA), 2004*, and provides the legislative framework for the creation of an electronic health record (EHR) in Ontario. RNAO is supportive of many of the proposed amendments to *PHIPA* as it will move us one step closer to having a provincial EHR in Ontario. By providing real-time access to key health information at the point of care, health professionals will be able to provide more co-ordinated person-centred care with less duplication of services.[1]

Security of Personal Health Information

Whenever personal health information (PHI) is collected, stored, and accessed, security and confidentiality are of paramount importance. Safeguards are needed to ensure that PHI is protected to maintain public trust in our health system. Robust security mechanisms must be in place to prevent intentional and accidental breaches in confidentiality. While privacy and security are essential, these issues can be worked through and we cannot let them hinder efforts to adopt an EHR.

Section 1(2) of the bill amends the definition of "use" of PHI under *PHIPA, 2004* to include the viewing of PHI. This comes in follow-up to several high-profile cases where health professionals made unauthorized access to view health records that contained personal health information. These situations are isolated, however. Ontarians deserve to have their sensitive health information accessed by the fewest number of people necessary to deliver effective care. This is essential to maintain public trust. Therefore, RNAO supports greater regulation around the viewing of PHI.

In the event of a privacy breach by means of the EHR, the proposed amendments stipulate that the prescribed organization must notify the health information custodian (HIC) that originally provided the PHI at the earliest opportunity [Section 55.3 (11)]. However, RNAO believes that the patient whose PHI was compromised must also be notified. Whether this notification comes from the HIC that initially collected the person's PHI, or from the prescribed organization that is responsible for the EHR, RNAO believes that the patient has a right to be notified that their PHI has been collected, used or disclosed without authority, or has been lost or stolen. This notification process must be clearly delineated and RNAO urges that this be reflected in the current bill.

We support mandatory reporting to the Information and Privacy Commissioner (IPC) when a privacy breach occurs, as laid out in Section 1(4)(3). We hold great respect for the IPC and want

to ensure that this reporting leads to a meaningful response. Thus, RNAO urges that IPC be empowered to respond in a meaningful way to privacy breaches that are reported.

Duty to Report to Regulatory College

RNAO is a strong supporter of Ontario's current self-regulatory system of health professionals under the *Regulated Health Professions Act, 1991*. The sustainability of this model demands strong public trust and the accountability of regulators. Section 8 of the bill mandates that HICs notify regulatory colleges if an employee is terminated, suspended, or subject to disciplinary action related to personal health information, or if the employee resigns and there are grounds to believe that the resignation is related to an investigation or other action with respect to personal health information. Similar provisions are provided for those health professionals who have privileges. While RNAO believes that health professionals must be fully accountable for their practice, we note that the College of Nurses of Ontario, under Section 85.5(1) and (2) of the *Health Professions Procedural Code,* already requires employers to report the termination of, intent to terminate, suspension or imposition of restrictions towards a nurse's employment or privileges for reasons of professional misconduct, incompetence or incapacity.[2] Employers are also required to report incidents of incompetence or incapacity, per Section 85.2(1) of the *Health Professions Procedural Code*.[3] RNAO believes the current reporting system sufficiently protects the public and holds nurses accountable for their practice. It is unclear to us why specific legislated reporting requirements are being sought for personal health information and what legislative precedent would be created? Thus, RNAO recommends that the clause under Section 8(3) of the bill be removed from the current bill, to allow for further discussion with stakeholders.

Section 23(8) of the Bill would remove a six-month limitation period, specified by the *Provincial Offenses Act* on the prosecution of offenses related to personal health information. While RNAO understands that a six-month limitation period may be insufficient for the prosecution of these cases, we are unable to support an indefinite limitation period as a principle of procedural fairness. Therefore, we recommend that the government study this further and propose a period of no more than five years after which the offence was alleged to have occurred.

Information for the public

RNAO believes that the public must be kept well informed about how PHI is collected and stored in the EHR. Under the proposed legislation [Section 55.3 (3)], it is mandated that plain-language information be made available to the public, as well as HICs, about how PHI will be safeguarded and protected. RNAO is in favour of public education to inform Ontarians on how their information will be collected, used and disclosed in the context of the EHR, as well as how they may exercise their right under this legislation to provide consent directives to direct which elements of their PHI may be shared and with whom, as well as the consequences of these actions. As well, RNAO advises that the public be informed about the circumstances under which these consent directives may be overridden, as described in Sections 55.7 and 55.8.

Consent Directives and Sharing of PHI

RNAO is concerned about the possibility that PHI that is collected by a HIC under a consent directive may still be collected for use in the EHR. For example, if a patient, through a consent directive, declines to have their PHI shared with certain health professionals, can they be assured that this PHI will not be shared with the prescribed organizations responsible for the EHR? This concern stems from the definition of disclosure given in the bill. According to Section 55.1 (3)(1), PHI provided by the HIC to the prescribed organization is not considered to be a disclosure of PHI under the definition given in this legislation.

Given this definition of disclosure, RNAO is concerned that PHI collected under a consent directive may not be kept confidential as the patient intended. Further clarification is needed regarding how HICs and their agents are to deal with this type of situation as it relates to the EHR. RNAO urges the government to ensure that mechanisms are in place to protect patient information that is collected under a consent directive, and to ensure that it is only shared with members of the health service team with whom the patient wishes it to be shared.

Opting Out of the EHR

Furthermore, under the proposed legislation, it is not clear whether a person could completely opt out of having an EHR. While all efforts should be made to promote participation in an EHR, as it will improve care and strengthen data quality, some may still choose not to have their PHI stored in this format. Under Section 55.6 of the bill, an individual may use a consent directive to decline to have their PHI collected, used or disclosed by a health information custodian by means of the EHR. However, this is subject to limitations to be prescribed in regulation, and an individual would presumably still exist in the EHR under their OHIP number, and any other identifying information that is collected. It is important that the government provide an explicit rationale regarding why the collection of this personal information is necessary, and work to remedy any concerns that the public may have about participation in the EHR. However, for those who still choose to opt out the provincial EHR entirely, with full knowledge of the consequences of this choice, this option should be available.

Representation by Nurses on Advisory Committee

As set out in Section 55.11, the Minister is to establish an advisory committee for the purpose of making recommendations regarding the practices of prescribed organizations. RNAO is supportive of this recommendation and we believe that the composition of the committee should be mandated to include health professionals from various professions and backgrounds. Given growing advances in interprofessional care, the public trust placed in nurses,[4,5] as well as our knowledge and expertise in health service delivery, RNAO urges the government to mandate that the advisory committee include at least one RN and one NP to be joined by other health professionals. In addition, we suggest that a member of the public also serve on the committee.

Education for Health Professionals

The issues of privacy and security of PHI are complex, and a provincial EHR adds an additional layer to this complexity. There is a need not only for education of public, but also for HICs and agents, including health professionals, to understand their obligations under this new legislation. RNAO urges the government to initiate a discussion with stakeholders about how to ensure that health professionals receive the education they need to understand the implications of this legislation. RNAO would be pleased to participate in this discussion, and to bring the perspective of RNs, NPs and nursing students.

Future Regulations

In Section 55.13, we are concerned that the regulation-making power granted to the Lieutenant Governor in Council is too broad. Specifically clause (b) would allow regulation to specify "additional powers, duties, and functions of the prescribed organization." We feel that this should be appropriately narrowed.

Summary of Recommendations: Schedule 1

1. Proceed with greater regulation around the viewing of PHI, as described in Section 1(2).

2. Section 55.3(11) stipulates that a prescribed organization must notify the HIC about a privacy breach to the EHR. RNAO urges for the inclusion of a requirement that the patient be notified in a timely manner, and specify by whom.

3. Proceed with Section 1(4)(3), which stipulates mandatory reporting to the IPC when a privacy breach occurs. We urge that the IPC be empowered to respond, in a meaningful way, to reported privacy breaches.

4. Remove the clause under Section 8(3) which requires HICs to notify regulatory colleges if an employee is terminated, suspended, or subject to disciplinary action related to personal health information, or if the employee resigns and there are grounds to believe that the resignation is related to an investigation or other action with respect to personal health information, given existing requirements under the *Health Professions Procedural Code.*

5. Specify an appropriate limitation period on prosecution of offenses under Section 23(8), of no more than five years after which the offence was alleged to have occurred.

6. Proceed with provisions in Section 55.3(3) regarding information that must be provided to the public. Add a clause that stipulates that the public be made aware of:
   a. How they may exercise their right under this legislation to provide consent directives to direct which elements of their PHI may be shared and with whom.
   b. Information about the circumstances under which these consent directives may be overridden (As laid out in Sections 55.7, 55.8).

7. Ensure that mechanisms are in place regarding PHI that is collected under a consent directive that is now part of the EHR, and to ensure that it is shared only with members of the health service team with whom the patient wishes it to be shared.

8. Work to remedy any concerns that the public may have about participation in the EHR, however, provide an option to opt out of the provincial EHR entirely for those who so choose.

9. Mandate the composition of the advisory committee (described in Section 55.11) to include at least one RN and one NP as well as a member of the public.

10. The Ministry of Health and Long-Term Care (MOHLTC) should initiate a discussion with stakeholders about ensuring that health professionals receive the education they need to understand the implications of this legislation.

11. Narrow clause (b) under Section 55.13 to appropriately specify what can be prescribed in regulation.

SCHEDULE 2

RNAO applauds the MOHTLC's efforts to update current legislation/regulation through the Quality Care Information Protection Act (QCIPA) Review Committee, and through repealing and replacing the *Quality Care Information Protection Act*, 2004 with the updated *QCIPA*, 2015. RNAO is supportive of processes that give health facilities the opportunity to review critical incidents so they can improve quality of care.[6] At the same time, the assurance of confidentiality is important for health professionals to be able to speak openly about critical incidents and to learn from errors. RNAO strongly believes that this need for confidentiality must be balanced with the need for transparency—for patients, their families and staff—all of whom deserve to know about the quality of care provided.

Defining When QCIPA Can Be Used

When critical incidents occur, key lessons can be learned to improve the quality of care and to prevent similar incidents in the future. Currently, there is a lack of consistency as to how health facilities apply QCIPA during the review of critical incidents. RNAO supports efforts to clarify when QCIPA ought to be used. The newly added preamble to *QCIPA*, 2015 does well to clarify the spirit and intent of the legislation. By affirming the need for confidential discussions, as well as openness and transparency with patients and families, this is a step forward towards clarity. However, further clarity is required regarding when QCIPA can and should be used to ensure health facilities are reviewing critical incidents in a consistent manner. Thus, RNAO urges for defined parameters that identify the circumstances under which QCIPA may be invoked to

ensure that information is not unnecessarily withheld from patients, families or the public in the name of quality improvement.

Furthermore, we support, in principle, broadening the application of QCIPA beyond the health facilities listed in Section 2 of *QCIPA*, 2015 as a next step. As there are sector-specific considerations and support needed, RNAO would welcome the opportunity to discuss how QCIPA could be expanded to other sectors, such as long-term care and home care.

Definitions: Section 2(1), (2), and (3)

Following a critical incident, it is understandable that patients and families want to know what happened. RNAO is strongly in favour of measures to increase transparency and prevent the unnecessary shielding of information. [7,8] Thus, RNAO supports the added definition of "Quality of Care Functions", and the revised definition of "Quality of Care Information" (QCI). Specifically, we are pleased that the facts of what occurred and the cause of the incident will not be shielded by the proposed legislation. By providing a specific definition of what constitutes QCI, this legislation helps clarify what information can be withheld under QCIPA following the review of a critical incident. It is our opinion that these added definitions provide clarity, and will help in striking a balance between the needs for confidentiality and transparency.

Learning from Past Events: Sharing Quality of Care Information

RNAO believes that access to quality of care information is essential for a transparent, accountable and always improving health system. RNAO applauds new additions to *QCIPA*, 2015 that facilitate sharing of QCI between health facilities (Section 8). As a next step, RNAO urges the MOHLTC to work with stakeholders to put forward policy options to support the sharing of QCI among health organizations for maximal benefit. Further, RNAO urges that this section be strengthened to facilitate sharing of QCI not only with other Quality of Care Committees, but also with the public in an appropriate way. Health facilities belong to the people of Ontario and are a public good, so there is a need for transparency. The information gained from reviewing critical incidents can help improve the quality of care, and is thus of public value. Therefore, RNAO strongly favours the QCIPA Review Committee's recommendation to establish a publicly available database with information obtained through the review of critical incidents.[9] The information that is made public must, of course, maintain the confidentiality of persons involved, including both patients and staff.

Protection and Support for Health Professionals

As stated above, RNAO is unequivocal in its support for transparency in reviewing critical incidents. There is also a need to balance this with an appropriate level of protection for the health professionals involved in critical incidents. It is RNAO's view that, in the absence of appropriate assurance of confidentiality, health professionals may be hesitant to speak openly about the causes of critical incidents, thus hindering the ability to learn from them. RNAO is supportive of Sections 10 and 11, which provide protection and assurance of non-retaliation for employees who have disclosed information to a quality of care committee.

However, RNAO is concerned that the above protection is afforded only when QCIPA is applied. It is our view that confidentiality must be assured when reviewing all critical incidents—both when QCIPA is applied and when it is not—to enable clinicians to discuss critical incidents openly and without fear of repercussions.[10] RNAO believes that this is a necessary step in order to combat a culture of blame and move towards a "just culture".[11,12] RNAO is strongly in favour of creating cultures of trust where inter-professional teams work together and learn from critical incidents to improve the quality patient care.[13,14] This culture shift must be fostered at all levels, as we work together towards the provision of safe, quality health service.

In addition, we are in agreement with the QCIPA Review Committee's recommendation to provide support for staff involved in critical incidents.[15] During the review of critical incidents, staff should have access to support, and health organizations should provide training for all staff, including those in formal leadership positions, on how to support those involved in critical incidents, as this can be a difficult experience for staff involved.

Education for Health Professionals re: QCIPA Implementation

Because of the complexity of Bill 119, and the implications for all health professionals, RNAO is mindful about the implementation of *QCIPA*, 2015. We would like to see necessary training and guidance for all health professionals, including RNs and NPs to understand the new legislation and to implement necessary changes to their practice. In this way, nurses and health professionals will maintain their usual high standard of care, and the legislation will be applied consistently across health care organizations. The government has committed to consulting with stakeholders on this issue, including the Ontario Hospital Association and Health Quality Ontario.[16] RNs and NPs represent the largest group of health professionals who possess valuable knowledge and insight into how to improve the quality of health care in this province. Thus, we urge the government to consult RNAO on the issue of QCIPA implementation.

<u>Summary of Recommendations: Schedule 2</u>

1. Clearly define the circumstances under which QCIPA may be applied to ensure that information is not unnecessarily shielded from patients, families or the public in the name of quality improvement.

2. Proceed with Section 2 (1), (2) and (3), which make explicit what is and is not considered QCI to help provide information to patients/families when critical incidents occur.

3. Strengthen Section 8(2) to allow the sharing of QCI with other quality of care committees, as well as with the public by establishing a database of QCI. RNAO urges the MOHLTC to work with stakeholders to support that sharing of QCI among health organizations for maximal benefit.

4. Proceed with Sections 10 and 11 to afford protection and assurance of non-retaliation for health professionals who disclose information to a QOC committee.

5. Identify further opportunities in legislation and regulation to assure confidentiality for health professionals when reviewing all critical incidents—both when QCIPA is applied and when it is not.

6. Consult with RNAO and other system stakeholders regarding the implementation of *QCIPA*, 2015, and provide training for all health professionals in the implementation of changes as a result of the bill.

Conclusion

RNAO is pleased to provide input to the Standing Committee on Justice Policy regarding updates to the *PHIPA, QCIPA* and other corollary legislation under Bill 119. Thank you for giving us this opportunity to present our perspective. We believe that the practical and achievable recommendations described above will strengthen the bill and advance health service delivery that is of high quality, transparent and person-centred and respects appropriate privacy and confidentiality. We urge you to implement our recommendations and look forward to ongoing collaboration on these important matters.

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