eHealth Saskatchewan

MySaskHealthRecord Open Clinical Documents

Excluding Clinical Documents from MySaskHealthRecord (MSHR) Full Reference Guide

Purpose

The Open Clinical Documents initiative will provide Saskatchewan residents with digital access to their clinician notes (or those to which they have proxy access) that appear in the eHR Viewer using their MySaskHealthRecord (MSHR) account. There are circumstances that may arise in which access to a clinical document within the patient's medical record should not be granted to an individual. This decision MUST be based on the exceptions outlined in The Health Information Protection Act (HIPA).

This guide outlines:

- How to identify when a clinical document should be excluded from MSHR.
- How to exclude a document from MSHR.
- What to do if a patient requests access to a record that has been excluded from MSHR.

Disclaimer: This document serves as a guide to assist with excluding clinical documents from MSHR. All trustees who receive an access to personal health information request are responsible for processing the request in accordance with HIPA.

Background

- 1992: Supreme Court of Canada rules that information in medical records belongs to the patient. The person or organization responsible for the creation, assembly and management of a paper record or EMR system is the custodian of the information. [1] [2]
- The trustee (custodian) for the eHR Viewer and MSHR is eHealth Saskatchewan.
- Privacy legislation reinforces patients' common law right of access to personal information contained in their medical record. [3]
- Currently, HIPA allows for oral requests as well as formal written requests for heath information with oversight by the Office of the Saskatchewan Information and Privacy Commissioner.
- HIPA almost always entitles patients to obtain copies of their complete medical records, including notes that a provider chooses to redact or block. Therefore, independent of open clinical documents, it's best to write notes with the ongoing understanding that patients may read them.

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1. CMPA - Physician-patient | Documentation and record keeping | CMPA Good practices (cmpa-acpm.ca)
2. HIPA stipulates that the trustee with custody or control is responsible for the creation, assembly and management of a paper record or EMR system.
3. CMPA - Physician-patient | Documentation and record keeping | CMPA Good practices (cmpa-acpm.ca)

- Sometimes a healthcare provider documents a note that they consider to be confidential, and/or which may cause risk or harm to the patient, should that individual or a proxy gain access. If a provider believes a guardian having access to a specific clinical document or portion of the document may cause an invasion of privacy or harm, the provider can consider using the technical solutions explained below to exclude a clinical document from MSHR in accordance with HIPA criteria.
- The technology prevents the full clinical document from being sent to MSHR. As MSHR is a service, the specific clinical document is not subject to an access request until an access to information request has been submitted to the eHealth Privacy Service (eHPS). Individuals may also submit an access to information request to a physician or agency directly (from EMR). If a formal request is then submitted, that organization/trustee who received it is responsible for responding, and any information that is not deemed necessary to exclude should still be released, based on that organization's review.
- MSHR uses a 48-hour delay between notes being approved by the healthcare provider, submitted to the eHR Viewer, and then appearing in MSHR.
- Notes finalized prior to the go-live date will not appear in MSHR.
- **Individual Sharing of their Information in MSHR**

  Processes are currently in place that allow patients to add and remove permissions for other individuals to access and view their MSHR account.

  Residents are in control of who views their health information in MSHR. All information in MHSR is stored securely and can only be accessed by individual users through a highly secure personalized login.

  › Patients can share their health information with another MSHR user through a feature called "Share My Record." Once they log into MSHR, under the "Account" drop-down in the top right corner there is a feature called "Share My Record."
- **Proxy access to MSHR**

  › Section 56 of HIPA allows others to act on behalf of an individual in certain circumstances. Eligibility for MSHR includes:

    - Saskatchewan residents aged 14 or older are eligible to register for their own MSHR account;
    - The legal custodians of a minor under age 14; and
    - Those legally responsible (i.e., personal guardians or health care decision makers) for providing ongoing day-to-day care to an individual who does not have capacity and is not expected to regain it.

Legislation

The Health Information Protection Act (HIPA)

HIPA provides individuals with the right to access their personal health information (PHI). However, HIPA also provides circumstances where exceptions to access need to be made. For this reason, providers will have the ability to mark clinical documents as "exclude from MSHR" to prevent them from being sent to MySaskHealthRecord. NOTE: this decision MUST be based on the exceptions outlined in HIPA. The clinical documents marked as excluded from MySaskHealthRecord are still subject to an access to information request. Should the trustee receive a request for access to the clinical document, HIPA must be followed to process the request.

It is important to become familiar with sections 38 and 56 of HIPA to **ensure the exclude functionality is not misused**. Before marking a clinical document as "exclude from MSHR", consider whether any of the following circumstances from HIPA apply to the information in it:

1. As per subsection 38(1) of The Health Information Protection Act (HIPA), clinical documents may be excluded rom MSHR when:
    - Knowledge of the information could reasonably be expected to endanger the patient's health or safety or the health or safety of another person.
    - Another person gave the information in confidence, and disclosure of that information would identify the other person.
    - The information was collected in anticipation of, or for use in, legal proceedings.
    - Disclosing the information could interfere with a lawful investigation or be injurious to the enforcement of an Act or regulation.
    - The health record contains information about another person who has not consented to the release of that information.
2. As per subsection 56 of HIPA, clinical documents may be excluded from MSHR when:
    - Patients with proxy or shared access to their MSHR request information to be kept confidential.

There is a high threshold set by the Office of the Saskatchewan Information and Privacy Commissioner (OIPC) for when the application of clause 38(1)(a) would apply. The IPC Guide to HIPA notes "the threshold cannot be achieved on the basis of unfounded, unsubstantiated allegations." Reviewing OIPC reports, such as 037-2020 or 2012-002 could help a physician decide whether their circumstance meets this threshold by comparing their circumstance to those identified in the OIPC reports. These OIPC reports can be found on their website at https://oipc.sk.ca/reports/.

Key considerations for applying section 38(1)(a) of HIPA:

The IPC Guide to HIPA provides the following definitions and further explanation about excluding clinical documents from MSHR to maintain the health or safety of the subject individual or another person.

Definitions:

- Endanger means the act of putting someone or something in danger, or exposure to peril or harm.
- Safety implies relative freedom from danger or risks.
- Physical health refers to the well-being of an individual's physical body.
- Mental health refers to the wellbeing of a person's mind.
- To determine whether a threat to the safety, physical or mental health of any person exists, the trustee should apply the following test:
    1. there must be a reasonable expectation of probable harm;
    2. the harm must constitute damage or detriment and not mere inconvenience; and
    3. must be a causal connection between disclosure and the anticipated harm.

Best Practice Guideline

The following is an example of where a provider could indicate a clinical document should be excluded from MSHR. Be advised that this decision needs to be made on a case-by-case basis as each circumstance may vary.

- Parents or legal guardians could have access to their child under age 14's MSHR
    - If an individual under 14 years of age provides a directive in which their parent or legal guardian should not know details in the clinical document, the document must be excluded from MSHR.
    - It is good practice to ask the patient about this, and document this when discussed.
    - It is good practice to ensure adolescents are aware who has proxy access to their charts.

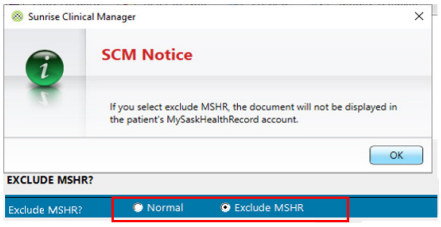
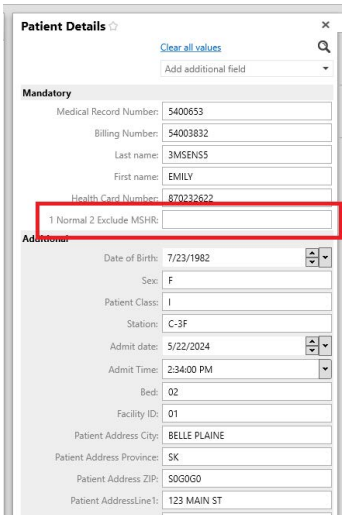
Current SHA process for release of information (ROI)

- All patients use a standard SHA "Request for Access to Personal Health Information Form" to request access to their own health information. The public form does not separate mental health from non-mental health patients, and all follow the same process.
- SHA Health Information Management (HIM) will then send an internal SHA "Access to Information Provider Review Form" to the author for their review.
- The author reviews the information.
- HIM ROI follows the direction of the author in releasing information.

Reminder
SHA HIM can be consulted before releasing clinical documents that originated from the SHA.

Technical Solution: How to exclude clinical documents from MSHR

Technical solutions for providers using Fluency Flex, Fluency Direct and Fluency for Transcription to mark notes as "exclude from MSHR" (i.e. not appropriate for a patient or individual with proxy access to view) are planned for implementation in 2024.

Providers authoring in Sunrise Clinical Manager (SCM)	Providers using Fluency for Transcription (1-844-666-3250)/Fluency Mobile App Regina speed dial 4700 Saskatoon speed dial 7745	Providers using Fluency Flex
Provider has the option to click an "Exclude MSHR" button within the document when completing the note. This will prevent the report from flowing to MSHR. The image below illustrates how the observation will appear in SCM. 	Provider will be required to use a prompt to indicate that the note is to be marked as "normal" (1) or "exclude from MSHR" (2) as they begin dictation through the phone prompts. A medical transcriptionist can also mark the report as "exclude from MSHR" if dictated by the clinician, offering an option for clinicians who failed to mark the report as "exclude from MSHR" when beginning the dictation. This will prevent the report from flowing to MSHR.	Provider has the option to select "2 Exclude MSHR" before dictating and finalizing. This will prevent the report from flowing to MSHR. 

Resources and contacts

- For HIPA interpretations, contact your privacy officer.
- For release of information requests, contact your local SHA HIM department.
- For technical help on how to exclude a clinical document from MSHR, contact: servicedesk@ehealthsask.ca
- The Health Information Protection Act (HIPA)
- Access and Disclosure of Personal Health Information Procedure SHA-07-003P4.pdf (saskhealthauthority.ca)
- USA: OpenNotes – Patients and clinicians on the same page