College of Physicians & Surgeons of Alberta

Medical Informatics Committee

Data Stewardship Framework

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Preface

The topic of data stewardship as pertains to health care is broad, deep and complex. There are many perspectives from which to examine the issues, and many context-specific factors which might apply in determining how to handle identifiable health information.

This document:

a) is intended to assist practitioners in the management of health information – a very dynamic, complex and fast-evolving subject. The variety of organizational structure makes specific guidelines for each difficult to outline, so the **emphasis here will be on principles and the framework for constructing good solutions.**

b) has consolidated existing information from a variety of sources and provides some new perspectives in response to the evolving needs of Alberta's physicians in their great variety of practice settings. As such, it should be considered a **reference document only**.

c) does attempt to cover a wide range of topics regarding information handling, **but should not be interpreted as providing legal advice**. Readers are encouraged to consult specific resources (such as source CPSA policy or guideline papers, the Office of the Information and Privacy Commissioner or the Canadian Medical Protective Association) for detailed guidance on these subjects.

While the primary audience for this document is intended to be physicians in clinical practice, the CPSA also hopes that it will provide a consistent basis for other organizations which are establishing data stewardship rules. As the healthcare environment is a tightly interconnected network, we believe that the greater the consistency of operating policies, the more smoothly it can operate.

Beyond the intended scope of this document are the uses of health information for research or administration/management purposes. These are large and complex areas of their own, and have purposely not been explored here.

As well, it is almost impossible to discuss standards of practice for handling of healthcare information without straying somewhat into the realm of standards of clinical practice. The latter is also beyond the intended scope of this document.

The CPSA Medical Informatics Committee would like to thank Mr. Doug Campbell of Fundy Consulting Ltd., as well as the many physicians and organizations who assisted in the iterations and extensive review of these materials. Given the dynamic nature of the subject, the CPSA expects this to be an evolving document and we welcome your comments and suggestions – info@cpsa.ab.ca.

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Executive Summary

A project was initiated by the Medical Informatics Committee in December 2005 to develop clear and comprehensive guidelines for the profession on the subject of data stewardship in response to the growing diversity of information management issues surrounding medical records.

Data stewardship, as defined in this initiative, is the management of health information by a health professional and includes the collection, use, disclosure, management and security of that information. Within each of these aspects there are legal, ethical and best practice considerations that a physician should consider in the management of health information in their trust.

Physician stewardship of medical information is a well established trust both in practice and legally enshrined in law. A physician is legally obligated to maintain a medical record of the care provided, while the doctor-patient relationship requires a patient's confidence and trust in the management of their information, and establishes a burden on the physician to maintain that trust.

There are many factors that will influence data stewardship within a physician's practice and with individual patients:

- the type of information and the purpose for the information collection, use and disclosure
- the doctor-patient relationship and the scope of care provided to a patient
- the circle of trust with other providers regarding the scope and level of information exchange
- the number and types of medical records available to the physician, and the level of integration of those records
- the processes that establish medical record ownership, policies and the management of information within the medical record.

The traditional model for information management is changing, driven by health system reforms, health information legislation, patient expectations as well as many information and technology factors including:

- the use of electronic medical records
- changing practice structures and care models
- access to external medical records
- posting of patient encounter information to electronic health records.

Given these impacts on the practice environment, as well as the evolving expectations of patients and society in general, physicians should periodically evaluate the practice's data stewardship framework to review and update policies and guidelines including:

- the policies and processes involved in the collection, use and disclosure of health information within the medical practice
- the practice's processes involved in the doctor-patient relationship (and the expanded circle of trust implicit in the care model)
- the availability and use of external medical records

- the status of the physician medical records and their effectiveness to ensure the continuity of care, the demonstration of the medical reasoning in the care provided, and the support of the care delivery model
- ensuring information protocols operate within the legislative framework, support a physician's ethical obligations, and follow best practices for information management and sharing within and external to the practice
- ensuring contractual agreements are in place for group practices, that define the ownership and ongoing management of medical records
- the transition of medical records (i.e. paper records to electronic records, integration of records from multiple practices, changing EMR's).

Data stewardship principles and policies and guidelines documented in this guideline:

Principles:

- Autonomy
  - Patient
  - Physician
  - Health system management
- Fiduciary Duties of a physician
  - Doctor – patient relationship
  - Beneficence
  - Non-malfeasance
- Balance
  - Legitimate infringement
  - Pragmatism
- Fiduciary Duties of the Custodian / Information Manager
  - Custodian – Information Manager relationship
  - Information integrity
  - Information privacy

Medical Practice Policies & Guidelines:

- Establishing or entering a medical practice
  - Establishing a Doctor–Patient relationship
    - Managing patient information
    - Managing doctor orders
  - Terminating a Doctor-Patient relationship
- Terminating or leaving a practice

Practice Networks Policies & Guidelines:

- Entering a medical practice network
  - Establishing a Doctor–Patient relationship
    - Managing patient information within the practice network
    - Managing patient information within the medical practice
  - Managing doctor orders

External Medical Records Policies & Guidelines

- Accessing an external medical record
- EHR for Diagnostic Report Distribution
- Post to an EHR
  - Limiting or extending disclosures.

1 Introduction

The Medical Informatics Committee of the College of Physicians and Surgeons of Alberta (CPSA) was created to:

1) provide advice to the profession on the use of IM/IT in their medical practices, focusing on the ethical, legal, privacy, patient safety and quality improvement aspects;
2) develop and coordinate CPSA input/leadership on IM/IT use in the healthcare system; and
3) provide advice to CPSA staff about integrating IM/IT best practices into CPSA operations and programs

A project was initiated in December 2005 to develop clear and comprehensive guidelines for the profession on the subject of data stewardship in response to the growing diversity of information management issues surrounding medical records.

1.1 Background

There has been a great deal of work over the past years in the implementation of electronic medical records (EMRs) by physicians, and electronic health records (EHRs) by Regional Health Authorities and Alberta Health & Wellness.

The evolution of the scope of medical records, the portability of electronic information and the growing ability to use medical records in new uses or purposes and to share records electronically between practitioners changes the dynamic of information management in medical practice. In addition, there are many emerging structures in the delivery of care and the associations of practice in which physicians provide care and manage patient records, such as in Primary Care Networks and Medical Specialty Networks, that fundamentally alter the medical record environment.

Enhanced information access and information sharing can have enormous implications on the quality of care, the continuity of care, and ultimately in patient safety. There are clear opportunities for improved care as well as enhanced qualitative measurement and quality improvement. However, there are also risks if the information is taken out of context, poorly managed or mishandled, or if the enhanced sharing compromises the sharing of information between the patient and a physician. Information technology is changing and influencing medical care at a rapid pace – however data stewardship is very much a professional responsibility and as such should not be minimized or considered a technology issue.

These changes and the growth in complexity is not a local phenomenon and the issue is not limited to Alberta physicians. However, the relative speed and adoption of these types of initiatives and the sum impact of all the related changes in the Alberta jurisdiction place Alberta physicians in a unique, leading-edge position of having to both adapt their practice to the changing environment and assess the impacts of change on their practice and their patients. These factors, and other related issues demonstrate the need to evaluate in a comprehensive manner the complex subject of data stewardship.

1.2 Initial Scope

The initial scope of this framework will be limited to personally identifiable diagnostic, treatment and care information for the purpose of providing health services.

1.3 Assumptions

CPSA policies and guidelines apply to all physicians in medical practice. The HIA applies to information resulting from health services paid for in whole or in part by the public health care system. These data stewardship guidelines are based on a combination of legal, ethical and best practices, so while some of the legal components of the framework may not apply to all physicians, the legal principles of the HIA are used whenever possible.

Enhanced information access and information sharing (with the appropriate support and control) can positively impact the quality of care, the continuity of care, and patient safety. It is in the best interests of the patient to promote this information exchange in the delivery of care, therefore these guidelines provide structure to enable appropriate sharing to those with a need to know and the appropriate level of detail.

Data stewardship policies and guidelines apply to the management of information in any form: paper as well as electronic systems.

2 Frequently Asked Questions

What is data stewardship, and why is it a major issue today?

What do I have to do regarding data stewardship?

How does the HIA definition of a custodian apply to physicians in group practice?

Who owns the medical record, what can I use the record for, and who can have access?

The information in my medical record is mostly confidential – what can I disclose? What do I have to disclose? What can I prevent from disclosure?

What are the issues of merging practices into a PCN or other types of practices structures?

Can I engage an information manager to operate my medical record? What if the information manager is also a custodian, such as a RHA or another physician group?

Accessing an EHR - do I have to look up data for every patient I see or can I be selective?

What EHR information am I responsible to record in my own medical record?

I receive lab reports I didn't order – do I have to follow-up on the report? What do I do with the report?

I receive reports from the lab and I see that they are all on the EHR. Do I have to continue to receive the reports or can I look them up when I need to?

Our practice shares on-call rotation with another practice – can we grant each access to our EMRs? Can we update their records?

I want to using my EMR data to perform my own quality assurance evaluation – is this legal? How about a clinical trial of a new medication?

Do I have to switch to an EMR from my paper records? What's involved in the transition?

What is involved in putting information on the provincial EHR? Am I responsible for how others use the information I post? Who can see, and use, my information?

What is masking? How does it differ from blocking?

What is data stewardship, and why is it a major issue today?

Data stewardship is the management of health information by a health professional and includes the collection, use, disclosure, management and security of that information. Within each of these aspects there are legal, ethical and best practice considerations that a physician should consider in the management of health information in their trust.

Physician stewardship of medical information is a well established trust both in practice and is legally enshrined in law. The health information landscape is changing dramatically - the enactment of the Health Information Act and the Health Professions

Act has introduced new duties and obligations, and there are many new models of practice. The evolving scope of available medical records including electronic medical records (versus paper records) and access to external medical records permits the sharing of patient encounter information in new ways. These changes are happening today and can create uncertainty about the rules of health information management and information sharing.

What do I have to do regarding data stewardship?

You should on a periodic basis, and in periods of major change:

- Evaluate your practice's processes for information management
- Develop/revise the practice's data stewardship policies and guidelines
- Update the processes supporting and using the medical record
- Evaluate the availability and uses of external medical records

The College of Physicians and Surgeons of Alberta www.cpsa.ab.ca has published this document as well as other policies and guidelines to assist in these evaluations.

How does the HIA definition of a custodian apply to physicians in group practice?

Physicians in group practice should establish, by specific contractual agreement, the ownership of medical records. The agreement should explicitly define the custody and control of records for the group (including explicit definition of the ongoing management of records in the event of termination of the group, or the departure of a physician from the group), as well as the rights and obligations of physicians as a custodian.

Unless otherwise specified, physicians in a shared group practice have joint ownership of the medical records of the group (enabling access) and are jointly accountable for the medical record policies and guidelines of the practice.

Physicians' rights and duties as custodians will apply to all records that they have access to in the group. Note that this may mean that could be multiple custodians for each record, if more than one physician was involved in the care of the patient.

Who owns the medical record, what can I use the record for, and who can have access?

The person or body that has the custody and control of the physical medical record is considered the owner of the record. This is differentiated from the information contained within the physical record, where the individual patient has the basic and controlling interest. Therefore the information contained in the record is held in trust by the owner of the record.

The Health Information Act enables the custodian to use individually identifying health information in its custody or under its control for the following purposes:

- providing health services;
- determining or verifying the eligibility of an individual to receive a health service;
- conducting investigations, discipline proceedings, practice reviews or inspections relating to the members of a health profession or health discipline;
- conducting research (specific restrictions apply regarding ethics approval and consent)

- providing for health services provider education;
- carrying out any purpose authorized by an enactment of Alberta or Canada;
- for internal management purposes, including planning, resource allocation, policy development, quality improvement, monitoring, audit, evaluation, reporting, obtaining or processing payment for health services and human resource management.

The information in my medical record is mostly confidential – what can I disclose? What do I have to disclose? What can I prevent from disclosure?

A physician has a professional obligation to manage the confidentiality of the patient information in their care. In addition, as a custodian as defined by the HIA you have specific duties and obligations to manage disclosures. The College of Physicians and Surgeons of Alberta has published a guideline on information disclosures, and the HIA has definitive criteria for defining the requirements for consent.

A patient's general right of access to his or her medical record is not absolute. Where there is a justifiable rationale to withhold information such as a significant likelihood of a substantial adverse effect on his/her physical, emotional or mental health or harm to a third party a physician may deny access to a record.

A physician is responsible to apply the general duties of a custodian for individual or systematic disclosures from the medical record, including the actions of group practice partners, affiliates and information managers. A physician is not responsible for the actions of another custodian's use of information once it has been legitimately disclosed.

A physician should determine the purpose of disclosures (even with the existence of consent) to make the appropriate level and detail of disclosure to meet the defined purpose. Disclosure should be limited to the least amount of information needed for the purpose of the disclosure. The custodian has a duty to ensure that the individual receiving the information has the need to know and the competency to use/interpret the disclosed information. Disclosures to 3rd parties should be based on a policy of explicit and informed consent unless explicitly defined by legislation. The medical record should maintain a record/audit trail of such disclosures.

Detailed recommendations can be found in the CPSA Guideline: Release of Medical Information – A Guideline for Alberta Physicians

What are the issues of merging practices into a PCN or other types of practices structures?

The details of the information sharing protocols and the ownership of the medical record should be detailed in a formal, written agreement. Participants in an agreement should be registered medical practitioners or health professionals regulated in a defined profession in the Health Professions Act. Physicians should ensure they have access to the shared record for the required retention period of a medical record in the event of the dissolution of the agreement.

The use of an integrated record is acceptable, however each entry in the integrated record must be attributable to the individual who created it and the unified record must

not compromise the ability to provide patient access to their information. In instances where multiple medical records exist, explicit policies must exist to identify which records are to be updated under which circumstances to ensure that as far as possible all components of the patient record are gathered into one location, and the transfer of care and follow-up of orders is clearly identified and managed.

Referrals and consultations must be documented even among physicians participating in a shared practice arrangement.

A physician's clinical findings, assessments, treatment recommendations should be clearly identifiable within a shared record, especially with team-based decision making processes. In cases where multiple physicians or health professionals working in association may share a patient medical record, it is recommended practice to ensure that a mechanism exists to separate each problem or treatment plan to clearly identify the responsibility for care, as well as to support the appropriate disclosure of information.

Transitions from multiple records to an integrated record should ensure:

- patient information is secure
- privacy of patient information is maintained
- the integrity of the medical record is maintained
- the integrity of the clinical workflow supported by the medical record is maintained
- continuity and quality of care is maintained through the transition period.

Can I engage an information manager to operate my medical record? What if the information manager is also a custodian, such as a RHA or another physician group?

A physician may engage an Information Manager to physically manage a medical record system (paper or electronic) which supports the medical record. A physician must have an Information Management Agreement which explicitly defines the information uses and disclosure instructions to the Information Manager. An Information Manager (who may be a custodian or an affiliate acting in an Information Manager role) must not use health information in any manner that is not in direct accordance with the explicit duties of the custodian.

Accessing an EHR - do I have to look up data for every patient I see or can I be selective?

External medical records provide an additional source of information for physicians providing care to patients. Legitimate purposes to access an external medical record include:

- The review of previous care and treatment of a patient in your care from public health programs, or other physicians and health care providers
- Monitoring the compliance with physician orders
- Monitoring the outcomes of treatments or referrals.

It is valid to evaluate the previous care a patient has received. In some cases, failure to use available information has been deemed "a critical omission" in legal proceedings. Situations where the use of an external medical record is ethically valid include:

- Emergency care, especially if the patient is incapable of providing information,
- Assuming the care of a patient based on a referral with limited background information, or where a referral indicates the availability of relevant information,
- Assuming care of a patient where the complexity of the patient circumstances is high (i.e. multiple conditions treated by multiple physicians),
- Assuming care after major or significant treatment from a facility or consulting physician,
- Monitoring of patient's compliance to physician orders or follow-up instructions (when there is cause to do so),
- Providing a 2nd opinion to a patient.

Additional situations where the use of an external medical record is suggested as a best practice include:

- If the patient is unclear or unable to present relevant information,
- Assuming longitudinal care of a new patient,
- Providing care with doubtful or suspicious circumstances, or where observations suggest complex or unusual circumstances,
- Indications from a patient that relevant information is available.
- Evaluation of existing information to avoid redundant tests/treatments or to guide the development of current treatment plans.

What EHR information am I responsible to record in my own medical record?

Information accessed from an external medical record remains in the custody of the originating physician, health care provider or healthcare institution. The custodian of the external medical record rather than the user of the information has the responsibility to record the disclosure.

If the information from external sources materially alters the treatment or care of a patient and is not collected as part of the physician medical record, it may be prudent to document the fact of access plus the relevant content in the physician medical record to demonstrate the rationale or thought process.

Information propagated from the external record to the physician record becomes part of the physician record and the receiving physician becomes a custodian of that collected information. Information collected in this manner should:

- Be limited to the scope of the care provided by the physician to the patient.
- Maintain the chain of trust from the original record (i.e. many external medical records have "masking capabilities" which provide additional security at a patient level or for specific information within the record – this information should be collected and respected in subsequent uses).

I receive lab reports I didn't order – do I have to follow-up on the report? What do I do with the report?

A duty exists to review in a timely manner order results, consultant notes or other information received in response to physician orders. This includes a review of treatment received and the follow-up recommendations for the patient. Physicians may receive information for current patients where they did not initiate the order, and can:

- discharge the duty by assigning responsibility for follow-up action to another physician who acknowledges the responsibility
- accept responsibility for the follow-up (as might be appropriate for patient-initiated participation in screening programs where the physician is identified as their treating physician)
- note the receipt of the information but not acknowledge responsibility for follow-up

In any event, a physician should document the receipt of the information in the medical record as well as the action or inaction taken. This duty does not extend to information received where no doctor patient relationship has ever existed – in this case there is no medical record and the input may be returned or rejected. Physicians who work in group practice or who are covering for other physicians must be particularly careful to ensure that a doctor-patient relationship does not exist before destroying information.

I receive reports from the lab and I see that they are all on the EHR. Do I have to continue to receive the reports or can I look them up when I need to?

A formal agreement between a physician and the diagnostic facility is required to discontinue the normal distribution of diagnostic reports. A physician may use the external medical record as the mechanism for the delivery of test results. Physicians have the same obligation to view the results in a timely manner and to confirm the receipt of the results as if the orders were delivered in document form. It is the physician's responsibility to ensure that the access and retention of that information in the external record fufills the physician needs for medical record access and retention.

Our practice shares on-call rotation with another practice – can we grant each access to our EMRs? Can we update their records?

In instances where multiple medical records exist, explicit policies must exist to identify which records are to be updated under which circumstances to ensure that as far as possible all components of the patient record are gathered into one location, and the transfer of care and follow-up of orders is clearly identified and managed. If the doctor-patient relationship is encounter based (i.e. on call rotation) and the ongoing relationship is supported by another physician in association, it may be appropriate to chart the encounter in the medical record of the physician with the ongoing relationship.

I want to use my EMR data to perform my own quality assurance evaluation – is this legal? How about a clinical trial of a new medication?

A valid purpose for custodian use of health information is managing internal operations such as planning and allocating resources, quality improvement, evaluation and obtaining payment for services – so internal quality assurance is valid. A clinical trial would likely require a consent and/or ethics approval.

Do I have to switch to an EMR from my paper records? What's involved in the transition?

There is an obligation to maintain adequate records but there are no requirements that define how a medical record should be maintained other than they are legible and in a permanent and retrievable form. EMR's are an acceptable format and a physician needs to assess that the record is adequate to maintain:

- A complete clinical patient record sufficient to ensure the continuity of care of the patient (i.e. enable another practitioner to assume the patient's care)
- A record of the information and medical reasoning used in medical care
- Proof of the services performed for fees submitted.

Transitions from paper to electronic records should ensure:

- patient information is secure
- privacy of patient information is maintained
- the integrity of the medical record is maintained
- the integrity of the clinical workflow supported by the medical record is maintained
- continuity and quality of care is maintained through the transition period.

What is involved in putting information on the provincial EHR? Am I responsible for how others use the information I post? Who can see, and use, my information?

A physician, upon consideration of the general duties identified of a custodian, has the legal authority to post patient encounter information without consent to an EHR if supported by an Information Management Agreement. A physician has an obligation to know the rules of access and to provide the appropriate level of detail necessary for the clinical objectives of the disclosure. A physician retains custodial responsibilities for information disclosed to the EHR, however they are not responsible for the subsequent uses and disclosures of that information.

Disclosures should be limited to information collected (or confirmed) by the practice as part of the patient encounter – information provided by third parties may be omitted. In the event information is to be posted where a physician is not the originating custodian, it should be identified as such.

Disclosures, consents, denials of consent, and limitations to disclose should all be documented in the medical record.

What is masking? How does it differ from blocking?

Masking is the application of rules that restricts access to data in an electronic record (unless additional action is taken to override the restriction) although the existence of the information is presented. This is differentiated from "blocking" which is an application of access restriction where the existence of the data is not presented.

A physician should consider the patient's expressed wishes to prevent or limit disclosures to an electronic health record (except where mandatory reporting is exercised through the use of an EHR).

3 Definitions

Where the following definitions have been quoted from a previously published source, that source is noted in brackets. HIA = Health Information Act; MCC = Medical Council of Canada.

Access
The process of viewing data or obtaining data from a medical record. In the context of HIA, access is considered part of collection.

Affiliate
An affiliate is an individual or organization with a formal relationship with an information custodian including an individual employed by the custodian, a person who performs a service for the custodian as an appointee, volunteer or student or under a contract or agency relationship with the custodian, or a health services provider with the right to admit and treat a patient.
(HIA)

Affiliate Medical Record Sharing Agreement
An agreement which defines the access, use and disclosures of medical records shared between affiliates.

Blocking
Denying access of an authorized user of an electronic health information system to a designated record within that system.

Chain of Trust
The concept of propagating the privacy and security attributes of a piece of information from one source to the next when it is shared.

Circle of Trust
A network of professionals involved in a patients care and with whom information is shared based on either a custodial or affiliate arrangement.

Collection
The gathering, acquisition, receipt or obtaining health information.

Consent
The autonomous authorization of an information access or disclosure by individual patients. Consent has three components: disclosure, capacity, and voluntariness.

Custodian
Individuals or organizations defined by the HIA that manage health information. Custodians include the Minister of Alberta Health & Wellness, regional health authorities, boards such as the Alberta Cancer Board and provincial health boards, pharmacies and pharmacists, and health service providers paid by the Alberta Health Care Insurance Plan such as physicians.

Data Stewardship
The management of health information including the collection, use, access, disclosure and retention; and the legal, ethical and fiduciary responsibilities of a physician in such management.

Disclosure
The making available of personal information to another custodian, third party, or to the individual that the information is about.

The provision of relevant and material information regarding a decision by a doctor to a patient (and its comprehension by the patient).
(MCC)

Ethics
The discipline dealing with principles and values defining what is good and bad, and with duties and obligations for various groups.
(MCC)

External Medical Record
Any medical record that the physician has access to but which is not under their direct management or control as a custodian. This can include an EHR, the physician office medical record of another physician, a provincial or regional information system, etc.

Fiduciary
Person to whom property or power is entrusted for the benefit of another.

Fiduciary Obligation
The obligation to promote the best interests of persons who have entrusted themselves to the fiduciary (e.g., the physician); an obligation of the highest loyalty, fidelity and trust.
(MCC)

Individual
The patient about whom information is collected, and includes persons who are authorized to exercise rights on behalf of an individual patient. Examples include a parent on behalf of a child, a guardian or trustee on behalf of a mentally incompetent patient and a personal representative on behalf of a deceased individual.

Information Management
The entire process of defining, evaluating, protecting, and distributing data within an organization.

Information Manager
A person or body that (a) processes, stores, retrieves or disposes of health information, (b) in accordance with the regulations, strips, encodes or otherwise transforms individually identifying health information to create non-identifying health information, and (c) provides information management or information technology services.
(HIA)

Information Manager Agreement

A formal agreement between custodians and other persons or bodies acting on behalf of the custodian that define specific uses and disclosures for shared data. The agreement should include

- uses for which the data will be used (further uses or disclosure are not permitted)
- who is permitted to use or receive the data
- exclude uses or further disclose the information other than as permitted by the agreement or as required by law
- mandate that the custodian use appropriate safeguards to prevent use or disclosure of the information other than as provided in the agreement
- ensure that any affiliates or including information managers agree to the same restrictions and conditions that apply to the recipient.

Health Information

Includes any information about an individual that is collected when a health service is provided to the individual, but does not include information that is not written, photographed, recorded or stored in some manner in a record.

Diagnostic, treatment and care

information about any of the following:

(i) the physical and mental health of an individual;
(ii) a health service provided to an individual;
(iii) the donation by an individual of a body part or bodily substance, including information derived from the testing or examination of a body part or bodily substance;
(iv) a drug as defined in the Pharmaceutical Profession Act provided ` to an individual;
(v) a health care aid, device, product, equipment or other item provided to an individual pursuant to a prescription or other authorization;
(vi) the amount of any benefit paid or payable under the Alberta Health Care Insurance Act or any other amount paid or payable in respect of a health service provided to an individual.

Health services provider information

information about any of the following:

(i) name;
(ii) business and home mailing addresses and electronic addresses;
(iii) business and home telephone numbers and facsimile numbers;
(iv) gender;
(v) date of birth;
(vi) unique identification
(vii) type of health services provider and licence number, if a licence has been issued to the health services provider;
(viii) date on which the health services provider became authorized to provide health services and the date, if any, on which the health services provider ceased to be authorized to provide health services;
(ix) education completed, including entry level competencies attained in a basic education program and post-secondary educational degrees, diplomas or certificates completed;
(x) continued competencies, skills and accreditations, including any specialty or advanced training acquired after completion of the

education referred to in subclause (ix), and the dates they were acquired;

(xi) restrictions that apply to the health services provider's right to provide health services in Alberta;

(xii) decisions of a health professional body, or any other body at an appeal of a decision of a health professional body, pursuant to which the health services provider's right to provide health services in Alberta is suspended or cancelled or made subject to conditions, or a reprimand or fine is issued;

(xiii) business arrangements relating to the payment of the health services provider's accounts;

(xiv) profession;

(xv) job classification;

(xvi) employment status;

(xvii) number of years the health services provider has practised the profession;

(xviii) employer;

(xix) municipality in which the health services provider's practice is located

Registration information

Information relating to an individual

(i) demographic information, including the individual's personal health number;

(ii) location information;

(iii) telecommunications information;

(iv) residency information;

(v) health service eligibility information;

(vi) billing information

(HIA)

Masking

The application of rules that restricts access to data in an electronic record (unless additional action is taken to override the restriction) although the existence of the information is presented. This is differentiated from "blocking" which is an application of access restriction where the existence of the data is not presented.

Medical Record

Health information in any form and including notes, images, audiovisual recordings, x-rays, books, documents, maps, drawings, photographs, letters, vouchers and papers and any other information that is written, photographed, recorded or stored in any manner, but does not include software or any mechanism that produces records. The information may be:

- the entire collection – medical record
- a distinct element or component – entry
- a consolidated list of elements or components – summary.

While medical records are primarily patient centric, different types of records exist which provide specific structure to support the delivery of care:

Collaborative Care Record (CCR)

A problem centric record of clinical information for a patient maintained to support multiple providers across the continuum of care.

Clinical Information System (CIS)
A facility centric system that collects, stores, manipulates information supporting the delivery of health information (either comprehensive such as admission, discharge, transfer or limited such as lab results).

Electronic Medical Record (EMR)
A provider centric record of clinical encounters maintained by the caregiver in an electronic system for reference and updating by the custodian.

Electronic Health Record (EHR)
A patient centric longitudinal collection of personal health data supporting multiple providers across the continuum of care with appropriate information securely delivered to authorized individuals.

Physicians' Office Medical Record
Clinical patient records - a unified medical record for each patient in which components (clinical notes, laboratory and imaging reports, pathology reports, consultation reports, hospital summaries and surgical notes, etc.) are gathered into one file in one location as far as possible. An accounting record with respect to each patient seen and a date book, daily diary, appointment sheets etc. to show for each day the patients seen and treatment or services rendered.

Minimum Scope of Disclosure
The principle that, to the extent practical, individually identifiable health information should only be disclosed to the extent needed to support the purpose of the disclosure.

Morals
The practice of ethics in everyday life.
(MCC)

Owner
The person or body that has the custody and control of the physical medical record is considered the owner of the record. This is differentiated from the information contained within the physical record, where the individual has the basic and controlling interest. The information contained in the record is held in trust by the owner of the record.

Post
A defined and structured process for the sharing of information from one information source to another. This can be a manual process where an individual selectively creates the new information or an automated transfer of selected information between systems. Posting of information creates a custodian duty and includes the propagation of updates.

Practice in Association
A professional relationship between a physician and a health professional who is not an employee of the physician.

Practice Network

A professional relationship between physician practices to provide medical services or to share common tools and processes (i.e. integrated scheduling, medical records, …).

Primary Care Network (PCN)

A Primary Care Network is simply a formal arrangement between two parties: a group of family doctors and the local health region. Family doctors and the health region work closely together to coordinate primary care services for patients. In a network, a team of family physicians and their health region work to determine primary care priorities in their local community.

Each network is unique and has the flexibilty to develop programs and to provide services in a way that works locally. For example, depending on need, a network might decide to strengthen the communication between the physicians and home care nurses by working together in a new way. Or, another network may set up a palliative care program with a team of family doctors and health care professionals to look after patients.

Each network determines how to best meet the needs of patients in the area, while working within the provincial Primary Care Initiative. In networks, other health care professionals may work closely with family doctors to provide some primary health services for patients.
(Primary Care Initiative)

Standard of Care

The current and accepted level of care that a prudent and diligent physician would be expected to undertake in reference to the reasonable conduct of peers in similar circumstances.

Use

The application of health information for a purpose and includes reproducing the information, but does not include disclosing the information.

4 Data Stewardship Framework

4.1 Health Information Management

Data stewardship, as defined in this initiative, is the management of health information by a health professional and includes the collection, use, disclosure, management and security of that information. Within each of these aspects there are legal, ethical and best practice considerations that a physician should consider in the management of health information in their trust. The legal framework is based on the Health Information Act, CPSA bylaws and policies, as well as case law. The ethical framework is based on various codes of ethics, CPSA guidelines and accepted standards of care. Best practices include effective and efficient ways to manage clinical and business processes.

Health Information Management

	Collection	Use	Disclosure	Security	Management
Best Practice					
Ethical					
Legal					

The CPSA has bylaws and policies which provide direction put forward from time to time by the Council of the College of Physicians and Surgeons of Alberta. Guidelines are also published by the College which do not have the legal weight of a policy, but which are intended to provide aid to physicians in their decision-making:

- Bylaws
  - Disclosure of Confidential Information
  - Physician Performance
  - Ownership & Operations in the Practice of Medicine
  - Practice in Association
  - Facility Records
- Policies
  - The Referral/Consultation Process
  - Practice in Association
  - Principles of Ownership
  - Physicians' Office Medical Records
- Guidelines
  - Release of Medical Information: A Guide for Alberta Physicians
  - Closing a Medical Practice: Things to Consider
  - Transition to Electronic Medical Records
  - Physician/Patient Relationships

Copies of all of the above are available on the CPSA's website: http://www.cpsa.ab.ca
.

The legal framework for the collection, use and disclosure of health information are embodied in the Health Information Act of Alberta. This includes the definitions of health information; specific authorities for collection, use and disclosure of health information; specific requirements for consent; penalties for the misuse of information; and patient

remedies and options. It also includes requirements to maintain reasonable safeguards to protect the confidentiality and privacy of health information, including the protection against reasonably anticipated threats to the security or integrity of health information, as well as unauthorized use, access, disclosure or modification.

Custodians are defined and include, among others, any health service provider paid in part or in whole by the Alberta Health Care Insurance Plan. Physicians, as custodians have the responsibility to act within the general duties and powers of custodians, as noted in the following sections of the HIA:

57 Duty to collect, use or disclose health information with highest degree of anonymity possible
58 Duty to collect, use or disclose health information in a limited manner
60 Duty to protect health information
61 Duty to ensure accuracy of health information
62 Duty to identify responsible affiliates
63 Duty to establish or adopt policies and procedures
64 Duty to prepare privacy impact assessment
65 Power to transform health information
66 Power to enter agreement with information manager
67 Power to charge fees

Common law has evolved from judgments rendered in legal actions that have proceeded through the court system.

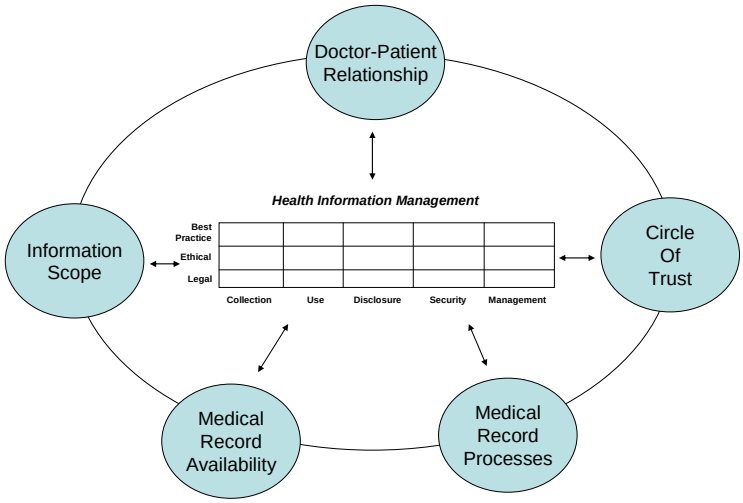
In addition to the legal framework, a history of ethical and best practice experiences are embodied in professional Codes of Ethics, medical school and continuing medical education curriculums, and ongoing communication within the health system.

4.2 Data Stewardship

Physician stewardship of medical information is a well established trust both in practice and legally enshrined in law. A physician is legally obligated to maintain a medical record of the care provided, while the doctor-patient relationship requires a patient's confidence and trust in the management of their information, and establishes a burden on the physician to maintain that trust.

There are many factors that will influence data stewardship within a physicians' practice and with individual patients:

- the type of information and the purpose for the information collection, use and disclosure
- the doctor-patient relationship and the scope of care provided to a patient
- the circle of trust with other providers regarding the scope and level of information exchange
- the number and types of medical records available to the physician, and the level of integration of those records
- the processes that establish medical record ownership, policies and the management of information within the medical record



4.2.1 Information Scope

The Health Information Act (HIA) defines the types of health information as well as purposes for the collection, use and disclosure of health information.

Health information means any or all of the following:

- diagnostic, treatment and care information
- health services provider information
- registration information.

Purposes for custodians may include:

- providing health services
- determining eligibility for health services
- conducting formal investigations including investigations, disciplinary proceedings, practice reviews and inspections
- conducting authorized research
- providing health service provider education
- complying with another piece of legislation
- managing internal operations such as planning and allocating resources, quality improvement, evaluation and obtaining payment for services.

4.2.2 Doctor-Patient Relationship

A doctor-patient relationship exists when the physician provides advice and/or treatment in a process of health care to which the patient consents (explicit or implied). Interactions between a physician and a patient are based on a trust that the appropriate information will be shared between the doctor and the patient, and that the information will be held in confidence and used for the benefit of the patient.

The specifics of the doctor-patient relationship should guide the data stewardship practices in the individual circumstances of the relationship. Key aspects of the relationship can include:

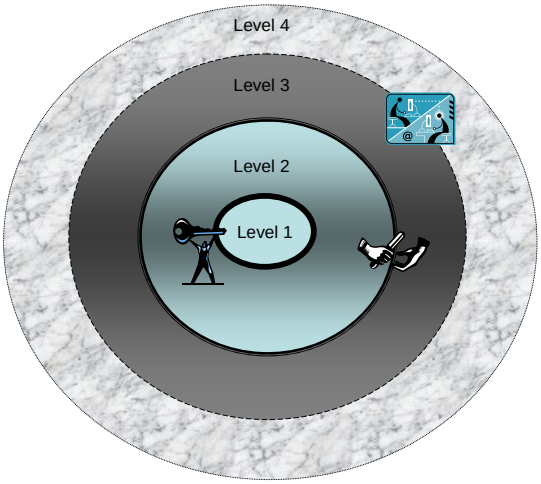
- scope of care – problem specific or primary care
- duration of care – encounter, episode or longitudinal
- care delivery model – primary care, secondary, tertiary, long-term
- physician autonomy - independent, team based, disease management protocols.

4.2.3 Circle of Trust

The circumstances of the doctor-patient relationship, the make-up of the care team and the care delivery model, the treatments involved in the care of a patient will influence the information use and disclosure and the level of trust that applied in a given circumstance. This creates a conceptual model that is unique to each situation that will usually be embodied in the access, storage and authorization rules for medical records; the information content and structure in the medical record; as well as the processes involved in referrals, consultation and results reporting.

The tightest circle of trust implies a free exchange of information. This circle could be limited to the doctor-patient, the immediate care team, etc. As the circle expands,

- the trust relationship diminishes resulting in the need for more structure and limitations on the use and disclosures of information
- there is less direct access to information, more structured views by role, and increased human intervention
- there is increased need for security, monitoring and auditing of accesses.



4.2.4 Medical Record Availability & Integration

The potential range of instances of medical records can span from 1-to-N (every physician and provider maintains a personal record of care) to a single integrated patient record (where each physician and provider contribute to a common record).

- physician record of care
- physician and associated professionals record of care

- group practice record of care
- facility based record of care
- patient centric record of care
- fully integrated patient record used by all providers.

The type of access to available medical records also spans a broad spectrum:

- a personal record of the care provided
- a group record where multiple individuals can contribute
- another provider's record (in the context of their care)
- another provider's record (in a context customized to your role)
- a shared record (in a specific care model)
- a shared record (role based access).

The level of integration between records:

- human intervention to integrate and/or transfer information
- human intervention to expressly transfer/push information from one record to another
- systematic push/pull from one record to another record based on defined rules.

4.2.5 Medical Record Processes

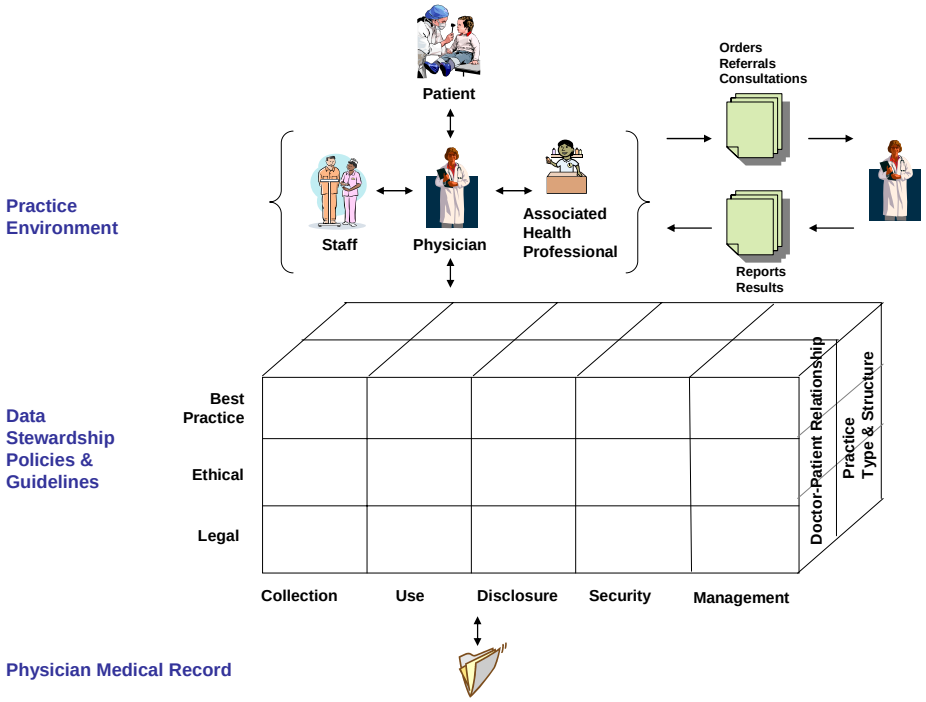
There are a number of processes in the setup and operations of a medical practice that involve the management of health information:

- establishing medical records policies for the practice
- defining standards for, and managing patient information within a medical record
- providing medical record access to staff and affiliates
- accessing patient information from external medical records
- posting patient information to external medical records.

4.3 Traditional Data Stewardship Model

A traditional model has a physician practicing in a clinic environment where they manage:

- the relationships with the patients as well others involved in the delivery of care
- the policies and practices of the use of medical information
- the management of the medical record



A physician's fiduciary responsibility is to maintain a medical record including policies covering the collection, use, disclosure, security and management of the data within the record. A physician is responsible for the content of the record, the medical record policies in the practice as well as the delegations of authority for use and access of the record. Within each of these activities there are legal, ethical and best practice parameters that guide the maintenance of the record.

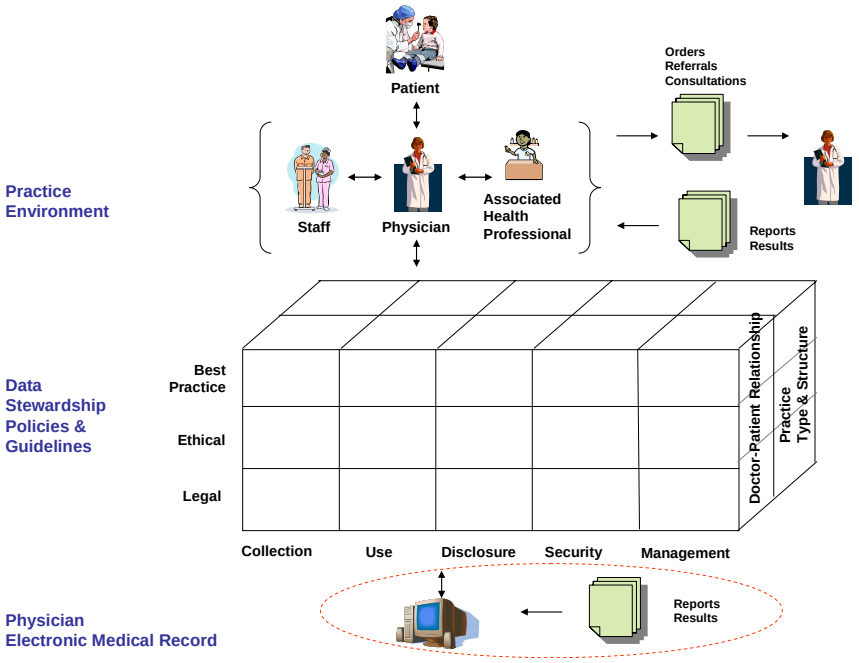
The doctor-patient relationship extends to physician staff and other health professionals working in association with the physician. Additional professional relationships exist through communications embodied in physician orders, referrals and consultations.
Historically the information management responsibility for the physician has centered on the Physician's Medical Record and the issues related to the content, access and confidentiality of the record. The formal purposes of the record include:

- A complete clinical patient record sufficient to ensure the continuity of care of the patient (i.e. enable another practitioner to assume the patient's care)
- A record of the information and medical reasoning used in medical care
- Demonstration of the performance of services for fees submitted.

In this model the majority of medical records are paper based, and access is limited to staff working in a facility/clinic, or with direct human intervention to provide external access or disclosure.

4.4 Use of Electronic Medical Records

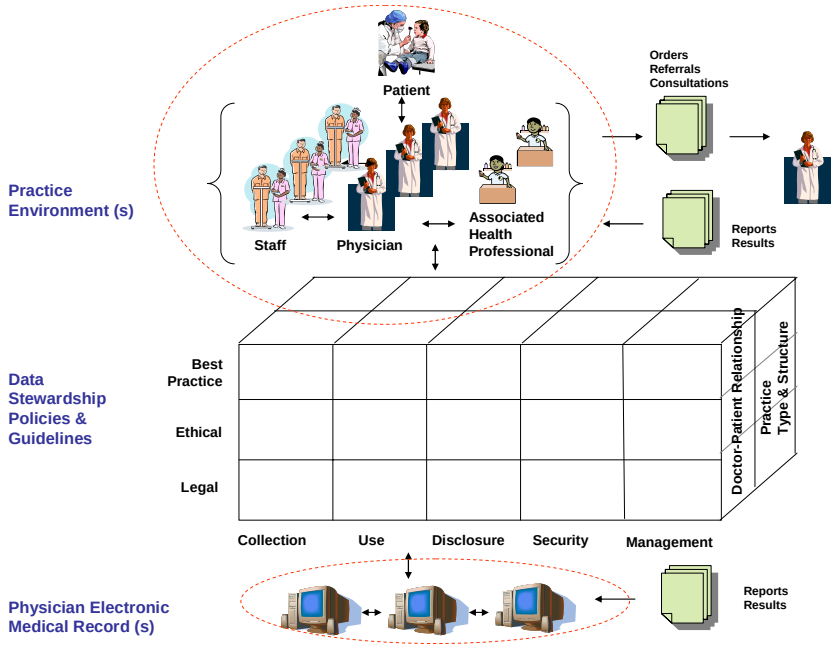
The pervasiveness and support for electronic medical records has dramatically been enhanced in recent years resulting in significantly increased use. Electronic records by definition offer both opportunities for additional uses and access and electronic communication, as well as additional obligations for security and management.



4.5 Changing Practice Structures & Care Models

There are evolving types and structures for medical practices including:

- Primary Care Networks
- specialty-related medical groups working in association
- medical practices located within RHA facilities.



The care model can include many associations of practice with other physicians and many more multi-disciplinary models each with different accountabilities, facility based standards of care, ethical guidelines, and custodial definitions.

These different types of practices can have dramatically different requirements for a medical record:

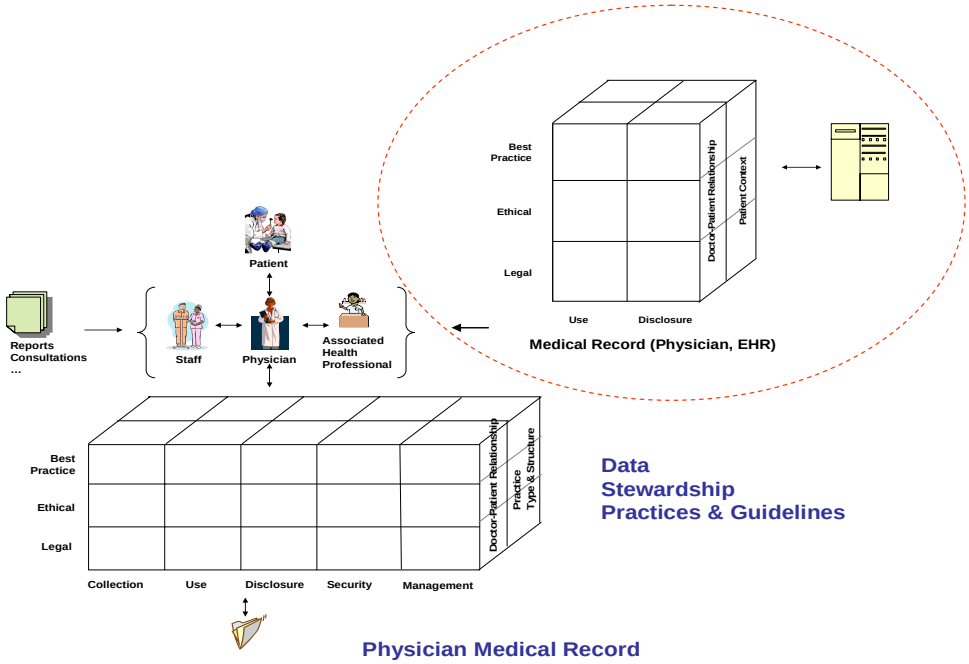
- Problem based care
- Episodic care
- Longitudinal care
- Coordinated care records based on role definitions

as well as different solutions for managing medical records:

- Integrated record across multiple facilities
- Contracted management of records among practices
- Remote access to records
- …

4.6 Accessing External Medical Records

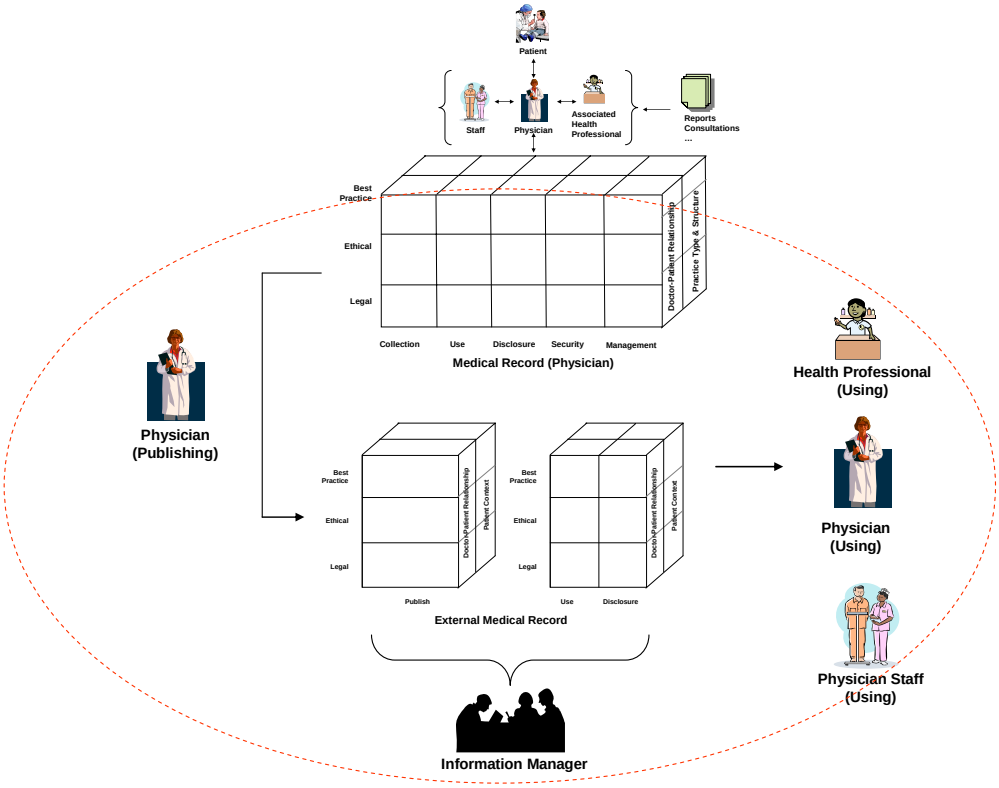
The number and scope of external medical records, in particular electronic records, is growing. This includes regional health authorities making portions of their clinical information systems available to physicians, patient-centric Electronic Health Records, and direct access to other physician's records through on-call arrangements or shared care models in an association of practice. There is a different purpose for these records versus the medical record kept by the treating physician in that they provide an additional information source versus a record of care provided by the physician.



4.7 Post to an Electronic Health Record

The opportunity to contribute to patient centric EHRs utilizing patient encounter data is also increasing. The purpose of these records is different than the Physician Medical Record in that they support the overall health system through the provision of additional

information sources to other physicians and health professions in the delivery of care, they provide support for health system planning and quality improvement, and also for purposes such as research.



The underlying premise of an EHR is that of a patient centric record is maintained, based on the contributions of multiple providers (including multiple health disciplines) and is accessible by multiple providers (including multiple health disciplines) based on defined roles and specific authorizations for each role.

This model introduces the role of an Information Manager who acts in the collective interest of the participating custodians to:

- Develop and manage rules for collection, use, disclosure of information in their custody
- Develop and apply information management agreements which bind custodians to the rules applicable to the shared record - the rules apply to custodians who post information as well as the custodians accessing the information
- Manage the operation of the EHR
- Manage the security of information in their custody
- Manage the security of information in transit to and from the custodian
- Manage disclosures to health professional bodies and other defined disclosures such as non-identifiable information
- Manage patient access to information
- Monitor and enforce compliance of the information exchange protocols.

The Information Manager is therefore not acting <u>as</u> a custodian, but is acting <u>on behalf of</u> the custodian (who retains full custodial responsibility).

4.8 The Evolving Data Stewardship Framework

Given the evolving nature of the practice environment, as well as the evolving expectations of patients and society in general, a physician should periodically evaluate the practice's data stewardship framework to review and update policies and guidelines including:

Practice Environment

- the policies and processes involved in the collection, use and disclosure of health information within the medical practice in relation to:
    - a physician as a information custodian
    - physician colleagues within the practice
    - staff within the practice
    - associated health professionals working within the practice
    - associated medical practices in an integrated care delivery model
    - associated health professional practices in an integrated care delivery model
    - regional, provincial and national services

- the practice's processes involved in the doctor-patient relationship (and the expanded circle of trust implicit in the care model):
    - establishing and terminating the doctor-patient relationship
    - managing patient information
    - managing orders, results and reports
    - managing referrals and consultations

- the availability of external medical records:
    - access relevant patient information
    - post patient encounter information

- the status of the physician medical records and their effectiveness to:
    - ensure the continuity of care
    - demonstrate the medical reasoning in the care provided
    - support the care delivery model

Data Stewardship Policies & Guidelines

- information protocols that operate within the legislative framework, support their ethical obligations, and follow best practices for information management and sharing within and external to the practice

- contractual agreements are in place:
    - for group practices, that define the ownership and ongoing management of medical records. The agreement should include the role of the individual physician as a custodian within the group ownership of the medical records
    - for practices with affiliates or relationships that share medical records, that define the legitimate collections, uses and disclosures
    - for practices that engage an information manager to support the medical record, that define the uses and disclosure instructions of the custodian

- effective information exchange in the referral / consultation process with colleagues and associated practices

- appropriate use of physician medical records by affiliates and associated medical practices:
    - clear accountabilities and policies regarding the use and management where multiple medical records are in place

- appropriate use external medical records:
    - when to use external medical records
    - the delegation of authority to staff
    - what information accessed from an external medical record should be recorded in the physician medical record

- posting to an EHR:
    - definition of the disclosure instructions
    - determine if and how a disclosure to an EHR needs to be recorded in the Physician Medical Record
    - determine if the disclosure needs to be more limited for the practice or in individual circumstances
    - evaluate how they might support a patient's desire to have their information available on an EHR if they do not have the capacity to post to an EHR

Physician Medical Record Processes

- the security structure of their medical records is sufficient to enable/restrict access to the medical record, consistent with the care delivery model and the delegations of authority

- manage transitions of medical records (i.e. paper records to electronic records, integration of records from multiple practices, changing EMR's) to ensure:
    - patient information is secure
    - privacy of patient information is maintained
    - the integrity of the medical record is maintained
    - the integrity of the clinical workflow supported by the medical record is maintained
    - continuity and quality of care is maintained through the transition period

5 Data Stewardship Principles, Policies & Guidelines

Inherent in the discussion of data stewardship is a natural tension of conflicting objectives. Examples of these types of tension include:

- Information needs of the health system versus the wants and desires of the individual patient and physician
- Public safety versus the privacy of the patient
- Legal, ethical and best practices versus practical demands of time
- Physician autonomy and health system care models
- Technology advancements versus historical standards of practice.

5.1 Data Stewardship Principles

Given the wide spectrum of practice situations these principles offer general guidance. It is recognized that principles are not absolute and can often be in conflict with each other in specific situations.

5.1.1 Autonomy

- Patient autonomy
  Patients have the right to self-determination of their health care, and to the extent possible, to direct the management of their information.

- Physician autonomy
  Physicians have the ethical and professional responsibility to direct the care of their patients, which includes their information management protocols.

- Health system management
  Physicians have a responsibility to support the planning, management and quality improvement inherent in the health system in which they practice, recognizing the scope of their professional practice and the increasing nature of the multi-disciplinary and cross-organizational nature of the system.

5.1.2 Fiduciary Duties of the Physician

- Doctor-Patient relationship
  A physician has a duty to act in good faith vis-à-vis their patients and to protect the confidentiality of the information in their trust. This includes informational privacy (information about the patient) as well as associative privacy (the potential impacts on the patient of the use of the information). This duty requires that physicians limit disclosures to those with a need to know and unless the physician is authorized by law to disclose the information without consent, requires the informed consent of the patient if the use or disclosure of the patient's information extends beyond the clinical use for which it was obtained.

- Beneficence
  A physician has a duty to advance the good of patients in their care, which includes the management of the personal information they hold in trust.

- Non-maleficence

A physician has a duty to do no harm to the patient, including through the handling of the patient's information.

5.1.3 Balance

- Legitimate infringement
  There is a balance of the individual control versus the needs of society including legal, regulatory and ethical obligations to disclose information.

- Pragmatism
  There is a balance to the time required to access/research all information sources versus the benefits and risks associated with those accesses.

5.1.4 Fiduciary Duty of an Custodian / Information Manager

- Custodian-Information Manager Relationship
  A physician is typically the owner of the physical record for information that they collect. Custodial ownership extends to the physical data stored in shared medical records under the contracted control of an Information Manager, such as an EHR. The Information Manager must act in good faith and trust to maintain the security and confidentiality on behalf of the custodian who collected the information.

- Information integrity
  A physician, as well as the information manager has a duty to ensure patient information is accurate and complete - subsequent changes must be duly noted to preserve an audit trail of changes to documentation.

- Information privacy
  A patient is the owner of the information maintained in all types of medical records, and has the rights of:
  - access (with explicit exclusions),
  - disclosure based on the need to know
  - accuracy of the information, including the right to request corrections
  - basic and controlling interest in the record.

5.2 Medical Practice Policies & Guidelines

Data stewardship policies and guidelines are applied for the medical practice, as well as management of the information of individual patients:

- Establishing or entering a medical practice
  - Establishing a Doctor–Patient relationship
    - Managing patient information
    - Managing physician orders
  - Terminating a Doctor-Patient relationship
- Terminating or leaving a practice

5.2.1 Establishing or Entering a Medical Practice

A physician establishing or joining a medical practice has an obligation to understand the legal and ethical framework for medical records within the practice, and to develop/adopt

information management protocols which guide the maintenance of the medical record by physicians, staff and other health professionals with access to the record.

Legal

Health Information Act
CPSA Policy: Physicians Office Medical Records
CPSA – Principles of Ownership
CMPA Information Letter IL0510E – March 2005
CMPA Information Letter IL0330E – October 2003

- *Management*
  A physician must be the owner of the medical record and is responsible for the accuracy and propriety of the record - the patient has explicit but defined rights of access. A physician, as an owner of the medical record is vicariously liable for the actions of his/her staff, as well as associated health professionals who may be granted access or use of the medical record.

  Exceptions on the ownership of the medical record can exist as in the case of Occupational Health Records where the organization may own the record - a contractual agreement must be in place to define the ownership in these cases.

  Physicians' rights and duties as a custodian will apply to all records that they have access to in the group. Note that this may mean that could be multiple custodians for each record, if more than one physician was involved in the care of the patient.

  A physician may engage an Information Manager to physically manage the medical record (a paper record or in a computer system). A physician must have an Information Management Agreement which explicitly defines the information uses and disclosure instructions to the Information Manager. An Information Manager (or a custodian or an affiliate acting in an Information Manager role) must not use health information in any manner that is not in direct accordance with the explicit duties to the custodian.

- *Use*
  A custodian may use individually identifying health information in its custody or under its control for the following purposes:
  - providing health services;
  - determining or verifying the eligibility of an individual to receive a health service;
  - conducting investigations, discipline proceedings, practice reviews or inspections relating to the members of a health profession or health discipline;
  - conducting research (specific restrictions apply regarding ethics approval and consent)
  - providing for health services provider education;
  - carrying out any purpose authorized by an enactment of Alberta or Canada;
  - for internal management purposes, including planning, resource allocation, policy development, quality improvement, monitoring, audit,

evaluation, reporting, obtaining or processing payment for health services and human resource management.

- *Security*
  A custodian must take reasonable steps to maintain administrative, technical and physical safeguards that will:
  - protect the confidentiality of health information that is in its custody or under its control and the privacy of the individuals who are the subjects of that information,
  - protect the confidentiality of health information that is to be stored or used in a jurisdiction outside Alberta or that is to be disclosed by the custodian to a person in a jurisdiction outside Alberta and the privacy of the individuals who are the subjects of that information,
  - protect against any reasonably anticipated
    (i) threat or hazard to the security or integrity of the health information or of loss of the health information, or
    (ii) unauthorized use, disclosure or modification of the health information or unauthorized access to the health information.

  A physician is responsible to ensure that capabilities exist to limit use or disclosure based on defined roles / scopes of practice.

Ethical

- *Use*
  A physician has a duty to use the information collected for the defined uses in the provision of care, including quality improvement. Other uses, which haven't have not been specifically included in the scope of this document (such as research, peer review, assessment, and health system evaluations) require appropriate legislated authority, consent, and may require confidentiality agreements and ethics approvals.

- *Security*
  A physician has a duty to protect by all reasonable and appropriate measures the privacy, confidentiality and physical security against loss of the medical information held in trust for the patient.

Best Practice

- *Management*
  A physician is responsible to ensure that procedures are in place to ensure the integrity of clinical processes that utilize the medical record (e.g. follow-up on lab test orders and the timely review of external reports initiated by the physician etc.).

  Physicians in group practice should establish, by specific contractual agreement, the ownership of the records. The agreement should explicitly define the custody and control of records for the group (including explicit definition of the ongoing management of records in the event of termination of the group, or the departure of a physician from the group), as well as the rights and obligations of physicians as a custodian.

Unless otherwise specified, physicians in a shared group practice have joint ownership of the medical records of the group (enabling access) and are jointly accountable for the medical record policies and guidelines of the practice.

- *Collection*
  The use of commonly understood notation, coding and classification standards is recommended across all medical records utilized within the practice.

  If affiliated health professionals have access to the medical record, enable a role based access mechanism to limit access to the health information for the purposes of the care in the scope of practice.

5.2.2 Establishing a Doctor–Patient Relationship

The doctor-patient relationship "…begins when the doctor agrees to treat the patient who has expressly or impliedly requested the services." [1] The existence of the relationship establishes a fiduciary responsibility, including the stewardship of data held in trust on behalf of the patient.

Legal

CPSA Policy: Physicians Office Medical Records

- *Collection*
  A physician has a duty to maintain a clinical patient record for each patient in their care.

Ethical

- *Collection*
  Any information collected in a therapeutic context is considered health information. All information collected should be in the pursuit of diagnostic and treatment goals to benefit the patient.

- *Use*
  The use of available medical records, including external records, to maintain an awareness of patient progress (i.e. monitoring patient compliance of treatment instructions where the status of the treatment is recorded by another provider) is legitimate for problems within the doctor-patient relationship.

- *Disclosure*
  A physician has a fiduciary duty to manage disclosures in compliance with patient expectations and wishes (except where legal disclosure requirements exist) and only to disclose information on a need to know basis.

- *Security*
  The use of a separate (private) filing structure for the additional security of selected records should have defined procedures for opening (or explicit consent for non-opening) in emergency situations.

[1] Picard and Robertson, *Legal Liability of Doctors and Hospitals in Canada*, 1996, p. 7

- *Management*
  In the event of the termination of a relationship or the transfer of care, it is the duty of a physician to ensure that all work in progress is managed and recorded in the medical record.

Best Practice

- *Management*
  To ensure the appropriate handling of notes, reports or other external information, or to provide a context regarding the content to a medical record, a procedure or notation on the record should exist to determine:
  - the accepted responsibility in the doctor-patient relationship indicating if the care is for a specific encounter, a specific problem, or longitudinal care
  - if the relationship is active, stale or terminated
  - appropriate uses for the record if there is a variance from the practice standard

5.2.3 Managing Patient Information

While a doctor-patient relationship is in effect, patient information is required to be maintained in a medical record.

Legal

Health Information Act
CPSA Policy: Physicians Office Medical Records
CPSA Policy: The Referral/Consultation Process
CPSA Guideline: Release of Medical Information – A Guideline for Alberta Physicians
CMPA Information Sheet IS0552E – Consent: A Guide for Canadian Physicians
CMPA Information Letter (January 2000 15-1)
CMPA Information Letter IL0020E (December 2000 15-4)
CMPA Information Letter IL0040E (May 2000 15-2)
CMPA Information Letter IL0510E (March 2005 20-1)

- *Collection*
  A physician has a duty to collect the minimum information required, but should include:
  - Patient Encounters
  - Patient Follow-up Instructions
  - Physician Orders & Results
  - Referral letters
  - Consultation Notes and information from consultants
  - 3rd Party requests for information and replies.

  All entries in the record need to be dated and attributable to the individual who collected the information. Alterations of medical records must be clearly managed according to CPSA policy. The individual collecting the data (or the

health professional accountable for the collection) is the custodian of that information.

- *Security*
  A physician is responsible to manage the retention of the entirety of the medical records for 10 years following the date of last service. Diagnostic images stored on film should be stored for a minimum of 5 years. In the case of minors, the retention period is 10 years or 2 years past the age of 18, whichever is later.

  Disposition of records should be accomplished with certainty that the information is destroyed and not able to be re-constituted.

- *Disclosure*
  A patient's general right of access to his or her medical record is not absolute. Where there is a justifiable rationale to withhold information such as a significant likelihood of a substantial adverse effect on his/her physical, emotional or mental health or harm to a third party a physician may deny access to a record.

  A physician is responsible to apply the general duties of a custodian for individual or systematic disclosures from the medical record, including the actions of group practice partners, affiliates and information managers. A physician is not responsible for the actions of another custodian's use of information once it has been legitimately disclosed.

  A physician should determine the purpose of disclosures (even with the existence of consent) to make the appropriate level and detail of disclosure to meet the defined purpose. Disclosure should be limited to the least amount of information needed for the purpose of the disclosure. The custodian has a duty to ensure that the individual receiving the information has the need to know and the competency to use/interpret the disclosed information.

  Disclosures to 3rd parties should be based on a policy of explicit and informed consent unless exempt from the requirement in legislation. The medical record should maintain a record/audit trail of such disclosures.

  Examples where a physician must report, regardless of consent include:
  - Specified communicable diseases, and patients affected with, or suffering from a "notifiable disease"
  - Suspected child abuse
  - Suspected abuse of a "person in care"
  - Animal bites (if rabies is reasonably suspected)
  - Deaths under conditions as defined by the Fatality Inquires Act
  - Results of blood alcohol testing, when blood has been drawn for that purpose at the request of a Peace Officer
  - Medical condition of flight crews, air traffic controllers and others, where a physician believes that the medical condition is likely to constitute a hazard to aviation safety
  - Medical conditions that could be a threat to safe railway operations, for railway workers occupying a safety position
  - Patients affected with, or suffering from a "notifiable disease"

- All pathological reports indicating the presence of malignant cells

A physician must provide health information upon the request of:

- The patient
- Court Order
- Any third party only when accompanied by proper authorization to release
- A patients legal guardian, with documentation
- A patients parent, when the patient is less than the age of **consent** (not the age of majority) – for further reference see the CPSA document on "Consent for Minor Patients"
- The executor or administrator of the estate, for a deceased patient if the disclosure is required for a purpose related for the administration of the patient's estate (limited information may be disclosed to the family or close friends of the deceased)
- The College of Physicians and Surgeons of Alberta pursuant to an investigation under the Medical Professions Act
- Order of a Statutory Board
- The WCB, as it relates to information relevant to a WCB claim regarding an injured worker
- Health Canada or the Minister of Health, regarding narcotic drugs
- A radiation medical officer, relating to the radiation health or safety of workers and the public
- The Alberta Cancer Board
- Individuals as set out by the Mental Health Act or the Hospitals Act

A physician without consent may report:

- Persons medically unfit to drive
- Patients who have been treated for a mental illness … that was associated with violence or threatened or attempted violence on the part of the patient against any person
- Health information relating to a person receiving diagnostic and treatment services in a Centre designated under the Mental Health Act
- Possible commission of an offence under a statute or regulation of Alberta or Canada
- Detection and prevention of fraud or abuse of health services
- Protection of the health and safety of Albertans

Except where there is consent, a Court Order or an imminent danger to the health or safety of any person, a physician is not obligated to initiate the reporting of:

- Gun shot or knife wounds
- Admitted use of illegal drugs
- Injuries suffered during the commission of a crime

Ethical

- *Collection*
  A physician has a duty to collect only the clinically relevant information to provide medical care.

- *Disclosure*

A physician may report:

- Patients where a physician has reason to believe there is an imminent danger to the health or safety of any person

- *Management*
  Any information collected should be kept as part of the medical record, however if no medical record exists (as might be the case if the information was sent in error) the received information should be returned to the originator or destroyed. A physician who receives such information, while not obligated to act on the information may use the information to communicate with the originator or the patient if they deem it appropriate.

Best Practice

- *Collection*
  Group, couple or family records should be kept distinct from individual records so that an individuals record can be easily extracted for disclosure purposes.

  Medical records should be chronological and systematic. If used, codes or shorthand should be understandable by subsequent users of the record. A cumulative patient profile is recommended (including, for example active or relevant diagnoses, interventions or treatments)

  Anatomy of a good note - legible, factual and objective, differentiating direct knowledge from second hand information, which is cautious about drawing conclusions based on incomplete or unsupported information. Documentation at the time of the encounter or shortly thereafter is preferable, and should demonstrate the thought process at the time of the encounter as well as the information provided to the patient including follow-up instructions.

  The collection of information into the physician medical record which was propagated from an external medical record should have the source of the information recorded in the collection. If the original information source had disclosure instructions recorded, these instructions should also be propagated to ensure the chain of trust established in the initial collection is maintained.

  If the information from external sources materially alters the treatment or care of a patient and is not collected in the physician's medical record, it is prudent to document the access plus the relevant content in the physician medical record to demonstrate the physician's reasoning.

- *Use*
  The medical record should be a tool to support effective communication amongst the care team, and to manage the information exchange and expectation in the transfer of care between providers. Access rights to the medical record should be limited to the level of detail required by the specific role.

- *Disclosure*
  Referral letters to other medical practitioners or registered health care professionals should include details from the medical record and expectations from the referral and in regard to any transfer of care.

- *Management*
  Establish procedures to match / track completion of orders and referrals, as well as patient compliance where possible (and warranted).

5.2.4 Managing Physician Orders

Physician orders have additional requirements in addition to the requirements for patient information.

Legal

CPSA Policy: Physicians Office Medical Records

- *Collection*
  Investigations ordered and results received are part of the minimum requirements for a medical record.

Ethical

CMPA Information Letter IL0320E (June 2003 18-2)

- *Collection*
  A duty exists to review in a timely manner order results, consultant notes or other information received in response to physician orders. This includes a review of treatment received and the follow-up recommendations for the patient. Physicians may receive information for current patients where they did not initiate the order, and can:
  - discharge the duty by assigning responsibility for follow-up action to another physician who acknowledges the responsibility
  - accept responsibility for the follow-up (as might be appropriate for patient-initiated participation in screening programs where the physician is identified as their treating physician)
  - note the receipt of the information but not acknowledge responsibility for follow-up

  In any event, a physician should document the receipt of the information in the medical record as well as the action or inaction taken. This duty does not extend to information received where no doctor patient relationship has ever existed – in this case there is no medical record and the input may be returned or rejected. Physicians who work in group practice or who are covering for other physicians must be particularly careful to ensure that a doctor-patient relationship does not exist before destroying information.

- *Management*
  A physician who orders an investigation has a duty to manage the receipt of the result, either personally or through a defined process for coverage. Particular care should be exercised within the practice for unexpected absences or departures from a practice.

Best Practice

CMPA Information Letter IL0320E (June 2003 18-2)

- *Disclosure*
  Requesting the distribution of additional copies of order results should be carefully considered so that physicians will not receive copied result reports without appropriate context for the report.

5.2.5 Terminating a Doctor–Patient Relationship

A doctor-patient relationship may be terminated by a physician in accordance with CPSA guidelines (e.g. retirement, fulfillment of the transferred care, breakdown in communication, etc.) or by the patient. In either circumstance, the physician should endeavor to facilitate the on-going management of the medical record.

Legal

CPSA Policy: Physicians Office Medical Records
CPSA Guideline: Closing A Medical Practice

- *Management*
  Transfers of medical records should be timely (i.e. within two weeks of a request) and should be a copy of the record rather than the record itself. The origin of the request (patient or requesting physician) is relevant in determining the correct billing party and procedures, if necessary.

Best Practice

- *Management*
  Explicit patient discharges from a practice (resulting from retirements, practice closures, breakdown in the relationship, etc,) should be in writing and provide adequate notice and a provision for the transfer of a copy of the medical records.

5.2.6 Terminating or Leaving a Medical Practice

Patients and parties on their behalf, Courts, investigating bodies and other physicians require access to past medical records which requires that a retention plan is established for all patient records. Special consideration should be given for the disposition of medical records when closing a medical practice.

Legal

CPSA Policy: Physicians Office Medical Records
CPSA Guideline: Closing A Medical Practice
CMPA Information Sheet IS0334E (March 2003)
CMPA Information Sheet IS0443E (September 2004)

- *Management*
  It is the obligation of a physician to manage the transfer of active patient records (requires a patient release if the custodial physician has not attended the patient) and to provide for the ongoing records management of all records. Ideally, transfers will be made with an arrangement with a colleague.

  Physicians ceasing practice for any reason must notify the College of Physicians and Surgeons of Alberta of the whereabouts of their records to ensure future

access. In the event where a colleague has assumed custody of the record, a patient release would relieve the notification responsibility.

A physician who leaves a group practice is entitled to take a copy of an entire medical record that they had contributed to (including other physician's entries). A physician leaving a group practice and re-locating to another practice may transfer the original record if the physician was the sole contributor to the record. A record of the record transfer should be maintained in the original practice.

- *Security*
  A physician is responsible to manage the retention of the entirety of medical records for 10 years following the date of last service. In the case of minors, the retention period is 10 years or 2 years past the age of 18, whichever is later.

5.3 Medical Practice "Network" Policies & Guidelines

Medical practices can operate in partnership to coordinate medical or support services. In addition to the data stewardship practices of a medical practice, a practice network has special requirements which must be considered.

- Entering a medical practice network
  - Establishing a Doctor–Patient relationship
    - Managing patient information within the practice network
    - Managing patient information within the medical practice
  - Managing doctor orders

5.3.1 Entering a Medical Practice Network

Legal

CPSA Policy: Physicians Office Medical Records
CPSA Policy: Practice in Association

- *Management*
  The details of the information sharing protocols and the ownership of the medical record should be contained in a formal, written agreement. Participants in an agreement should be registered medical practitioners or health professionals regulated under the Health Professions Act. Physicians should ensure they have access to the shared record for the required retention period of a medical record in the event of the dissolution of the agreement.

  The use of an integrated record is acceptable, however each entry in the integrated record must be attributable to the individual who created it and the unified record must not compromise the ability to provide patient access to their information.

Best Practice

- *Management*
  Transitions from multiple records to an integrated record should ensure:
    - patient information is secure

- privacy of patient information is maintained
- the integrity of the medical record is maintained
- the integrity of the clinical workflow supported by the medical record is maintained
- continuity and quality of care is maintained through the transition period.

In instances where multiple medical records exist, explicit policies must exist to identify which records are to be updated under which circumstances to ensure that as far as possible all components of the patient record are gathered into one location, and the transfer of care and follow-up of orders is clearly identified and managed.

- If the doctor-patient relationship is encounter based (i.e. on call rotation) and the ongoing relationship is supported by another physician in association, it may be appropriate to chart the encounter in the medical record of the physician with the ongoing relationship.
- If the doctor-patient relationship is problem based (i.e. a referral or consultation), it may be more appropriate to establish a new record at the facility where care is delivered and to document the care through a traditional consult note to the referring facility (if necessary).

5.3.2 Managing Patient Information within the Practice Network

Legal

Health Information Act
CPSA Policy: Physicians Office Medical Records
CPSA Policy: Practice in Association
CPSA Policy: The Referral/Consultation Process
CMPA Information Letter IL0040E (January 2000 15-4)

- *Collection*
  Physician clinical findings, assessments, treatment recommendations should be clearly identifiable within a shared record, especially with team-based decision making processes.

- *Disclosure*
  A physician, as a custodian of the medical record (or entries in the record) is responsible for the management of individual or systematic disclosures from the medical record.

Best Practice

- *Collection*
  In cases where multiple physicians or health professionals working in association may share a patient medical record, ensure that a mechanism exists to separate each problem or treatment plan to clearly identify the responsibility for care, as well as to support the appropriate disclosure of information.

- *Management*
  If coordinated care records exist (i.e. a chronic disease management register) then information collected in the physician's medical record and the information

posted to the coordinated care record must be integrated (i.e. the disclosure is noted in the originating record so that updates made in the original record are propagated to the second record, and if appropriate that follow-up notes made in the second record are forwarded back to the original record).

5.3.3 Managing Physician Orders

Legal

CPSA Policy: The Referral/Consultation Process

- *Disclosure*
  Referrals and the transfer of care must be documented even if the collaborating physicians are practicing under a group arrangement.

5.4 Medical Facility Policies & Guidelines

Medical staff working in a hospital or publicly-operated institution can be either independent contractors or employees. Depending on their agreement with the facility owner, they may also be considered a custodian (or affiliate) with the associated duties and obligations.

Legal

CMPA Information Letter IL0040E (December 2000 15-4)

- *Management*
  Records and notes created by a physician working in a hospital or publicly-operated institution belong to that organization unless specific arrangements are made to the contrary. A physician should ensure that they have access to the records they create or contribute to.

- *Disclosure*
  Disclosure policies and guidelines are defined by the hospital or institution.

- *Collection*
  Physician clinical findings, assessments, treatment recommendations should be clearly identifiable within a shared record, especially with team-based decision making processes.

5.5 External Medical Record Policies & Guidelines

External medical records are any records not within the custody and control of the physician or the medical practice. They could be Electronic Health Records, or the medical records of physicians or other health professionals to which a physician is granted access.

5.5.1 Access to an External Medical Record

External medical records provide an additional source of information for physicians providing care to patients. Legitimate purposes to access an external medical record (for patients within the doctor-patient relationship, irrespective of the payment model) include:

- The review of previous care and treatment of a patient in your care from public health programs, or other physicians and health care providers
- Monitoring the compliance with physician orders
- Monitoring the outcomes of treatments or referrals

Legal

Health Information Act

- *Use*
  A physician has the obligation to ensure they have the legal authority to access an external medical record, and to be aware of the uses that are allowed in the access.

  Information accessed on the external medical record remains in the custody of the originating physician, health care provider or healthcare institution. The custodian of the external medical record rather than the user of the information has the responsibility to record the disclosure.

- *Disclosure*
  Information propagated from the external record to the physician record becomes part of the physician record and the receiving physician becomes a custodian of that collected information. A physician should ensure they have the legal authority to disclose information collected from an external medical record.

  Information propagated to a physician medical record from an external medical record should:
  - Be limited to the scope of the care provided by a physician to the patient.
  - Maintain the chain of trust from the original record (i.e. many external medical records have “masking capabilities” which provide additional security at a patient level or for specific information within the record – this information should be collected and respected in subsequent uses).

  Disclosures which override masking should have a defendable rationale which should be documented either in the external record itself or in the physician’s medical record. Recording of masked information disclosed from the external record and propagated to the physician medical record should also have the masked status propagated.

- *Security*
  Physicians have the obligation to ensure they have the legal authority to delegate access to an external medical record, and to ensure that the credentials of staff and associated health professionals meet the standards of the agreement for use.

Ethical

EHR Information Exchange Protocol V2.0
Health Information Act
CMPA Information Letter IL0304E (December 2003 18-4)
CMPA Information Letter (January 2000 15-1)
CMPA Information Letter IL0320E (June 2003 18-2)

- *Use*
  It is valid to evaluate the previous care a patient has received. In some cases, the failure to use available information has been deemed "a critical omission" in legal proceedings. Situations where the use of an external medical record is ethically valid include:
  - Emergency care, especially if the patient is incapable of providing information,
  - Assuming the care of a patient based on a referral with limited background information, or where a referral indicates the availability of relevant information,
  - Assuming care of a patient where the complexity of the patient circumstances is high (i.e. multiple conditions treated by multiple physicians),
  - Assuming care after major or significant treatment from a facility or consulting physician,
  - Monitoring of patient's compliance with physician orders or following up instructions (when there is cause to do so),
  - Providing a 2nd opinion to a patient.

  If information obtained during the review of information within an external medical record indicates that the patient is at an unacceptable level of risk or that the information is misleading to the point which places the patient at risk, A physician, in addition to managing the patient care, has an obligation to act in some manner to rectify the information risk by:
  - Providing explicit instructions to the patient to follow-up with the original custodian,
  - Following-up directly with the original custodian,
  - Appending, updating or creating new information (if this functionality exists).

Best Practice

- *Use*
  In addition to the above, situations where the use of an external medical record is suggested as a best practice include:
  - If the patient is unclear or unable to present relevant information,
  - Assuming longitudinal care of a new patient,
  - Providing care with doubtful or suspicious circumstances, or where observations suggest complex or unusual circumstances,
  - Indications from a patient that relevant information is available.
  - Evaluation of existing information to avoid redundant tests/treatments or to guide the development of current treatment plans.

  Upon review of the external medical record by a physician providing care, if there is a concern or question on the validity of the medical care indicated by the limited scope of the information available on an external medical record and their direct observations, a physician should follow-up with the originating physician.

  If information obtained during the review of patient information within an external medical record indicates that the patient is non-compliant with medical advice or

the patient is potentially misusing the system (i.e. obtaining multiple prescriptions for the same condition) a physician may:

- Provide explicit instructions to the patient to follow-up with the original custodian,
- Follow-up directly with the original custodian,
- Append, update or create new information (if this functionality exists).

5.5.2 EHR for Diagnostic Report Distribution

A physician may use the external medical record as the mechanism for the delivery of ordered information (i.e. lab results are systematically obtained from an EHR rather than a distributed report).

Legal

CPSA Policy: Physicians Office Medical Records

- *Management*
  It is a physician's responsibility to ensure that access and retention of information in the external record will satisfy the physician's needs for his or her own records access and retention.

Best Practice

- *Management*
  A formal agreement between a physician and the diagnostic facility is required to discontinue the normal distribution of diagnostic reports by the diagnostic facility to ensure that both parties understand the delivery mechanism for the result reports. A physician has the same obligation to view the results in a timely manner as well as to manage the confirmation of the receipt of the results as if the orders were delivered in document form.

5.5.3 Posting Patient Information to an EHR

Legal

EHR Information Exchange Protocol V2.0
Health Information Act

- *Use*
  Information posted to an EHR can be used for quality review purposes by the originating physician or by bodies with the legislative authority to conduct quality reviews.

- *Disclosure*
  A physician, as the custodian should evaluate their posting obligations as well as the rules for disclosure that will apply to the information manager of the EHR as defined in the Information Management Agreement.

  A physician, upon consideration of the general duties identified of a custodian, has the legal authority to post patient encounter information without consent to an EHR if supported by an Information Management Agreement. A physician has

an obligation to know the rules of access and to provide the appropriate level of detail necessary for the clinical objectives of the disclosure. A physician retains custodial responsibilities for information disclosed to the EHR, however they are not responsible for the subsequent uses and disclosures of that information.

In the event that information was posted in error or was subsequently determined to be in error, a physician should propagate updates to the previously posted information.

- *Security*
  A physician has the obligation to ensure that appropriate security is in place to ensure the security and integrity of the information exchange between the physician medical record and the information manager.

Ethical

- *Disclosure*
  It is ethically sound to share information with other health professionals who are providing care to patients.

  A physician may seek an explicit consent if there is reason to suspect consent would be normally be denied by the patient if specifically asked (except where mandatory reporting is required).

Best Practice

- *Disclosure*
  If the common procedure is to post information to an EHR, a physician should have a handout explaining the extent and rationale for participating in an EHR as well as the procedures for a patient to limit disclosures.

  The provision of supporting contextual information where the function is available is beneficial to support other health provider's use of the information (i.e. a note that an allergy is patient reported and not medically confirmed).

  Disclosures should be limited to information collected (or confirmed) by the practice as part of the patient encounter – information provided by third parties may be omitted. In the event information is to be posted where the physician is not the originating custodian, it should be identified as such.

  Disclosures, consents, denials of consent, and limitations to disclose should all be documented in the medical record.

5.5.4 Decision to Limit or Extend Disclosures

The limiting of disclosures can be accomplished by not posting information, as well as through the process of masking posted information.

Legal

EHR Information Exchange Protocol V2.0
Health Information Act

- *Disclosure*
  A physician should consider the patient's expressed wishes to prevent or limit disclosures to an electronic health record (except where mandatory reporting is exercised through the use of an EHR).

Best Practice

EHR Information Exchange Protocol V2.0

- *Disclosure*
  Posting portions of patient information (e.g. three prescriptions ordered in an encounter but only two are posted) could lead to subsequent mis-interpretations and are discouraged. Use of the masking capabilities for limiting disclosures is preferred in these circumstances.

  In some cases, the patient situation or the treatment being provided indicates a that the best interests of a patient might be to post information even if the normal procedure is to not post (i.e. prescribing a medication with many known serious drug interactions when the patient has multiple conditions treated by multiple physicians).