Information and Privacy Commissioner,
Ontario, Canada

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

PHIPA DECISION 178

Complaint HA20-00021

Central LHIN o/a Home and Community Care Support Services – Central

April 21, 2022

Summary: The complainant's representative submitted a correction request under the *Personal Health Information Protection Act* to the Central LHIN operating as the Home and Community Care Support Services – Central (the custodian). The complainant submits that a home care assessment form contains a number of errors. The custodian agreed to make some corrections, but not others. In this decision, the adjudicator finds that the exception to the duty to correct at section 55(9)(b) (good faith professional opinion or observation) applies. The custodian's decision to not make the requested corrections is upheld.

Statutes Considered*: Personal Health Information Protection Act, 2004*, S.O. 2004, c. 3, sections 55(8) and 55(9)(b).

Decisions Considered: PHIPA Decisions 36 and 37.

BACKGROUND:

[1] This decision disposes of the sole issue raised as a result of a complaint made to the Information and Privacy Commissioner of Ontario (the IPC) under the *Personal Health Information Protection Act* (the *Act*). The complainant's wife had submitted a multi-part correction request to the Central Local Health Integration Network (the custodian) on behalf of the complainant. She requested corrections to an inter-RAI home care assessment form (RAI HC) with respect to a home care assessment that was conducted. Following the assessment, the custodian determined that the complainant was not eligible for increased hours of personal support services.

[2] In response, the custodian issued a decision, in which it agreed to make partial

corrections and denied others. The decision stated the following:

> Your request has been partially corrected as per the attached List of Assessment Issues.

[3] The custodian's letter did not set out which section of the *Act* it relied on to deny the corrections. The custodian's letter included the attachment of 'List of Assessment Issues', which laid out all the corrections and decisions.

[4] The complainant's wife (referred to in this decision as the complainant's representative) subsequently wrote to the IPC advising that she wished to file a complaint with respect to the custodian's decision to refuse to correct the RAI HC in full.

[5] During the mediation of the complaint, the mediator asked the custodian to indicate which section of the *Act* it was relying on to deny the corrections. In response, the custodian issued a revised decision.

[6] The decision stated the following:

> I have reviewed the correction requests and the applicable section of PHIPA has been added to each item on the revised, and attached, List of Assessment Issues.
>
> You will note that for most items where we have denied correction Section 55(9)(b) is cited and that some items have been denied under Section 55(8). Corrections where applicable have been noted and completed. I have also included the applicable sections of PHIPA that are cited in our correction decision for each item.

[7] Also during mediation, the complainant's representative explained that her husband who is "non-verbal" was not provided with an opportunity to participate in the assessment" the assessor asked very few questions listed on the RAI HC; and the assessor did not provide an objective professional opinion.

[8] With respect to the questions on the RAI HC, the custodian provided an explanation to the mediator in an email, as follows:

> The interRAI Home Care (HC) is part of the suite of interRAI assessment tools. The interRAI tools are used internationally and across Canada by hospitals, long-term care homes and other health service providers. The interRAI Home Care (HC) (the "interRAI HC") is the standard provincial assessment tool used by all LHINs in Ontario. LHIN care coordinators use the interRAI HC to assess patient needs and eligibility for home and community services. LHIN care coordinators are regulated clinical professionals who receive training on the interRAI to facilitate accurate assessments and consistent outcomes.

> The interRAI HC assessment is not a questionnaire. Therefore, not all of the information recorded in the interRAI HC is based on questions that are asked and then answered by the patient or caregiver in this manner. When assessing a patient, the care coordinator uses a conversational approach to elicit much of the information required to complete the assessment. The care coordinator will directly ask the patient a question and only consider the patient's responses for all interRAI HC sections that are indicated as self-reported, such as self-reported mood, self-reported health, and person's expressed goals of care.
>
> Where information or a score recorded in the interRAI HC is not based on a question that is asked and then answered by the patient or caregiver, the care coordinator uses their training and professional clinical judgement to determine the most appropriate response/score based on all sources of information. Sources of information include communication/interactions with the patient (verbal and non-verbal responses), caregiver(s)/family member(s); observation of the patient in their home environment; and, information from service providers and other health care providers, when available.

[9] The complainant and his representative were not satisfied with the respondent's explanation. They maintain that although the patient/complainant is non-verbal, he is 'uniquely qualified to understand and to answer questions about his own health and disabilities.' The complainant's representative also advised that the opinions and observations shared by herself and the complainant's treating health professional i.e. the Behaviour Consultant, with the assessor during the assessment, were not properly considered by the assessor. The complainant and his representative argue that the assessor failed to act in 'good faith.'

[10] There is no dispute between the parties that the custodian is a "health information custodian" as contemplated in section 3(1) of the *Act*, and that the information contained in the RAI HC contains the complainant's "personal health information" as defined in section 4(1) of the *Act*.

[11] The file was then transferred to the adjudication stage of the complaints process, where an adjudicator may conduct a review. I sought and received representations from the custodian and the complainant's representative. The custodian's representations were shared with the complainant.

[12] The complainant's representations canvass a number of issues, which I have not re-produced in this decision, but I did take them into consideration in making my findings. In addition, the complainant raised an issue with respect to the Statement of Disagreement that he filed with the custodian, which I address below.

[13] For the reasons that follow, I find that the exception to the duty to correct at section 55(9)(b) (good faith professional opinion or observation) applies. The custodian's decision to not make the requested corrections is upheld.

RECORD:

[14] The record at issue is an inter-RAI Home Care Assessment Form (the RAI HC).

DISCUSSION:

[15] The sole issue is whether the custodian has a duty to make the requested corrections under section 55(8) and whether the exception to the duty to correct at section 55(9)(b) apply to any of the information the complainant seeks to have corrected. The purposes of the *Act* are set out in section 1, and include the right, at paragraph (c):

> to provide individuals with a right to require the correction or amendment of personal health information about themselves, subject to limited and specific exceptions set out in [the *Act.*]

[16] Section 55(8) of the *Act* provides for a right of correction to records of an individual's own personal health information in some circumstances. It states:

> The health information custodian shall grant a request for a correction under [section 55(1) of the *Act*] if the individual demonstrates, to the satisfaction of the custodian, that the record is incomplete or inaccurate for the purposes for which the custodian uses the information and gives the custodian the information necessary to enable the custodian to correct the record.

[17] Section 55(9) of the *Act* sets out exceptions to the duty to correct records. In this review the custodian relies on the exception at section 55(9)(b) to deny some of the requested corrections. This section reads:

> Despite subsection (8), a health information custodian is not required to correct a record of personal health information if,
>
> > (b) it consists of a professional opinion or observation that a custodian has made in good faith about the individual.

[18] Read together, these provisions set out the criteria pursuant to which an individual is entitled to a correction of a record of his or her own personal health information. The purpose of section 55 of the *Act* is to impose a duty on health information custodians to correct a record of an individual's personal health information where the record is inaccurate or incomplete for the purposes for which the custodian uses the information, subject to the limited and specific exceptions set out in section 55(9) of the *Act*.

[19] Section 55(10) states that upon granting a request for a correction, the health information custodian shall make the requested correction by recording the correct

information in the record and striking out the incorrect information in a manner that does not obliterate the record. There is no right in the *Act* to have the incorrect information in a record removed, replaced, or amended in such a manner that the incorrect information is completely obliterated—it must remain legible.

[20] Therefore, even if the IPC were to order that information in a record be corrected, the order can only require a custodian to strike out the incorrect information in such a way that the original entry remains legible.

[21] In this case, the custodian asserts that the exception to the duty to correct at section 55(9)(b) applies to all or parts of the records.

Duty to Correct in Section 55(8)

[22] Section 55(8) imposes a duty on a health information custodian to grant a request for correction if certain conditions are met. In particular, section 55(8) requires that the individual making the request for correction:

1. demonstrate, to the satisfaction of the custodian, that the record is incomplete or inaccurate for the purposes for which the custodian uses the information, and
2. give the custodian the information necessary to enable the custodian to correct the record.

Representations

[23] The custodian submits that it considered the request for correction to the record at issue and made appropriate corrections to certain information under section 55(8) of the *Act*, where the complainant's representative demonstrated that the information was incomplete or inaccurate for the purpose of the home care assessment. The custodian also argues that the corrections it made to the RAI HC had no impact on its decision that the complainant was not eligible for increased hours of service. By way of background, the complainant requested an internal review of the decision not to increase his hours of service. In response, the custodian conducted an internal review of this decision, holding an internal appeals committee and the custodian upheld its decision to not increase the complainant's hours of service.

[24] The complainant submits that the custodian has the ongoing responsibility to assess and re-assess his requirements for home care and his eligibility for community services, and that it should have used the RAI HC for the following purposes:

- to determine his home care requirements,
- to determine his eligibility for services,
- to create a plan of service, and
- to calculate the amount of service included in the plan of service.

[25] The complainant goes on to argue that the custodian has been obscure in describing the purpose for which the RAI HC assessment is used, stating that it has been less than transparent in providing information publicly about their assessment tools and processes and how service levels are granted to patients. For example, the complainant submits that the custodian stated that the use of standard assessment tools allow it to make consistent service decisions based on a patient's needs, but later stated that the corrections it made to the assessment had no impact on its decision regarding the provision of services. The complainant's position is that these two statements are contradictory, but the custodian does not elaborate on why that is. In addition, the complainant submits that the custodian used the assessment process to reduce his eligibility and is likely to use this assessment as the basis for future ones, given that information from a previous assessment was simply copied into the current assessment by the custodian.

[26] In addition, the complainant submits that the custodian is the gatekeeper for services he desperately needs in order to continue to live at home, and that it has been intractable regarding making corrections to factors within the home care assessment that affected his level of care and safety. The complainant's position is that the custodian did not accurately determine his home care requirements during the assessment.

[27] The complainant also advises that, contrary to the custodian's position, this complaint is not about the custodian's service level decisions. Any decisions about service levels, the complainant submits, fall under the jurisdiction of the Health Services Appeal and Review Board and the complainant has not pursued an appeal with that board.

Analysis and findings

[28] In PHIPA Decision 36, Adjudicator Jennifer James examined the relationship between and the application of, sections 55(8) and 55(9)(b). In doing so she stated:

> There is no question that the accuracy of records containing personal health information is essential to the effective provision of health care. However, the correction provisions of *PHIPA* are limited by the requirement that the individual requesting the correction "demonstrate to the satisfaction of the custodian, that the record is incomplete or inaccurate for the purposes for which the custodian uses the information." The accuracy of the information that is requested to be corrected is therefore connected to the purposes for which the information is used.

[29] She also found that not all personal health information contained in records held by health information custodians needs to be accurate in every respect to the extent that the health information custodian is not relying on the information for a purpose relevant to the accuracy of the information.

[30] The complainant's position is that the "inaccurate" information in the RAI HC was

relied upon by the custodian in making its decision regarding the hours of care he would receive. The custodian's position is that it made the requested corrections to the RAI HC under section 55(8) that it was satisfied were inaccurate or incomplete, and that section 55(8) did not apply to the remaining information at issue. Instead, the custodian's position is that this information falls within the exception in section 55(9)(b), which is discussed below.

[31] As previously stated, in order for section 55(8) to apply the complainant must first demonstrate, to the satisfaction of the custodian, that the record is incomplete or inaccurate for the purposes for which the custodian uses the information. The parties are diametrically opposed in their positions and there is conflicting evidence on the elements of section 55(8).

[32] In the circumstances, I decline to make a finding on section 55(8) because I find that even if the complainant had met the initial onus under section 55(8), the exception in section 55(9)(b) applies.

The Section 55(9)(b) Exception

[33] The purpose of section 55(9)(b) is to preserve "professional opinions or observations," *accurate or otherwise*, that have been made in good faith. This purpose is based on sound policy considerations, including the need for documentation that may explain treatments provided or events that followed a particular observation or diagnosis. This approach is consistent with the approach taken to similar provisions in other jurisdictions.

[34] Where a "professional opinion or observation" is involved, section 55(8) does not give a right to request a correction that amounts to a substitution or change to the custodian's "professional opinion or observation," unless it can be established that the professional opinions or observations were not made in good faith. Moreover, a request for correction or amendment should not be used to attempt to appeal decisions or professional opinions or observations with which a complainant disagrees, and cannot be a substitution of opinion, such as the complainant's view of a medical condition or diagnosis.

[35] Where the custodian claims that section 55(9)(b) applies, the custodian bears the burden of proving that the personal health information at issue consists of a "professional opinion or observation" about the individual.

[36] However, as explained below, once the custodian has established that the information qualifies as a "professional opinion or observation," the onus is on the individual seeking a correction to establish that the "professional opinion or observation" was not made in good faith. Therefore, if the exception applies, it does not matter whether or not the individual has met the onus in section 55(8) because even if the complainant satisfies this office that the information is incorrect or inaccurate under section 55(8), a finding that the exception in section 55(9)(b) applies means that the custodian does not have a duty to make the corrections.

[37] Section 55(9)(b) also involves a two-part analysis. The first question is whether the personal health information in the record is a "professional opinion or observation." The second question is whether the "professional opinion or observation" was made "in good faith."

[38] In order for section 55(9)(b) to apply, the personal health information in the records must qualify as either a "professional opinion" or a "professional observation." Only those observations and opinions that require a health information custodian or an agent to exercise or apply special knowledge, skills, qualifications, judgment or experience relevant to their profession should be defined as "professional observations" or "professional opinions" within the meaning of section 55(9)(b) of the *Act*.

[39] Court decisions have stated that a finding that someone has not acted in good faith can be based on evidence of malice or intent to harm another individual, as well as serious carelessness or recklessness. The courts have also stated that persons are assumed to act in good faith unless proven otherwise. Therefore, the burden of proof rests on the individual who seeks to establish that a person has acted in the absence of good faith to rebut the presumption of good faith.[1]

[40] Accordingly, in the context of section 55(9)(b) of the *Act*, the burden rests on the individual seeking the correction to establish that the health information custodian did not make the professional opinion or observation in good faith.

Representations

[41] The custodian submits that the assessor is a Registered Social Worker with the knowledge, skills, qualifications and experience to form the professional opinions and made the professional observations recorded in the assessment. The assessor has been assessing LHIN patients using the RAI tools for 14 years and has been trained and educated on the use of the RAI assessment tools and has completed regular RAI competency evaluations.

[42] The custodian goes on to state:

> The inter-RAI-Home Care (HC) tool is used for in home assessments by LHIN Care Coordinators across Ontario. In all cases, the assessment process involves self-reporting by the patient or reporting by the patient's caregiver/family. Reported information about the patient's health, medical conditions and care goals is recorded by the Care Coordinator. Where information or a score recorded in the inter-RAI-HC is not based on a question that is asked and then answered by the patient or caregiver/family, the Care Coordinator uses their training and professional clinical judgment to determine the most appropriate response/score based on all sources of information. Sources of information may include communications/interactions with the patient (verbal and non-verbal

[1] *Finney v. Barreau du Québec,* [2004] 2 SCR 17, 2004 SCC 36 (CanLII).

responses); observation of the patient in their home environment; and, information from service providers and other health care providers.

[43] With respect to the requested correction, the custodian submits that it consists of the professional opinions and observations of the assessor at the time of the assessment and that the custodian provided the complainant with detailed explanations for assessment scores and that rationale for not making the corrections.

[44] Turning to whether the professional opinions and observations were made in good faith, the custodian submits that there are no reasonable grounds to conclude that these professional opinions and observations in the assessment were not made in good faith. The custodian's position is that an allegation of bad faith is akin to an allegation of dishonesty or intent to deceive, and it strongly denies the allegations of bad faith and malicious intent on the part of the assessor. It further denies the complainant's allegations that the complainant's opinion was not considered during the assessment, that there were deliberate omission of facts, fabrication of reports, arbitrarily recorded scores, distortion of information or attempts to limit input from the complainant's spouse or anyone else.

[45] Concerning the issue of a Statement of Disagreement, the custodian submitted to the IPC a letter it sent to the complainant's representative following its decision regarding the correction request. In that letter, the custodian advised the complainant's representative that the Statement of Disagreement which the complainant had provided to it would be attached to the complainant's record and would be disclosed if and when the assessment is disclosed and that any further Statements of Disagreement would be attached to the complainant's file.

[46] The complainant advises that he has narrowed down his complaint to three corrections, which he submits are factors that the custodian should have relied on in order to assess his needs and make decisions about his eligibility for service and the amount to include in his plan of service.

[47] The three corrections requested are the following:

1. His "self-reported mood." Prior to the assessment, the custodian wrote to the complainant making it clear that the only acceptable evidence for this assessment factor would be a direct response from the complainant. The custodian suggested that the complainant use the self-reported questions it had outlined to prepare for the assessment. The complainant did so, using his assistive communication tool. The assessor did ask the "self-reported" mood behaviour questions, but according to the complainant, the assessor changed the complainant's answers. For example, he answered "3" for pleasure in life, but the assessor wrote "0" which is a higher score for pleasure. As another example, the complainant submits that the assessor denied him the opportunity to have his depression rating scale downgraded from a "7" to a "6." According to the complainant, the custodian's specific response to the correction request

was that the time frame for the question regarding "self-reported mood" is the last 3 days and that the complainant provided a response during the assessment that would be the most valid response for that time frame. It is the complainant's position that the assessor's ratings were made with malicious intentions.

2. Wandering. The complainant advises that he has an impulse to escape the bed, the chair and the house with or without his wheelchair. He submits that during the assessment, his representative provided the assessor with a list of 16 falls that took place in the 8 months prior to the assessment, and that the majority of the falls were due to wandering. The custodian also submits that his representative provided further information to the assessor about the injuries and "dire consequences" of the falls associated with his wandering. According the complainant, the assessor marked a "0" for the wandering category, i.e., that wandering was not present. As a result, the custodian stated that there was not enough evidence to support "coding" for wandering. According to the complainant, the custodian's specific response to the correction request was that wandering behaviour should be differentiated from purposeful movement such as a hungry person searching for food, and does not include pacing back and forth, which is not considered wandering, and that based on the information provided during the assessment and the complainant's responses, there was not enough evidence to support coding for wandering. The complainant's position is that no amount of evidence would have been sufficient for the custodian in this regard and that the only plausible explanation is that the assessor acted in bad faith by deliberately mischaracterizing the risk of harm to him.

3. Eating. The complainant submits that at the time of the assessment, the assessor assigned a score of "3" which meant that he would require limited assistance with help required on some occasions. Subsequent to the request for corrections, the complainant submits, the custodian upgraded the score to "2" which means supervision with cueing is required. The complainant argues that this correction was the opposite to what was requested. According to the complainant, the custodian's specific response to the correction request was that the description provided for breakfast includes set up and supervision assistance and that, during the assessment, the assessor observed and confirmed that the complainant was able to eat his breakfast on his own, with set up and supervision. As such, the custodian concluded that the coding should be corrected to supervision. The complainant's position is that the custodian and the assessor were being vexatious and misused their power. The complainant requests that the IPC correct this factor back to the assessor's opinion at the time of the assessment.

[48] Finally, with respect to his Statement of Disagreement, the complainant advises

that he has informed the custodian that he will postpone filing a revised Statement of Disagreement until after this complaint has been adjudicated. In addition to the response the custodian provided regarding the original Statement of Disagreement, namely that it would attach it to the assessment and would disclose it if and when the assessment is disclosed, the complainant requests that the following conditions also apply to the revised Statement of Disagreement:

- the custodian will provide a copy of it to any member of the Central LHIN Appeals Committee who were granted access to the original assessment, including the Care Coordinator who assessed him and the Risk Manager who edited the custodian's response to the corrections request, and

- the custodian will provide him with a copy of the revised RAI HC when the corrections are made to it.

Analysis and findings

[49] As previously stated, section 55(9)(b) involves a two-part analysis. The first question is whether the personal health information in the record is a "professional opinion or observation." The second question is whether the "professional opinion or observation" was made "in good faith." The burden rests on the individual seeking the correction to establish that the health information custodian did not make the professional opinion or observation in good faith.[2]

[50] I have carefully considered the representations of the parties, as well as studied the record itself. I find that the three areas of personal health information which the complainant seeks to be corrected consist of the professional opinion or the professional observation of the assessor, who is a regulated health professional. I also note that these professional opinions and observations were made as a result of this regulated health professional's assessment of the complainant, which was conducted in person by her and that they involved the exercise or application of special knowledge, skills, qualifications, judgment or experience relevant to her profession as an assessor. In my view, the complainant's request to correct this information seeks to substitute or rewrite the assessor's opinions or observations contained in the RAI HC.

[51] Turning to whether the professional opinions and observations were made in good faith, as previously noted, in PHIPA Decision 37, Adjudicator Jennifer James found that the burden rests on the individual seeking the correction to establish that the health information custodian did not make the professional opinion or observation in good faith. Based on my consideration of the information before me, I find that this information does not rebut the presumption of good faith in the circumstances of this complaint. In arriving at this decision, I took into account the contents of the record which describe the circumstances in which the complainant sought a home assessment from the custodian, along with the absence of evidence from the complainant suggesting that the custodian acted in bad faith in writing the content of the RAI HC.

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[2] See, for example, PHIPA Decision 37.

While the relationship between the complainant, his representative and the assessor may or may not have entailed disagreements, I find that there is no evidence of malice, intent to harm, serious carelessness or recklessness on the part of the custodian in writing the content of the RAI HC. Because the complainant has not met his onus to show that the custodian's professional opinions or observations were made in "bad faith," I find that the exception at section 55(9)(b) applies in the circumstances of this complaint. Accordingly, I find that the custodian does not have a duty to correct the record under section 55(8).

[52] Lastly, with respect to the Statement of Disagreement, whether original or revised, sections 55(11) and (12) of the *Act* provide that where a correction request has been denied, the individual who made the request may prepare a concise statement of disagreement that sets out the correction that the health information custodian has refused to make. It also requires that a health information custodian attach the statement of disagreement to the relevant record of personal health information (in this case the RAI HC), and disclose the statement of disagreement whenever the custodian discloses the record to which the statement of disagreement relates. It also requires a health information custodian to make all reasonable efforts to disclose the statement of disagreement to any person who would have been notified, at the request of the individual, of a correction request that was granted regarding a record that had been disclosed to that person.

[53] The complainant has requested that the custodian provide a copy of the revised Statement of Disagreement to any member of the Central LHIN Appeals Committee who were granted access to the original assessment, including the Care Coordinator who assessed him and the Risk Manager who edited the custodian's response to the corrections request. As previously stated by the custodian, it conducted an internal review of the assessment, at the complainant's request. In doing so, I find that the Care Coordinator and the Risk Manager, who are employees of the custodian, were acting as the custodian's agents and "used" the RAI HC within the meaning of section 29 of the *Act*.

[54] The requirements of section 55(11) set out above refer to the *disclosure* of the record to which the statement of disagreement relates and, by extension, to the disclosure of the statement of disagreement itself. In my view, because the RAI HC was not disclosed to the Care Coordinator and the Risk Manager, but rather "used" by them, there is no requirement under section 55(11) that the statement of disagreement, revised or not, be provided to them.

[55] The complainant has also requested that the custodian provide him with a copy of the revised RAI HC when the corrections are made to it. Given my finding that the custodian is not required to make the requested corrections, I do not need to consider this request.

ORDER:

For the foregoing reasons, no order is issued.

Original Signed by: April 21, 2022

Cathy Hamilton
Adjudicator