ClinicalConnect Privacy Pre-Assessment

To assess your organization's eligibility to become a ClinicalConnect Participant, you are required to complete this Privacy Pre-Assessment. The Privacy Pre-Assessment provides background information on your organization to help determine if you meet the criteria required to become a Participant in ClinicalConnect. This Pre-Assessment is considered by the ClinicalConnect Program Office as part of your overall submission.

Please complete this form and return to privacy@clinicalconnect.ca. If you require assistance with the questions, please contact the ClinicalConnect Program Office at privacy@clinicalconnect.ca or 905-577-8270 ext. 9.

General Information

1. Provide the legal name of your organization. This is the name documented on your previously-submitted Participation Agreement.

2. Provide a high-level description that outlines the primary purpose of your organization.

3. A) Describe the various clinical service(s) offered **directly** to your patients/residents.

B) Complete the table below, listing one role per line. If additional rows are required, contact the ClinicalConnect Program Office.

Identify the role(s) in your organization who would use ClinicalConnect.	Provide the number of individuals in each role who could perform the service described.	Identify if the role is a Regulated Health Service Provider (Yes or No).	What information from ClinicalConnect do you envision being used by the role to perform service?	How do you envision these individuals accessing the information in ClinicalConnect?	How do these individuals currently obtain this information?	Do you obtain patients' express consent to gain access to this information for provision of their care (Yes or No).
Example: RPN	***2***	***Yes***	***Microbiology results***	***Weekly***	***Faxed from outpatient lab***	***No***
Example: Physician	***1***	***Yes***	***Discharge Meds***	***Once***	***Faxed from hospital***	***No***

C) Are all of the staff/roles identified above employed by your organization?

☐ Yes, all of the above staff/roles are employed by our organization.

☐ No, all of the above staff/roles aren't employed by our organization. If no, indicate in the box below whether there is a contract in place with those who are not employed by your organization. Explain their relationship to your organization and what processes are in place to ensure:

a) Privacy training is conducted annually.
b) Good standing with Regulated Health Professions' Colleges.
c) Use of the ClinicalConnect Portal will be restricted to work within your organization and not for other work assignments.

4. Does your organization rely on Implied (assumed) consent based on your information practices or Express (written) consent for use, access and disclosure of personal health information for the purpose of providing health care or assisting in the provision of health care?

Select your model of consent

Access to Personal Health Information in ClinicalConnect

5. According to the following definition of healthcare, indicate which activities you are planning to use ClinicalConnect for. Healthcare means "any observation, examination, assessment, care service or procedure that is done for a health-related purpose" and that: *(Select all that apply to the services you provide to your patients)*

☐ Is carried out or provided to diagnose, treat or maintain an individual's physical or mental condition,

☐ Is carried out or provided to prevent disease or injury or to promote health, or

☐ Is carried out or provided as part of palliative care,

and includes:

☐ The compounding, dispensing or selling of a drug, a device, equipment or any other item to an individual, or for the use of an individual, pursuant to a prescription, and

☐ A community service that is described in subsection 2(3) of the Home Care and Community Services Act, 1994 and provided by a service provider within the meaning of that Act; ("soins de santé")

For questions 6-8, refer to the information below that describes the various Health Information Custodian (HIC) types.

3.(1) *In this Act,*

"health information custodian", subject to subsections (3) to (11), means a person or organization described among others, in one of the following paragraphs who has custody or control of personal health information as a result of or in connection with performing the person's or organization's powers or duties or the work described in the paragraph, if any:

1. *A health care practitioner or a person who operates a group practice of health care practitioners.*
2. *A service provider within the meaning of the Home Care and Community Services Act, 1994 who provides a community service to which that Act applies.*
4. *A person who operates one of the following facilities, programs or services:*
    - i. *A hospital within the meaning of the Public Hospitals Act, a private hospital within the meaning of the Private Hospitals Act, a psychiatric facility within the meaning of the Mental Health Act or an independent health facility within the meaning of the Independent Health Facilities Act.*
    - ii. *A long-term care home within the meaning of the Long-Term Care Homes Act, 2007.*
    - iii. *A retirement home within the meaning of the Retirement Homes Act, 2010.*
    - iv. *A pharmacy within the meaning of Part VI of the Drug and Pharmacies Regulation Act.*
    - v. *A laboratory or a specimen collection centre as defined in section 5 of the Laboratory and Specimen Collection Centre Licensing Act.*
    - vi. *A home for special care within the meaning of the Homes for Special Care Act.*
    - vii. *A centre, program or service for community health or mental health whose primary purpose is the provision of healthcare.*
5. *A medical officer of health or board of health within the meaning of the Health Protection and Promotion Act.*

6. Describe the processes your organization has in place to ensure that the Regulated Health Professionals rema in good standing with the respective Regulated Health Professions' Colleges.

Note: If you are a HIC under section 3. (1) 2., Service Provider within the meani of the *Home Care and Community Services Act, 1994),* provide a copy of Section 5 of your Service Agreement with the LHIN.

7. If you are an organization that qualifies as a HIC under section 4. vii, a entre, p ram service for community health or mental health whose primary purpose is the provision of healthcare, indicate w ich types o comm ity services your organization provides. *(Select all that apply)*

- ☐ Community Support Services: e.g. meal and transportation service nd adult d y programs
- ☐ Homemaking Services: e.g. housekeeping and shop
- ☐ Personal Support Services e.g. personal hygie activities.
- ☐ Professional Services including Nursing, Occupati l Therap Physiotherapy, Social Work, Speech Language Pathology and Dietetic Services.

8. If your HIC type is a **Retirement H e unde PH A,** provide the following information:

A) License number:

B) License status (e Issu , Issue wit conditions, Terminated):

C) Describe the care services provided to your residents:

D) Describe any nursing services provided to your residents:

E) Are there charges to your residents for nursing services that are provided on[illegible]ar basis?

F) Specify how your organization obtains advice on matters of care.

☐ Medical Director on site

☐ General Practitioners in the community

9. A) If your HIC type is a **Group Practice under PHI[illegible]** how many [illegible]ealth care practitioners currently provide patient care as part of this practice?

B) Please identify if you have in place a wr[illegible]en [illegible]ement s[illegible]ating the legal entity named in Question 1 above has the authority to act as the health information custodian (HIC) [illegible]n beh[illegible] the health care practitioners working in the practice, for example a "PHIPA Agency Agreement":

☐ No ☐ N[illegible] - Practice co[illegible]ists of a single, non-physician health care practitioner.

☐ Yes. If yes, please list all leg[illegible]ities (ind[illegible]iduals, corporations, etc.) that are part of this written agreement:

Privacy

10. Does your staff have access to any internal systems that hold personal health information?

☐ No

☐ Yes. If yes, please describe the type of personal health information that staff have access to in your internal systems.

11. As required under Section 16 of PHIPA, an organization must make available a written public statement (Privacy Notice) that provides a general description of the organization's information practices such as uses of personal health information (e.g. to provide healthcare or assist in the provision of healthcare, how to contact the Privacy Contact, etc.).

Include a copy of your organization's posted Privacy Notice with your completed Privacy Pre-Assessment.

Insurance

12. As outlined in Section 13 of the ClinicalConnect Terms & Conditions, all Participant Organizations must have:

a. general liability insurance with a minimum of five million dollars ($5,000,000.00) coverage for any one occurrence

In addition, Participant Organizations must be able to provide, upon request, proof it has coverage for the following:

b. coverage for damages for breach of privacy, in relation to Personal Health Information;

c. personal injury;

d. cross-liability; and

e. contractual liability.

Please select the most appropriate answer.

☐ Yes, our Certificate of Insurance includes all of the above. **Please provide a copy of your organization's COI with your completed Pre-Assessment.**

☐ No, our Certificate of Insurance does not currently include all of the above, but the organization's insurance coverage will be updated to be compliant pending the organization's conditional approval as a ClinicalConnect Participant.

☐ No, our Certificate of Insurance does not include all of the above and our organization is unable to comply with the requirements. I understand this will result in our organization not being approved as a Participant in ClinicalConnect.

13. As required under PHIPA, each organization must have a named privacy contact person (Privacy Contact). List the name, privacy credential (if any), and the contact information for your organization's Privacy Contact who will ensure compliance with PHIPA on behalf of your organization and undertake the privacy responsibilities outlined in the Participation Agreement and associated Terms & Conditions. This should be the same individual identified in your previously-submitted Participation Agreement.

Privacy Contact Information

First Name	
Last Name	
Job Title	
Street Address	
Suite / Unit / Floor	
City/Town	
Postal Code (e.g. K1A0B1)	
Business Telephone (e.g. 1234567890)	
Business Telephone Extension	
Business Fax (e.g. 1234567890)	
Business Email Address	
Privacy Credential(s), if applicable	

Attestation:

I, _____ on behalf of _____

(Name of Privacy Contact) **(Name of Organization)**

have provided the information above, in consideration of becoming a Participant of ClinicalConnect.

Signature	
Date	

Option to sign this form with a Digital ID/Signature may not be available depending on your version of Adobe.