



Legislative Assembly of Alberta

The 27th Legislature
Second Session

Standing Committee
on
Health

Bill 52, Health Information Amendment Act, 2009

Monday, May 11, 2009
6:30 p.m.

Transcript No. 27-2-4

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Standing Committee on Health

Horne, Fred, Edmonton-Rutherford (PC), Chair
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Denis, Jonathan, Calgary-Egmont (PC)
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Also in Attendance

Rogers, George, Leduc-Beaumont-Devon (PC)
Woo-Paw, Teresa, Calgary-Mackay (PC)

Participants

Allen Ausford	Physician and Netcare Demonstrator
Mark Brisson	Acting Assistant Deputy Minister
Martin Chamberlain	Acting Assistant Deputy Minister
Linda Miller	Deputy Minister

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[Mr. Horne in the chair]

The Chair: Good evening, colleagues. I'd like to call this meeting of the Standing Committee on Health to order. We have a number of guests, and we'll introduce them in just a moment. To begin, perhaps we'll just ask members of the committee and other MLAs in attendance and LAO staff to introduce themselves.

Ms Pastoor: Thank you. Bridget Pastoor, Lethbridge-East, deputy chair.

Mr. Rogers: George Rogers, Leduc-Beaumont-Devon, not a member of the committee.

Mr. Dallas: Cal Dallas, Red Deer-South.

Mr. Denis: Jonathan Denis, Calgary-Egmont.

Mr. Vandermeer: Tony Vandermeer, Edmonton-Beverly-Clareview.

Ms Dean: Shannon Dean, Senior Parliamentary Counsel.

Ms LeBlanc: Stephanie LeBlanc, legal research officer with the Legislative Assembly Office.

Dr. Massolin: Philip Massolin, committee research co-ordinator, Legislative Assembly Office.

Ms Blakeman: Hello. Laurie Blakeman. Welcome to my fabulous constituency of Edmonton-Centre. I'm a subbed-in member for Dr. Taft.

Ms Friesacher: Melanie Friesacher, communications consultant, Legislative Assembly Office.

Mr. Quest: Dave Quest, Strathcona.

Ms Woo-Paw: Good evening. Teresa Woo-Paw, Calgary-Mackay, not a member of the committee.

Mr. Fawcett: Kyle Fawcett, Calgary-North Hill.

Mrs. Sawchuk: Karen Sawchuk, committee clerk.

The Chair: I'm Fred Horne, MLA for Edmonton-Rutherford and chair of the committee.

Seated at the far end of the table is Linda Miller, deputy minister, Alberta Health and Wellness. Linda, would you like to introduce the two people accompanying you?

Ms Miller: Yes, I would. To my immediate right is Gail Almond. She's with the electronic health record deployment team at Alberta Health and Wellness. To her right we have Dr. Allen Ausford, who is a family practice physician in the province of Alberta, here in Edmonton, and an avid user of the electronic health record. He is here to demonstrate the product to the committee.

The Chair: Okay. Thank you very much, Ms Almond and Dr. Ausford, for being here. We'll get to the presentation in just a few moments. We just have a couple of items of business to attend to.

We're just being joined by Dr. Sherman. Would you like to introduce yourself for the record.

Dr. Sherman: Raj Sherman, Edmonton-Meadowlark.

Ms Notley: Rachel Notley, Edmonton-Strathcona.

The Chair: Mr. Olson, if you'd just like to introduce yourself as well.

Mr. Olson: Verlyn Olson, Wetaskiwin-Camrose.

The Chair: I believe we have everyone here now. Mark Brisson from Alberta Health and Wellness is here as well. Welcome.

Mr. Brisson: Hello.

The Chair: We'll just move to the approval of the agenda, then. Can I have a motion, please, to approve the agenda? Mr. Fawcett. Any discussion? Changes? Those in favour? Opposed, if any? Carried. Thank you.

Item 3, review and approval of minutes. We have a number of sets of minutes here to deal with this evening, and I'll just go through them in order. These were posted on the website, and they're fairly short, as you know. They're primarily just a quick record of the meetings we had during estimates and then one prior to that time. The first item here is the minutes of the meeting of February 4, 2009. May I ask for a motion to approve the minutes? Mr. Dallas. Any discussion? Changes? Those in favour? Opposed, if any? That's carried. Thank you.

Minutes of the meeting of the committee held April 15, 2009. Can I ask for a motion, please, to approve the minutes? Mr. Quest. Thank you. Discussion? Any changes? Those in favour? Opposed? That's carried. Thank you.

Next are the minutes of our meeting held May 4, 2009. Someone care to move adoption? Mr. Olson. Any discussion? Changes? Seeing none, those in favour? Opposed, if any? Carried. Thank you.

Finally, the minutes of our meeting held May 6, 2009. Someone care to move adoption of those minutes? Mr. Olson. Any discussion or changes to these? Seeing none, those in favour? Opposed, if any? That's carried. Thank you very much.

We're going to move now to a presentation and an actual demonstration of Alberta Netcare, the provincial electronic health record, by officials of the Department of Health and Wellness. Dr. Ausford is going to lead the presentation. We have up to about an hour for this. If I could suggest it, Dr. Ausford, if you'd like to sort of go through the demonstration and then leave us some time for questions at the end, I'm sure we'll have several for you. I think Bridget and I will move off to the side.

Dr. Ausford: Thank you very much. What I was going to do is go through a demonstration first, and then I actually have some PowerPoint slides that'll go through a little bit of detail. We find that it's usually better to get a feel of the application first, and then we can go through some of the things that are going on in the background and talk through it.

This is a tool that I use on a daily basis. I think it's used in emerg quite commonly on a daily basis as well. It's something that we use to aggregate information together when we're trying to care for patients. It's been around for a number of years. It is a very popular tool. I'll show you some of the statistics in terms of its utilization as well.

What we're on right now – I apologize if the screen is a little bit small there – is the page that you arrive to once you have gone through a log-in. I'll show you a little more detail about the steps you have to go through to log in when we're on the slide set. Basically, what you see here is the ability to look up a patient.

What I want to emphasize with this is that the screen you're seeing right now is what a physician sees when they log on. It's a different screen if you have a different role. Our roles are based on what the requirements are in terms of the information you should be allowed to see. If this was a receptionist, they would not be able to do a lookup on a patient by using a first and a last name. They would have to have it on a list that they already had populated that was, say, an appointment list within a facility.

So when we're on here, what you'll see is a way of doing a lookup using a number of identifiers, whether they have different hospital medical record numbers or their actual health number, or you can do a lookup on the basis of their name as well. Along this side you'll see that we have some tabs. One is called favourites. What I'm going to do is I'm going to just go to what's called recently viewed patients. This will actually show you patients that previously were used.

One other important part of this is that what you're seeing is not live patient data. You're seeing our training database. The training database is made up of information that has been scrambled so that it is not identifiable to any particular patient. You'll see by virtue of the name – Sally Lung, Jerry Thrombosis – that these are mocked-up patients. So you may, actually, when we're looking through this, see a male patient with a pregnancy test on it. That's because it's a training database. Okay?

If we look along here, you'll see that on the basis of these lists I can go into any patient. What I'm going to do is I'm just going to take you for a little tour looking at a couple of patients. We're going to start with William Brown. By clicking on here, we'll actually go into this patient's view. What you're seeing is a portal that is looking at a whole bunch of different data sources, and it's pulling all the information together for us to see. It's organized along this side here into different types. So pathology, blood bank, chemistry, coagulation, diagnostic imaging, which is X-rays, discharge summaries: all of those things are coming from different locations and aggregating together for us to see on this patient.

What you'll also see is their demographics here. In fact, if we click the "more" button here, you would actually go into a bunch of additional information in terms of demographics. If they change their name, if their health number had been changed, all their other numbers that are used are sitting behind this, so you can basically find a patient when you need to or look at previous data. Their primary address is here. Emergency contact information is here as well if we're getting hold of them.

If we go in here and just look at an example of going, say, to hematology, what you'll see are complete blood counts. This is a standard blood test that we use. You'll notice that they're in orange. It actually looks like red, but we use orange because of red-green colour blindness. That means that there's something abnormal about it. When I drill into this, you'll see that they have a slightly low hemoglobin – the normals are over here – and you can see the other parameters that are there.

6:40

We can actually take this information and we can look at it both as a single result, or we can look at it in a cumulative fashion. So what I've done now is I've gone to looking at all of their CBCs that have been done, and I can trend these things as well. This is a very valuable tool when we're trying to figure out abnormal results,

especially if we're cross-covering. Or, for example, in emergency when a patient arrives and you don't know the patient, it's nice to know what the trending has been over a number of results because you may sometimes overreact to a very slight abnormality. If you'll look here, the normal is 120, 119, pretty close to normal. If I didn't know this patient, if I had this single result only, I may order a thousand dollars' worth of tests to investigate something, whereas when I look here, I can see that – you know what? – it's been hovering around that level for a while, and I may be able to find that other people have already investigated that. So I won't go to the detail that I need to because of the ability to trend it.

You can actually go in here as well, and from both a teaching perspective in terms of patient teaching and in terms of interns and residents or just for trending by the physician, you can graph this information as well. Although this is the hemoglobin, the standard thing I like to demonstrate with this – let's pretend this is a patient with cholesterol. They came in; their cholesterol was elevated. We gave them the talk; it came down. Christmas came; it went back up. That sort of thing. It's the kind of thing where we can make use of this from a patient education perspective.

If we go further down, we can look at some other areas, chemistry for example, where we can sort. What you'll see is that we have different indicators that are showing up here. This is a thyroid result, and you'll see a question mark here. Basically, what that tells us is that there's a bit of a demographics mismatch. We're not positive that this is on the right patient, but we think it is, so we want to alert the user to that information. We've had a lot of discussion amongst clinicians, and they feel it's important to still show this information because most of the time it is correct information on the patient. But when you actually go in, it will tell you what the issue is in terms of where it doesn't quite match, and then you can make your best judgment with that.

As well, if you look over here, you'll see a C that stands for a critical result; it's critically abnormal. When you look in here, you'll see where the result was if it's highly critical and an issue where you want to pay attention to it right away.

If we close this down, what you'll also see is that we have certain things that are scanned into the record as well rather than digital information, so cardiograms for example, where you can see the cardiogram itself. Very, very important thing to see a previous cardiogram when somebody rolls into your office with chest pain. When you see a slight abnormality, you want to know: is this new; is this old? It makes a big difference in what you do with the patient. Emergency records are also scanned in, so you can actually see if they were in emerg the day before and show up in your office afterwards. You can see the results as far as that goes, too.

We also have reports. Here's an example of an operative procedure. We also have summary reports as well. Basically, this is a community care profile. Home care nursing posts profiles as well so that people know what is going on in the community.

With this tree it can be organized as you see it right now, on the basis of type, or in fact we can organize it in different ways. We can organize it by date, and this is actually the way I prefer to use it because I'm looking at it all the time. I can see the latest result regardless of which category it falls into. As well, we can order it by status – normal, abnormal, or there is for reports an unknown status, because in a text-based report we don't know if it's normal or abnormal – or by author. If they said, "I saw a specialist the other day, and he ordered a bunch of tests," I can very quickly go to what the specialist ordered, see those tests as a result. Or we can actually look at the source that it was ordered by. Remember that we have information coming in from a number of repositories and also from a number of regions: Calgary, the rural areas, and Edmonton.

As well, if I go back to the home page, we can configure this home page so that we can show other things in these panels as well, so we have the capability of generating lists. One of the lists that you saw was the recently viewed patient list. If you were to look at my set-up that I have on here, there are actually two things that sit on this. One is a listing of patients that have declared that I'm their family physician and where they are within the system. This morning when I looked at Netcare, I could see that I had a patient in emergency at the Royal Alex hospital even though I work out of the Misericordia. I could see that I had a patient getting a CT scan at a different hospital. Somebody was attending a lipid clinic at yet another site. So I have a good view of what's going on with my practice in terms of what's happening with the patients, and I can track those things. Even if I'm not the one caring for them, I can pull that information together.

There are lots of instances where, in fact, we will see that a patient is in emerg and we know the patient well. We'll pick up the phone, and we'll call, and we'll let them know that: "By the way, this is the third time they're going in. Usually when they get sent home, they get sent home on this drug, and we end up stopping it because of the following, so please don't do that." Those kinds of things. So communication is facilitated in a big way in terms of knowing what's going on with the patients.

We have the ability as well to generate lists on the basis of a physician or a care group. So when I'm on call on the weekend, I can pull up the listing of all of the physicians in our clinic that have patients admitted to the Misericordia hospital when I make rounds, and I can track them. What's even more important than that is that when I get the phone call at 3 in the morning from one of the wards about one of my partner's patients, I can very quickly find the information that I need to make a much better decision. Or if, in fact, the resident or the intern has ordered an X-ray on them, I can actually view the X-ray through this tool and see what's going on literally at home. So you can make quick decisions from that perspective as well.

There are all kinds of other ways of organizing your lists. You can do it by care group. You can do it by units. So if you work on a specific unit, you can just have, say, the ICU show up. If you're a cardiologist and you have patients scattered over a number of wards, you can aggregate it by cardiology patient type as well. It's a very useful tool for generating patient lists as well.

We also have resources in terms of links. You'll notice that Alberta Health and Wellness is the first link on here in terms of getting information. If we go back to our recently viewed patients, I'm just going to flip to Edward Black. What I want to show you with Edward Black is that over and above what you've seen here in terms of all of the information we have, we also have a series of icons across the top. This icon is the basic load. We load about 200 pieces of information initially, and then you can actually do a larger load with this. That's how we make sure that the system is responsive and fast.

We can also take and aggregate all of their data together in a single flow sheet. Basically, what you'll see is all of their results come together, where we can trend in one big picture. A very, very useful tool in terms of looking at the big picture. Also a very useful tool sometimes in sending consults out, where we aggregate all of that information for the consultant to see at a glance.

We also have an acute-care sheet. This is the sheet that's used in the intensive care unit. This patient doesn't have any acute-care information on them. Intensive care units, ICUs, emergency wards tend to use this sheet a lot. In the old days they would write them all down manually, and there was always a risk of transferring the incorrect data when you wrote it manually. With this tool they get the actual data showing up.

We also have a number of icons across here as well. This is immunizations, for example. You can see that this person has had a tetanus shot. This information is pulled from the public health system, showing that they've had a tetanus shot.

You've probably heard of the pharmaceutical information network. This is basically a listing of all of the dispensed medications that this patient is on. We can very quickly see the medications that they're on, how often they're taking them. We can also see if they have any allergies, whether they're true allergies, nondrug allergies, or intolerances, which is a very important thing in terms of making decisions when we're prescribing. We can look at their previous medication list as well. You'll see that their previous medications are listed on there also.

That's just a very quick sort of run-through in terms of how the application works. We can always come back to this when we have questions or we can talk about more detail, but I want to just go over some slides now and talk a little bit about the system in general.

Just a little bit more background on myself because I think it adds a bit of context. I've been in practice for 28 years. I trained here in Edmonton. I grew up in Edmonton, and I practise in Edmonton. I'm in a suburban practice. I have hospital privileges, so I have the privilege of working both in the community in a clinic and in the hospital. I make house calls. I do palliative care. I also go to extended care facilities. So I cross all of the different continuums of care. Because of that, a tool like this is very, very important. It allows you to have the context of the patient not just in your site but wherever you see them.

I'm a continuous care fee-for-service physician, but as you'll see at the bottom, I'm also part of a primary care network, so technically I have blended funding. I have funding on a fee-for-service basis, but there's also some population care funding that I get through the PCN.

The diabetic care, the chronic disease management that we do on our patients is very important, and a lot of that information is actually contained in this tool as well, where we can track what's happening from a chronic disease perspective.

Our clinic has been electronic for about nine years now. We have both an electronic medical record, which I'll talk a little bit about, and the electronic health record, which is what this is. Also, we teach first- and second-year medical students. We teach residents. We have pharmacy students coming through as well. We're involved a lot in the education of our new physicians that are coming through the pipe.

6:50

A little brief sort of intro about where I'm coming from in terms of having been involved with these things so that it'll help you, maybe, on the question side. All the way back to the Wellnet days, in 1999 I think, Linda has seen my smiling face, sometimes smiling and sometime frowning. Basically, I've been involved with the design of PIN, with the provincial EHR, with the physician office system program, with Capital health in developing Netcare, followed by work on eClinician, which is an electronic medical records system. I've been involved at the Canada Health Infoway level, also with the College of Physicians and Surgeons in terms of chairing their information technology committee from a regulatory status. I've been involved with Alberta Health and Wellness in terms of doing disease and decision support, environmental scans, and in working with some of the committees. I sit on the provincial data stewardship committee as well. Currently I am what's called the co-lead chief medical information officer for Alberta Health Services. We're involved in doing a lot of the rollouts of some of the systems that are there.

A brief note on the difference between an EMR and an EHR. You'll get lots of alphabet soup from us, unfortunately, so I'll try not to use too many sort of shorthand terms. Netcare is an electronic health record. What that means is that it's a subset of information aggregated together to view. It is patientcentric. When you look at it, you're looking at a patient's data across a number of providers and a number of facilities. It comes from many, many different computer systems. Netcare itself is simply a portal. It's a connector to all of those repositories that are out there. Access is via secure networks. We'll talk a little bit about how you access that.

That is not the same thing as an electronic medical record, which is the equivalent electronically, if you want, to the paper chart that a physician would have in their office. In that system, basically, it is providercentric. It is centred around how the providers do things. For the most part the data in it has to do with what occurs at that facility. We do receive information coming from repositories into there that have come from other providers if they CC us, but we don't always see it otherwise. Also, we have scheduling, billing, administrative tools in there. The data that we create is local, and it's generally stored locally although we're moving towards provider systems where they are remotely delivered as well.

There's a big difference between these two tools. One is much more read-only, and the other is more of a read-write tool. One is more local, and the other is more global.

If we look at how Netcare functions, basically what it does is it grabs information from a number of sources, pulls it together into an integration engine, and then sends it to different repositories. Those repositories are what feeds Netcare. At the same time, if you look here, we also take lab results and we send it to physicians directly into their EMRs as well.

An important concept here that I think people need to know about as well is that there's a difference between push and pull in the electronic world. In my electronic medical record, what I use as a chart in my office, when I order a test, the test is pushed to me. That means that I receive it in an inbox the same way you receive an e-mail in Outlook. It's bolded, you click on it, you do something with it, it unbolds, and you move it.

That is not what Netcare is. Netcare is a pull tool, so you use it to top up information. You go to it when you need information from other providers or other sources to add information to your decision-making. On any given day, when I see 30 to 35 patients a day – and I've got about 2,000 patients in my practice – I will use Netcare five or six times, and it will directly make a difference in the care that I provide at least five times a day. I do something different than I would have done because I have the additional information coming in to be able to make a better decision.

Just to give you another pictorial of this, when you looked at the screen that we saw there, when you were looking, basically, at the patient demographics, that was coming from one repository. When you were looking at their event list, that was coming from the ADT list. When we were looking at their lab results, it was coming from a different repository. When you were looking at their radiology, it was coming from yet another repository.

So how is it being used in terms of numbers? Well, these statistics literally came out today. Basically, the total number of unique users we have right now, over the last six months, is 19,038. In the last six months 2,851 physicians and 1,185 residents signed on, so we have a total of over 4,000 users in the physician category. The total number of people using Netcare since March 2006 is almost 24,000. The total number of screens viewed since the product was turned on is at this point in time probably 18 million screens that have been viewed for this product. On May 7 we had 928 user accounts disabled because in looking at whether they'd been used in the last

180 days, we discovered they weren't, so we turned them off. If you're not using it, you don't get to continue using it. You have to tell us why you need to be reinitiated on it.

Total number of users by type. What you'll see in here is a breakdown. You'll see that physicians and nurses are the commonest users of the product, but there are other people that use the product as well. Remember that the way they use it is not necessarily to access medical information, so when you see staff administration support, a lot of times that is for looking up addresses, health care numbers for billing purposes, those kinds of things, and those people may only have permission to see those specific items.

When we look at the portal in terms of region, you'll see that Capital health currently is the largest user group, and that's because it originated in Capital health and we have the most data in the product from Capital health. We are expanding out the data from Calgary, and it's actually growing quite aggressively right now. I would expect you'll probably see more of a 33-33 split between Edmonton and Calgary within the next two to three years because we're turning on two major feeds into there that are coming online very quickly. But the other health regions use it a lot as well.

I want to talk a little bit about security and privacy. Basically – and probably everybody here knows this better than I do – when we first started with the Alberta Health Information Act, there was a section in it that allowed for patients to be opted out, and they had to basically consent in. A decision was made that we would reverse that after we found that most clinicians were spending a huge amount of time talking with patients about this and that a very small percentage of them actually requested to be out. The amount of work generated to do informed consent was quite large.

Basically, when we look at information, we have some concepts that I want to talk a little bit about. We have the idea of masking and blocking, and we have the idea of partial versus global. I'm going to spend a few minutes on this just to explain it to you as carefully as I can.

We do masking, which means that when a patient asks for information to be protected, the information is contained in the product, but the ability to view it is prevented. Unless you unmask that data and you go through a specific protocol that is audited, you cannot see the information. That is different from blocking, where we basically say: we do not post the information into the product. Okay?

There is also the concept of partial versus global. When we first started with the pharmaceutical information network and we had no other products out there, we went into what was called elemental masking. You could mask a specific item within your pharmacy grouping. So if you were on a drug, let's say lithium for bipolar, you could say: "I don't want the lithium to be shown to other people. I don't want them to know that I have a bipolar illness." We enabled that.

What we have found is that as we have expanded the information into the product, we now have, for example, discharge summaries in the product. So when you're discharged from a ward, it may contain text-based information outlining all the medications you're on, including the lithium. To tell a patient that we're going to mask lithium in PIN yet know that it's available in terms of a text-based product was a little unrealistic because it gives them a false sense of security. So what we've gone to is global masking only. If people have a concern, we recommend that they globally mask all access, and somebody has to go through, basically, a break-the-glass procedure in order to look at that data. That way we can assure them that that data is protected.

We also have two-factor authentication in order to get into the system. I'm not sure if everybody has seen the security fob or not.

Has everybody seen one of these before? Does anybody need to see one of these? We can pass it around if you want. There you go. Everybody has probably got one.

Basically, when I am in my clinic and I have to access this, I have to have a username, a password. I then have to enter a four-digit pin number, followed by the fob number, and every minute the fob number changes. That's how I get into the system. When I am within a facility that's on the intranet or into a secure facility – say I'm in the hospital – I have the single-factor authentication in terms of a username and a password, but I don't have to go through the fob component of it in order to get into it.

For all of our offices, including the community offices, a privacy impact assessment is required, and a PIA has to be signed off. We basically have, for example, in our clinic a staff privacy manual and an oath of confidentiality. Everybody signs it. Everybody follows the rules. Every clinic has an assigned security officer. In our clinic it happens to be me. Every time a resident or a student shows up in my office, they can't touch the system until they've read the manual and signed off that they agree with it. Then we give them a user name and a password. It's done in a very strict fashion as far as things go.

7:00

The other question we get asked a lot is about access: who gets to see what? This, I apologize, is a little too small for you to read. Basically, it breaks down the different roles that we have and what pieces of access they're allowed based on their role. It's common to talk about roles in terms of jobs such as physicians and nurses, but really we talk about them in terms of letters: A, B, C, D. The reason we do that is because it's not uncommon for nursing practitioners to need full access, so we talk about the highest level of access, going all the way down to the lowest level of access.

We've split it down into different ways to allow for different users to be able to do this. The receptionists in our clinic cannot see any clinical data. They can only see demographic data. The nurse on seven west at the Misericordia hospital is only allowed to see patient data for those patients that are registered to that ward. She virtually has no lookup screen to be able to look at anybody else. She can only see the patient list for that ward and only access that information.

Physicians have a much broader access and are allowed to look at a broader level of information. They can do name lookups, and they can do different kinds of searches from that perspective. However, they are still bound by a code of ethics in terms of what they look at and what they're not allowed to look at. One of our strictest rules is that you can't look at your own data and you can't look at your family's data.

How do we make sure we keep this working? Well, we have a fairly robust audit system. It was created in consultation with the data stewardship committee provincially and the IMC. It's done in a number of fashions. There are proactive audits, which are random checks. One of the things we have is just random looks at different people to see what they're doing. If we find anybody doing anything that we feel is a problem, then we make sure that they're contacted immediately. In fact, the idea of the public hanging is there for everybody to know if somebody has done anything in terms of a violation.

We have a new-user audit. Anybody who first comes onto the system we track fairly carefully to make sure that they understand the rules. They may have taken the training, but we need to make sure that they're abiding by the training.

We have a same-last-name search audit. This is an interesting one. When we first built Netcare, some of us that were involved in

designing it needed to test it. The way we tested it was that we were actually looking at our own data, and we were actually looking at, with permission, our spouse's or our parents' data. In fact, my father had just passed away, and I was looking to see whether the deceased indicator came up. This was all in the test environment and all with permission while we were first looking at this. When we turned on the audit process, I received a number of letters automatically telling me that I'd violated the audit rules, saying that I needed to come before a committee and talk with them and all the rest until we realized that it was in the training session that was there. So this works very effectively in making sure that we monitor these things.

Also, of course, when somebody has a masked chart, to unlock that chart is a very important process that is audited. There is a pick list, and I'll show you that pick list at the very end here and how that's done. That is audited on a regular basis to make sure that we know who's looking at those charts.

As well, we have proactive audits for anomalous use, so people that have frequently failed log-in attempts may be suggestive that somebody is trying to hack into a user name or password, whatever. We have audits for repeated access to a single record by a single user. We have audits on multiple accesses to a single record by multiple users as well.

Some organizations in the United States actually create what's called flypaper. They actually will take a celebrity, mock up a chart for them – it's really not somebody that's been admitted – and they'll actually look and see who goes and looks at that celebrity's name. It's almost, I guess, a bit of entrapment in a way, but it's a way of looking at abnormal behaviour as well.

We also have a lack-of-use audit, so you'll see that if people aren't using it, then we just don't want their user name and password out there. We want to turn that off.

We also have audits that are done as a reactive audit or a disclosure log. This is when people have a request. Requests can be done either by users or by patients. Everyone has an access to know who has accessed their record. What's important with this is that sometimes they don't understand when somebody has looked at it, if it's a name that they haven't heard of, that it may be somebody that's still intimately involved in their care. A classic example of that may be a biopsy that I do where a pathologist who's reading that biopsy needs a little more context to know what else is going on with this patient in order to know how to rule on the pathology itself sort of thing. We may have radiologists or pathologists looking at these because it helps them to make a better decision. It's important that we explain to our patients who they are when they have looked at that information. These are things that occur in the paper world on a regular basis.

Basically, for anything that is requested there are request forms – and I have them here – where patients can request that they can have their log looked at, and that information is provided to them. We actually have the capability in Netcare, when you're on any lab result, to have a second tab beside that lab result to actually show every single person that has accessed that single piece of data. We chose not to make that visible in the product after extensive consultation both with patients and with providers. They felt that that would cause too much discussion rather than getting at what we needed to do medically with patients. But it's there and we're capable, if we ever wanted to, of turning that on.

So what have we learned? We've learned that privacy legislation has to be balanced. If we have too much, no one will use the system. If you have to go through 15 passwords to get into a system, nobody uses the system. If you have too little, we don't have confidence either by providers or by patients that this is a secure system. So balance is very important.

We need to have privacy impact assessment tools. We need to make sure that everybody understands those tools, and we need to be careful that we monitor the use of those tools. We need to understand the concept of risk versus benefits because this is a major component of what we do. As a physician every time I make a decision on a medication to give to a patient, I'm looking at risks versus benefits. That medication may help them; that medication may harm them. It's never a black-and-white decision. There's some grey to that decision. You're making the best choice you can. It's the same in terms of using these tools. There is no perfect way of ensuring that absolutely everything will be totally, totally secure, but if we were to not use it because of that, the benefits in terms of what we can do in making better decisions in terms of health care would be lost. So we have to balance those two.

In summary, Netcare is a valuable clinical tool used by a large number of health care providers in this province. If you were to try and take away Netcare from the Edmonton area right now, I think you would have a revolt on your hands. Netcare is not a replacement for the paper or electronic medical record used by clinicians. It is a top-up tool. Once again, the balance of clinical information security and privacy policies are critical so that we have confidence by both users and patients.

What I want to end with here is just to show you how we unlock as well. If we go back into this recently viewed patient, Mary MacDonald, you'll see the little lock there. This is a locked chart, so in order for me to go into that, as soon as I click on it, what I get is: the information being accessed is masked. I understand that if I choose to proceed, it is because I need to know the information. I understand that this access is being monitored and will be audited. Then I must pick a reason why I'm doing this: direct patient care, medical emergency, patient consented, public health follow-up, release of patient information, or required by law or licensing. Once I pick one of those and say okay, I am then allowed to go into the system.

I'm going to end it there unless there is anything people want to see from a demonstration perspective in terms of other application uses.

The Chair: Maybe we'll just leave it up there, Dr. Ausford. If you want to refer to it, then it's there.

Dr. Ausford: I think Raj wanted to come and take it for a test drive as well.

The Chair: We have time for questions. Ms Blakeman.

Ms Blakeman: Thank you very much for your time in appearing today before the committee. I'm sure everyone appreciates your expertise. Can you talk to me about the governance structure for Netcare?

Dr. Ausford: Yes, but there are probably better people that can talk to you in terms of it than I can. Basically, there are a number of committees involved. From a clinical perspective we have a clinical working group and two co-chairs. I'm one of the co-chairs for that working group. It's made up of a group of allied health care providers, including physicians, nurses, and pharmacists. Basically, they look at the kinds of things that we put into NetCare, and they talk about the kinds of issues that come up around NetCare.

There are also committees above us in terms of policy that make decisions around that, and there is also the data stewardship committee that's looking at it as well.

7:10

Ms Blakeman: Is there public representation?

Dr. Ausford: On some of the committees there is.

Ms Blakeman: But not all?

Dr. Ausford: Not all.

Ms Blakeman: Thank you.

The Chair: Thank you.
Mr. Olson.

Mr. Olson: Thanks. Thanks a lot, Doctor, for the information. My question is just about the override that you were just showing us, where you click on and you could say that the patient consented. Then is it required that you have some sort of backup documentation to show the consent, or is a verbal consent sufficient? How does that work?

Dr. Ausford: It's your choice. What some physicians will do is record that the patient gave them permission. You'll notice when I went in there – actually, because I've done it, I can't show you now – there's a comments area, and you can actually detail in the little comments area when you break the glass whether you've had a consent form signed or whether you've done anything that way. In general, most people, I think, are going on the basis of what they would put in their EMR around that.

Mr. Olson: Thank you.

Ms Notley: A couple of questions on the issue of the mask. You said that it used to be that you could do a partial mask if there was a particular thing that the patient didn't want widely known, and then you ultimately concluded that, really, if you were going to mask, it had to be global. What are the implications to a patient if, in order to keep one thing private, they need to go to a global mask? What are the implications to their care?

Dr. Ausford: I guess the implication is that if they wanted to have independent sort of elemental masking done and we created that high, high level of security and we looked at all the things we'd have to do, the chances are that clinicians wouldn't use the tool as much. So there would be a risk from that perspective. It gets very complicated to start to figure out: what can I look at, what can't I look at? How do we have all these systems do all these things in the background when you're amalgamating all of these systems. As a clinician I would far rather have a single thing where I go through it, open that door, and it means the patient has given me permission to look at things, rather than saying: "Well, okay, you've got this masked, and this, this, this. Which can I look at? Which one can't I look at?"

Ms Notley: I think you misunderstood my question. My question wasn't what were the implications to you. My question was: what are the implications to the patient who, because they have one thing that they want to keep masked, have to opt for the global mask, and they want to keep it masked? What's the implication to their care if they don't give consent to you to, quote, break the glass?

Dr. Ausford: Well, I guess what I'm saying is that it's how well the

tool gets used. The implication to the patient is that the providers may find that there are so many layers, they're not making use of the tool as much. That has implications in their care.

Ms Notley: I understand that, but that's not my question. Let's say they had manic depression or whatever, and they didn't want that widely known. Because there isn't the opportunity for the layers, as you're describing, they say: okay; well, I want it masked. So they have a global mask, and they want to hold onto that. They're not going to give the consent for that to be unmasked. What is the implication for their care?

Dr. Ausford: Their care goes back to the level that we had prior to Netcare.

Ms Notley: Right. Okay. I guess, my concern is that the patient doesn't have quite as much option to mask as they think because they're having to make a pretty major decision about their care.

Dr. Ausford: That's true. I guess the other thing I would throw in there is that if they don't want their depression known, they're going to have to know all the different areas that we're going to have to mask within that tool; in other words, it's the medication, so if they were allergic to a medication for depression, it's that; if they had a discharge summary, it's that; if they were in an office that was specifically for mental health, it's that. There's a whole bunch of different areas. So when they say, "I don't want my mental health known," you're talking about a very difficult task in terms of all of those sources of information.

Ms Notley: So then what I'm hearing is that for a patient to actually say, "I don't want this information known," they basically have to have a physician who's going to agree to not use Netcare for them. In some cases they may have difficulty masking in practice.

Dr. Ausford: I think what I would hope they would opt for is a global mask. Then when needed, it's unmasked.

Ms Notley: Okay. Can I go on to another question, or do you want other people, and I can come back?

The Chair: Can I come back to you?

Ms Notley: Sure.

The Chair: Okay. Ms Pastoor, followed by Mr. Dallas.

Ms Pastoor: Yes. Thank you, Mr. Chair, and thank you, Dr. Ausford, for bringing your expertise to the table. Just something in your presentation kind of twigged a question. We appear to be having a marvellous cottage industry on vaccinations. So if it's a private cottage industry on the local corner that's going to give you your yellow fever or whatever you want, they can or cannot get into Netcare. Then it is strictly up to the owner of that particular clinic or service provider if they opt into Netcare or not. Is that how that would work?

Dr. Ausford: I guess it comes down to whether it's a true third party or not. The rules are that if you are a physician caring for a patient and you have access to Netcare, in the care of that patient you're allowed to look at their data. For example, an insurance company cannot look at Netcare data in any way, shape, or form. A physician even for an insurance company cannot do that because anything

that's third party is not allowed. So it would depend on if that immunization clinic was considered to be a part of the health care system, they would have access to make a decision to not give a second shot if they already had a shot, for example. If they were pure third party, they may not have access to Netcare on the basis of the rules.

Ms Pastoor: Yeah. Thank you.

The Chair: Mr. Dallas, followed by Dr. Sherman.

Mr. Dallas: Thank you, Mr. Chair, and thank you, Dr. Ausford, for the excellent presentation. I think you did an excellent job of explaining the difference between the two types of records and, you know, some examples with the data repositories and, particularly, the push-and-pull piece of that.

The question that I have is related to a conversation that we've been having around this table about how the system will provide access for care regardless of where the patient is located, whether it was an emergency situation or a patient visiting in another area, that type of thing. My question is around the ability to provide appropriate care with just the information in the electronic health record as opposed to being able to also access some of the information that's contained in your clinic record or individual physician record. Has this evolved to the stage where you've found that appropriate dividing line, or is it still a work-in-progress in terms of what information, ultimately, would be appropriate to share inside that arena of providers?

Dr. Ausford: I think it is evolving, and I think we're learning a lot as we go. There are some electronic medical record applications that have the capability now of housing the same information as is in Netcare. So in your EMR you could have the same access to the information that's in Netcare and not have to go out to that piece of information separately.

I think that, you know, we're learning as we go with this as is the entire world. I've had the opportunity of going to a number of sites across the world and seeing what they're doing. We are leading the way, so we are learning as we go, but what it comes down to is that sharing of information needs to be appropriate and needs to be limited to, as the Health Information Act states, the least amount of information that's allowed to do the appropriate job. We've always had the ability to get any information we want with a phone call, on paper, and have it faxed to our office, so it's not like this is any different. We tend to sometimes think that because it's electronic, it's different. I guess it's different in the fact that maybe we can access more things once we're on the tool, but it's also different in that we have very, very accurate ways of knowing who did access the information.

Mr. Dallas: Thank you.

The Chair: Mr. Brisson, did you want to supplement?

Mr. Brisson: It's just to help out there. Some physicians aren't on an electronic medical record right now and have through discussions on some of these committees and the governance structure identified some data that they would like to see in Netcare, that isn't in there, that is in electronic medical records, some encounter information, et cetera, or like that. Depending on the physician, depending on where they're providing care, which you did talk about, they'll want to see a certain type of information.

Dr. Ausford works in both settings, so he has the advantage of

having the tools and the technology and access to the data, but not all providers do. Providers in emergency rooms will want to see an enhanced data set because they need more information for patients that come in that they don't care for on an everyday basis. I think we're starting to see an evolution towards the type of data that we want this tool to evolve to to help support patients across that continuum of care.

I hope that helps.

Mr. Dallas: Thank you.

The Chair: Thank you.

Dr. Sherman, followed by Ms Blakeman.

Dr. Sherman: Thank you, Mr. Chair. Dr. Ausford, thank you for spending a better part of your career in helping this record to evolve. My understanding is that we're five to seven years ahead of others in the country.

As a front-line health care provider I'll tell you that it's an absolute godsend with respect to getting information, clinically relevant information, in making decisions. In answering Ms Notley's question about clinically relevant, the relevance is that to make a decision you need information, and you need all the information. You could have one medication that you don't know about; you start the patient on another medication, and all of a sudden they'll have a dangerous interaction. The challenge is that a lot of the patients don't know all the medications they're on. They can't remember the names. Many of them show up in a condition that if they have a mental health illness, you have no insight into knowing what condition they have and what drugs they're taking. Many of them show up medically confused.

7:20

Dr. Ausford, I had just a couple of questions. I guess maybe I'll ask all the questions first. One, why is it that you can't look at your own record? Two, do you see patients one day being able to look at their own record to see where their blood pressures are trending, their weights are trending, or their BMIs? Why don't we start with those two.

Dr. Ausford: Sure. The patient portal concept is something we've been looking at as well. One of the ways, I think, that we'll solve the problems of looking at your own data or looking at your family's data – it's interesting how your family members will say: "Well, can you just have a look and tell me what's going on? You know, I know you and I trust you and I want to know." We're not allowed to look at it. When we have the patient portal, which means that as a patient you will have the ability to look in a secure fashion at only your data and subsets of your data – we have to remember that you need, sometimes, an interpreter to understand how the data works – then that will solve some of our problems.

The challenge is where we put the patient portal. Do we run it off of an EHR or an EMR? What pieces of data do we allow? A lot of tools that are out there right now, for example, will put a normal result out right away, but an abnormal result we'll delay for two weeks. It gives you a chance to talk with the patient before they see it.

I think in the long run patient-directed care is moving forward in a very aggressive fashion. I guess the other thing is that team-based care is really moving in a big fashion as well. I have a chronic disease management nurse. When I was literally at the mountains this weekend teaching a course, she was seeing patients, and we were talking back and forth using these tools in co-ordinating the

care of a patient, and I wasn't even there. As a team-based tool, it makes a big difference to bring it together.

Dr. Sherman: Thank you.

Mr. Brisson: Just to add a bit of information on the personal health portal, we're looking at that initiative right now. Just as we went through the evolution of this process to see what data should be on here, what's clinically relevant data, we'll be going through that same process with both the public and with providers to see what subset of information should be on a personal health portal. Some examples you provided there. Through that process we want to make sure that we're not developing a tool that harms patients but more, in fact, informs patients on their health care and can empower them through their health care process. We're starting that initiative now, and we have a ways to go, obviously, but the lessons learned from Alberta Netcare and strong provider participation will be essential.

The Chair: Thank you.

Ms Blakeman: I'm struggling with this concept of patients being able to have some of their information not made readily available through whatever kind of electronic system database we're talking about here, so I'm picking up on Ms Notley's questions. It strikes me that even if a member said, "I want this masked, and I want it masked globally," based on what we saw you do, any physician, any allied health worker who's on this system can go to that patient's chart and say, "I need to know," click on whichever one of the six choices they want to choose, for emergency or whichever, and they're in.

Dr. Ausford: If they had permission to look up the patient in the first place, so not any; a smaller set. A physician could, for example, yes.

Ms Blakeman: A physician, ICU nurse, pharmacist, anybody who's allowed to be on that system. So the idea of masking; it doesn't really mask. All someone has to do is say, "I need to know," and they're in.

Dr. Ausford: It doesn't block; it masks is what it does. Masking means that you have the ability to unmask. What you're talking about is blocking. You would prefer to see blocking, where no one could . . .

Ms Blakeman: I'm just trying to explore what's possible here.

Mr. Brisson: Just to add a bit to that, the masking functionality, what it does. First of all, you have to pass the test: can you be on the system to see these records? That's the first test that you need to pass. The second test is the masking window. Any indication to unmask for those reasons is audited, and it is followed up by those that are auditing the records. We have very few records that are masked, and those are followed up when any access is made to those records. But it is a global mask. For a partial mask, we don't have that right now. We have a global mask, which works. Partial masking of records in the system is very difficult to do from a technical perspective. We only mask in Alberta Netcare. We don't mask in the source applications either. This is a mask for the use and disclosure and access to Alberta Netcare, just to be clear on some of those pieces. I hope that helped.

The Chair: Anything further?

Ms Blakeman: Well, yes, but there are others in line.

The Chair: Thank you.

Mr. Rogers, followed by Ms Notley.

Mr. Rogers: Thank you, Mr. Chairman. Dr. Ausford, I just want to thank you for the presentation. I found it very enlightening. I'm really pleased to see where we are today and, certainly, where we're heading in the future.

In your explanation you talked about push versus pull. I'm just going to give you back what I thought I understood, and I'd like you to clarify it for me. I took it to mean that push is a system that continually feeds information to enhance the record, enhance that pot of information, speaking as a layman, so to speak, and pull would be where you're reaching for different pieces. What I heard, and just my summation of that, is that the push or the system that continually feeds information – again, I'm talking like a layman – into the pot would be more desirable. I would expect that that's the future. I'm just wondering if I've got that right. I'll ask another question, but if you can clarify that for me so we don't lose that.

Dr. Ausford: Partially, yes. I mean, what you have to recognize is that I have over 2,000 patients in my practice. If every piece of information that was ordered by every clinician was sent to my inbox so that I had to read it and sign it off, I would spend my whole day looking at data and not see a single patient because there's a ton of data there. Plus when I get that abnormal hemoglobin and I didn't order it and I hadn't seen that patient, I have no context. I don't know what the situation was. I don't know if it got treated. Maybe Raj saw them in emerg, and he already took care of that and did something.

It comes back to what we call the in-basket functioning. To my in-basket I only want data sent to me that I order or that is CCed to me by someone else. I do not want all that other data. I want to be able to go get it and pull it when I need it, but I don't want it sent to me or delivered to me because you'll literally, from an information overload perspective, bring me to my knees, and I'll be spending all of my time phoning patients to find out: did somebody do something with this? Generally, whoever orders a test is responsible for acting on the results is the general rule of thumb. The ability to get that information quickly is when you do the pull.

Mr. Rogers: Okay. The point, though – and, again, please help me – is that I was taking it to mean that whoever provides those allied pieces of what you need to get that complete record for the patient, that information is fed into the file. It's not to your inbox. That's the way I read it.

Dr. Ausford: That's correct.

Mr. Rogers: It's not to your inbox, but it's fed into the file, so you know that he was treated by Dr. Sherman in emergency. You know that the test was done for the hemoglobin and whatever else. That information is fed, pushed, I believe.

Dr. Ausford: It's available. Yes.

Mr. Rogers: So you don't have to go and pull that. It seems to me that that would defeat the purpose of being able to gather all this information. Am I missing something?

Dr. Ausford: It comes down to the definition of pull, I guess, more than anything.

Mr. Rogers: Well, I don't even care about the definition. I'm just envisioning a system that all the allied treatment pieces for that patient are continually gathered in this cup. When you look inside the cup, you should be able to see, then, the pertinent parts of what it means to that patient's well-being, so to speak. That's the pull function?

Dr. Ausford: I think from most clinicians' perspectives and, surprisingly, from most patients' perspectives as well. I mean, I have an electronic medical record in my office that is now a central medical record, and it's a shared health record as an EMR. In going from my old EMR, which was local, to my new one, which is shared, for every single one of my 2,000 patients I had to discuss with them the fact that we're now in a shared information tool on the EMR side. We can protect certain things, but they needed to understand that.

First of all, half of them assumed we were already doing it, but the other half – remember, I have a lot of physicians as patients; I have a lot of nurses as patients; I actually have a lot of senior health people as patients as well – when they understood the concept of being able to do better care, I have not had anybody that has had a problem with that sort of thing, knowing that it's available readily for you.

7:30

Mr. Rogers: Thank you very much. Then my final question. You talked about family and not being able to look at your family. Now, just a quick scenario. Are there many doctors like yourself that would treat, normally, your own family members, and if you do, would you not be able to look at those records?

Dr. Ausford: If a result is sent to you by another clinician, you can look at it. What it comes down to is that the College of Physicians and Surgeons has rules around ethics. Unless you're, say, in a remote area and you're the only doctor there, it's considered unethical to treat your own family because it's hard to be impartial in your decision-making, and sometimes you do a poorer job.

Mr. Rogers: Thank you very much.

The Chair: Okay. Thank you.

Ms Notley, please.

Ms Notley: Thank you. I have several questions, so I'll try and make them quick and/or until Fred jumps in and tells me to stop.

Is it Dr. Brisson or Mr. Brisson?

Mr. Brisson: I'm a regular guy.

Ms Notley: Okay. Sir Brisson.

With respect to the EMR versus the EHR, I mean, we were talking a bit about, you know, how it impacts the doctor and how much information comes in to the doctor. My question is more about the migration of the EMR information into the EHR and that process. You said that there is a division, and that's evolving. I looked in the act, and all the act really talks about in terms of defining what goes in the EHR are things that will ultimately be defined by regulation. So where do you see that line? Is there a black-and-white line now, or is it already grey and kind of lacking borders? And what's the timeline for that to change or evolve?

Mr. Brisson: I wouldn't say that it's black and white. We have a process at a working level with providers, other health system users from Alberta Health Services, the ministry, lessons learned from where we have moved with Alberta Netcare. Those stakeholders are working together to come up with the data set in a number of pieces that would start to move from electronic medical records to Alberta Netcare to help support that continuum of care for all providers in support of patients. On the data sets, we've been in this initiative for the last, I would say, two years, starting these discussions, talking about technology, talking about the rules. We're just now in the process of starting to identify what that data is at a high level. Over the next 12 months we'll be working with providers from both the college and other associations to say: can we get agreement on what those data elements would be?

Ms Notley: Do you think there is a chance that chart notes would ultimately be part of that?

Mr. Brisson: I couldn't say one way or another, but I'd say that there's other information that providers have indicated to us is more important than that. Those discussions would be way downstream. Encounters and immunizations and other summary notes from events seem to be the most important right now from the discussions we've had with the providers to date.

Ms Notley: But you can't exclude the possibility?

Mr. Brisson: From where I'm at right now, we're looking at the entire data set. Chart notes seem to be valuable to some providers and not to others. When we get into those types of situations, there's a lot more work to do, working with the provider, the community to look at the value of bringing them in there. It's more about the patient and providing them the care they need and having the right information at the right time for that provider to provide that care. That's the test we're using. It's less about identifying key data sets. It's to support that patient care.

Ms Notley: Right.

Can I ask one more question?

The Chair: Certainly. One more.

Ms Notley: Okay. I can't remember who it was, but somebody over there mentioned the whole issue about third parties not being allowed to access Netcare. Where are the rules for that found? Is it regulatory, legislative, or policy?

Ms Miller: It's the custodians. They're not recognized as a custodian. You have to be able to be recognized as a custodian. Anybody that works for that custodian or has a contract with that custodian is considered an affiliate, and then they are provided access contingent on your supervisor deeming that it is appropriate for you to have direct access to clinical information.

Ms Notley: So that's information that would be, then, ultimately defined under the regulations.

Ms Miller: Who can be custodians or not? Yes, definitely.

Ms Notley: Okay. We don't have that right now.

Ms Miller: We have a general definition of that right now in terms of categories. I don't have the act in front of me right now.

Ms Notley: Okay.

Ms Miller: But further definition will be in the regulation for sure.

Ms Notley: Okay. Thanks.

The Chair: Okay. Thank you.

I think we have time for a couple more. Ms Pastoor.

Ms Pastoor: Thank you very much. This is kind of a curiosity question, a little bit about evolution. Bill 44 hasn't passed yet, so it's okay; we can discuss this. I'd like to know: what was the evolution of Netcare? Whose brainchild was it? Who owns it? Is it something that's contracted to the government? It's like it's got a life of its own, but I don't really understand what it is. Like, who owns it? Is it contracted? Who thought about it? How many companies are involved?

Ms Miller: I don't know that I can identify that for you.

Ms Pastoor: It just is?

Ms Miller: It's identified world-wide, the need to share information at the point of care. To facilitate patient care and system needs, the need to have information wherever a patient presents themselves is seen as absolutely critical. The term "electronic health record" was coined maybe 10 years ago by people most involved in this business. That's how it's evolved. Without question Alberta is leading the mark, I would argue, within the top four or five world-wide. It is a journey, as we've said many times, in terms of how this will happen. Things we knew back in the year 2001, when the act was proclaimed, are much different than what we know today, and I'd suggest that probably in the year, you know, 2015 we'll know a lot more than we know today. It is a journey that nobody has taken before, but it's essential to modernizing the health care system and improving patient care. I mean, it's just seen as an essential tool that providers who use it say they can't do without anymore.

Ms Pastoor: No. I understand that part of it, but who owns the tool? Does some company own this software, and it's contracted to the government? It had to have come from somewhere.

Ms Miller: That tool, the Netcare tool, is owned by a company named Orion out of New Zealand. You own your own data. You know, where the data is housed, the data repositories, some are owned by the Alberta Health Services organizations, some are owned by Alberta Health and Wellness, some are owned by physicians themselves. So it's a collection of custodians that are participating in the sharing of this information. No one person owns it although you could argue that a large part of the funding is from the government of Alberta. We are viewed as the information manager in the electronic health record in terms of facilitating the data exchange, but there are various parts that are owned by various different provider groups, I guess, to answer your question most correctly.

Ms Pastoor: Thank you.

The Chair: Okay. Thank you.

Last question. Ms Blakeman.

Ms Blakeman: Thank you. If you want to upgrade your health care through an employer plan and want to go up one step, they always

make you sign one of these sort of blanket informed-consent documents that they can go to your health care provider and get information, and then there's a long list of all the things they can get information on. If they came to you, Dr. Ausford, as my primary care physician, and said, "Okay; open her up; let's have a look," do they get access?

Dr. Ausford: No, they don't. They only get access to the data that I'm custodian of directly. If I have a patient record within my clinic, it's anything that I have done or anything that I have ordered and if the patient has given permission. In fact, even though they sign these things, we always phone them as well because a lot of times patients don't know what they're signing. So a general rule is that you also confirm verbally from the patient: do you recognize what you've given permission to release? Then the only information I release is information I have directly written on or I have directly ordered on. I would never do a Netcare summary and send it with their insurance form, for example. That would be breaking the rules of the Health Information Act because I am not the custodian of that information.

Ms Blakeman: But don't you have information in your electronic medical record that would contain information from other physicians? For example, every time you go to a doctor, they have you fill out a long form: did your parents have high blood pressure, diabetes, da-da-da-da? All of that information.

7:40

Dr. Ausford: If I generated that, yes.

Ms Blakeman: Okay.

Dr. Ausford: But, for example, in our clinic if one of my partners saw the patient, I would not send that information. They would have to ask my partner for that information that they generated.

Ms Blakeman: But you could give a third party like an insurance company access to anything you actually had that you'd generated.

Dr. Ausford: That I am custodian of, yes.

Ms Blakeman: Okay. Thank you.

The Chair: Okay. Well, thank you, Dr. Ausford. On behalf of the committee I'd like to extend our sincere appreciation for making this presentation this evening. My only regret is that we didn't ask you at the outset, when this bill was referred to us, because it's been extremely helpful to see the demonstration and to have the explanation, and as an added bonus, from the perspective of a family physician.

I want to thank you very much for taking the time to do this, Ms Almond, Ms Miller, and Mr. Brisson. Very, very helpful. Thank you.

Dr. Ausford: Thank you.

The Chair: Colleagues, we have a few items of business to take care of here. This has to do with things that have been in process since our last meeting on this particular bill. We're going to start with item 5, which is a brief update on communications, including a summary of website activity on this bill. For that I'd like to turn to Melanie Friesacher.

Ms Friesacher: Thank you, Mr. Chair. I won't go over specific numbers here as you've all got the document, the web trends summary report. Essentially, what we're pleased with is that the increase in website activity correlated with our advertising campaign, so we know that when we sent out the ads or we had them published, people came to the site, and they stuck around. The average session length was six minutes, which is a good length. It means people went around and looked at files. The spikes actually did correlate to beginning of advertising and submission deadline, so we know that people were on top of that.

That's it.

The Chair: Okay. Thank you, Melanie. That's your report that was posted to the internal website for the committee.

Ms Friesacher: Exactly. It certainly is.

The Chair: Thank you.

The next thing I'd like to do is just talk a bit – I'm under item 6 now – about the submissions that we've received. We do need to make a decision with respect to public release of the submissions. As you may know, the committee received submissions from 59 different organizations and individuals regarding Bill 52. The submissions were posted to our internal committee website, and just to reiterate, they were posted as they were received over the course of the last several weeks. Hopefully, you had a chance to keep up as they were coming in although I know we were all quite busy with estimates. In addition to that, a summary of the submissions was prepared by the LAO research section, and for that we thank Stephanie LeBlanc, who's here this evening as well. Again, that summary was posted some time ago.

I guess at this point I'd just ask if there are any questions for Stephanie regarding either the individual submissions or the summary that was prepared.

Ms Blakeman: I know that the last time I was on the health information review, we got a sort of chart that told us: this issue was raised or there was a request that the legislation deal with it in such and such a way X number of times by the following people. Was something like that prepared? Or the document from May 4, the summary of written submissions and stakeholder presentations: is that it?

Ms LeBlanc: I think you're referring to what we usually call a focus issues document. There wasn't a direction from the committee to prepare that, so at the stage that we're at right now, there's just a submission summary, that summarizes all of the 60 submissions that came in.

Ms Blakeman: Okay. Thank you.

The Chair: If I could, Stephanie, that document is organized in a thematic way, though, isn't it, according to specific issues that were raised?

Ms LeBlanc: Yeah. That's correct. I broke down all the submissions, instead of by submission, according to topic area.

The Chair: Okay. Any other questions on that report?

Seeing none, Melanie, thank you very much on behalf of the committee for that work.

The decision that we need to make now is whether we are going to publicly release the submissions. You'll recall that we reached

the same point when we were reviewing Bill 24. I believe the way that we handled this last time – and I think it’s consistent with what has been suggested here – is that the committee could resolve to make the submissions available to the public with the exception of those portions containing the following types of information: one, personal information other than name; two, where the submitter has requested certain information not be made publicly available; and three, where the submission contains identifying information about a third party, for example, the third party’s name and health information. I think that’s similar to what we did under Bill 24. This was an issue that you raised, Ms Blakeman, at our first meeting.

I’ll just go over that again, if I could, just so it’s clear to me as well as everyone else here. The suggestion is that the submissions could be made publicly available with the exception of submissions containing the following types of information: personal information other than name; where the submitter has requested certain information not be made publicly available; and where the submission contains identifying information about a third party, so the third party’s name and health information. If you’ve reviewed the submissions, you’ll see that we have some that fall into each of those categories.

I invite discussion on this, but my suggestion to the committee was that a motion along these lines would probably be appropriate at this point.

Mr. Dallas.

Mr. Dallas: Thank you, Mr. Chair. Just for the purpose of getting this on the table for discussion, I would be prepared to make a motion, the wording of which we could construct from the information you have or I can try and ad lib the wording to match up to what we used on Bill 24, if you like.

The Chair: Just before we do that, though, any other comments on this issue?

Ms Blakeman: I think my primary concern is that the public is able to understand how we came to a decision by looking at the submissions. My concern is that where we exempt information from being on the web, would that cause a member of the public to not understand how we arrived at a position? I understand and am supportive of the first and the third provisos that you’ve outlined. Where I’m struggling with this is someone who decides to, as I’ve had in other committees actually, give some fairly controversial but persuasive information and then say: I don’t want any of this released. So it did really influence the committee, but anybody from the outside trying to look at this could not figure out how we had arrived at this decision because a key piece of information was now missing.

That’s my concern about making this sort of decision. I guess we’d have to have someone who knew which submissions were holding that piece where they said, “Don’t release this,” before I’d be comfortable as a committee member to say, “Well, yeah, okay, exclude them,” or some way of saying on the web that, you know, there was a submission but we’re not putting it up here for the following reason. That’s my struggle with this section.

Ms Notley: We’ve been through this discussion at least twice now, and I always forget exactly where we end up. When we advertised for the submissions, what did we say? Did we say, “Your submission may well be made public,” or did we invite them to tell us they didn’t want it to be made public? Like, what did we say?

Ms Friesacher: We said, “Submissions will be made public. Please specify if you wish to have identifying information removed from your submission.”

Ms Blakeman: Just identifying information.

Ms Friesacher: Correct.

Ms Notley: Based on that, even without that actually, I tend to agree with Ms Blakeman in that I think the first and the third criteria are in line with already existing privacy information, but I’m not comfortable with giving people the opportunity to exclude their information if they’ve been told in advance that, you know, it would be made public.

7:50

The Chair: Okay. Ms Dean, would you like to comment on this?

Ms Dean: We’ve identified six possible submissions that may be at issue, and I’ll ask Stephanie to step in if I’m missing something here. Three of the six didn’t ask for their content to be excised in any way. It was just their name. The remaining three: the issue there was disclosure of family members’ health information.

Ms Notley: Really, maybe it’s a question of how the motion is worded. I think we can respect people’s wishes were the motion more in line with how the ad went out as opposed to just sort of allowing for stuff to be not released because people requested it, which was how it was worded in the motion I think.

The Chair: I think the way this has been worded potentially for us to consider is the following: where the submitter has requested certain information not be made publicly available. I don’t know if you can give us an example, not specific but a general example, of what type of information that might include.

Ms Dean: My understanding is that it was only with respect to names for those three that I identified.

Ms Notley: Can I amend the motion?

The Chair: Okay. Well, actually, we didn’t put it on the table yet. I thought we’d just discuss it a bit and see if we might have some consensus.

Ms Notley: Okay. Good enough. If you just said “identifying” instead of “certain.”

The Chair: So where the submitter has requested that identifying information not be made publicly available.

Mr. Dallas: Well, Mr. Chair, if I could have our communications support just reread that phrase that we included in the ad for submissions because I think we would be violating the spirit of that if we went in that direction.

Ms Friesacher: Certainly. The advertisement stated, “Submissions will be made public. Please specify if you wish to have identifying information removed from your submission.”

Mr. Dallas: We’re probably good to go.

The Chair: Any other discussion on this point, then?

Mr. Dallas, do you want to make the motion? Then we can have further discussion if we need to.

Mr. Dallas: I would be prepared to make a motion, but if you would

just indulge me first, Mr. Chair. My recollection of the debate on Bill 24 is that we actually ended up on opposite sides of this because I specifically recall arguing that we shouldn't strip that information away.

Now, if you'll permit me, I'll make the motion. I would move that

the Standing Committee on Health make the submissions received available to the public with the exception of those portions containing the following types of information:

- (1) Personal information other than name,
- (2) Where the submitter has requested certain information not be made publicly available, and
- (3) Where the submission contains identifying information about a third party (third party's name and health information).

The Chair: Okay. I think you might have a friendly amendment here.

Ms Notley: In the second one, requesting that "identifying" information not be made available as opposed to "certain."

Mr. Dallas: All right. That would be good.

The Chair: Any other discussion on this?

Those in favour? Opposed? Carried. Thank you very much.

The next thing. Just before we get into some discussion and deliberation on our report, it has been suggested to me that normally in these situations what happens is – as you know, we're supported by Parliamentary Counsel. As in Bill 24, it's going to be necessary for Parliamentary Counsel to work with legal counsel for the department, in this case Alberta Health and Wellness, to provide assistance in drafting any amendments that may emanate from our discussion. So it has been suggested to me that we have a motion that the Standing Committee on Health

direct Parliamentary Counsel to work directly with legal counsel for the Department of Health and Wellness on proposed amendments for the committee's consideration at its next meeting.

I would just take it on good advice that it's good form to have such a motion. It seems like an obvious move.

Any discussion on this point?

Ms Dean: Mr. Chair, I think that's presuming that the committee is in a position to give instructions with respect to the form of the amendment. Perhaps that might be moved later on.

The Chair: Well, then, I'll just suggest that we'll remove the words "at its next meeting," and we'll just have it on the record that as appropriate, counsel can work with one another. Would that be agreed?

Ms Dean: I guess it's pending instructions from the committee as to what we'll be working on.

The Chair: Obviously. Yeah.

Any other discussion on this point? Would someone care to move the motion? Mr. Olson. Those in favour? Any opposed? Thank you.

Okay. Now, we're still on item 6. I guess, colleagues, we're at a point, then, where we could begin to have some discussion now about the issues that have been raised in our earlier meetings and leading into a discussion about what could go forward in our report to the Assembly. In terms of process, we all know that the end of session is soon upon us. Perhaps others would be hoping sooner than it may actually occur. I don't really know the answer to that

question. I do know that we have this week, we have a constituency week next week, and then we're back in the House on the 25th. In any event there's going to be a limited time to complete this. So I'm going to just sort of throw it open for people to give some thoughts on this whole question of where we may want to focus our attention for the report.

Mr. Denis, you had your hand up earlier. Was it on this point?

Mr. Denis: Yeah. I actually just have an amending motion. I don't know if you want to just complete the discussion of that point first.

The Chair: Okay. Well, perhaps it would be useful just to talk a bit about some of the issues that have been raised in earlier meetings. Obviously, you've got some thoughts on specific issues that we may wish to comment on in the report.

Does someone want to start us off?

Ms Notley: I can, if you like.

The Chair: Go ahead, Ms Notley.

Ms Notley: Well, I know we had a chance to talk a little bit about some of your proposed amendments, so I'm going to stay away from those issues because I think those do address some of the concerns.

At the outset, I guess, we all had some concerns after, you know, listening to the various presenters all associated with what this does to people's privacy. I remain concerned about certain elements of it that continue to be subject to the regulations. I think one thing that we can take from the presentation – well, there are number of things that we could take from the presentation today – is that this process is evolving and changing all the time, and the capacity of the electronic system is evolving and changing and growing all the time. The implications for people's privacy, as a result, are also going to be evolving and changing, so what we agree to propose to the Legislature needs to not only stand the test of current assurances provided to people about how things are right now, but it needs to stand the test of where things might be five years from now or six or seven years from now because it's changing so much.

Obviously, one of the areas which I did ask about and I am concerned about is this whole issue of what ultimately forms part of the electronic health record. I know that people have talked to us about that throughout the course of our receiving submissions, and that's not, I don't think, something that you contemplated addressing in one of the amendments that you were talking about. That remains a concern of mine.

8:00

The other thing that remains a concern of mine is this issue around third-party access and who constitutes a custodian. That is something that the act would leave up to the regulations. Once again, given the overall context of our concern about the privacy rights people have to this very, very, very critical and personal information, that's something that I continue to have a concern with.

I'm also concerned – and I didn't get a chance to get to this in the questions. Ultimately, whatever we do needs to be modelled as much as possible after the structure that we have in place for our privacy legislation, and it needs to allow for this collection of extremely detailed personal information to be modelled along the same lines, whether we're talking about FOIP or PIPA or the Health Information Act. All of those talk about, you know, the principle of collection, use, and disclosure and the need for there to be consent for all of those things.

What happens with this system is that people don't get to actually

see the information that is being collected about them. They don't get access. That is actually a unique element about this collection and privacy information which separates it from all other privacy information that's covered under FOIP or PIPA or whichever. It seems to me that we need to be even more careful about how we manage it because people don't have that fundamental right necessarily to correct the information, and that's something that appears to happen with this kind of thing. I'm not sure if there's an opportunity for us to consider that issue and evaluate it because that's another thing that concerns me greatly.

I know we talked about this before, but in a previous life as a result of my professional experience, having had to read 1,500 doctors' reports about people, I know that it is possible in our overstressed system for incorrect information to be on the record quite frequently, alarmingly frequently. That information is invariably deeply personal. It invariably has significant implications for people's lives, and the degree to which that can then leak into these other electronic systems as the systems evolve over time, which we can't really define right now, which, ultimately, we have to leave to regulation, is all very concerning.

Those are some themes that I have concerns about in addition to the very clear ones that you have identified and, I know, share concerns with me about. There's my start to the discussion.

The Chair: Thank you.
Others?

Ms Blakeman: Sorry. I'm understanding that there are already – or maybe I've missed the discussion – amendments that are being brought forward. If we knew what those were, if there was a list of them, I would not repeat them.

The Chair: Okay. Some members have indicated that they have potential amendments that they would like to discuss with the committee. I think we were just trying to allow an opportunity for people to raise the themes that were important to them, but perhaps if we do that, then we'll maybe see what isn't there that we might like to address as well.

Ms Blakeman: Sure. Because I'm happy to go through a list of what I'd like see, but that could just mean a bunch of you sitting around listening to stuff that you're holding amendments on that you want to put forward. So there's no list of everything that the government members have prepared? Is there anything handy dandy?

The Chair: Yeah. I believe so.
Mr. Denis, why don't you proceed.

Mr. Denis: Okay. Thank you very much. I'm just going to circulate around copies of three amendments that I'm going to move. Mr. Chair, I'm not sure if you want me to proceed just in an omnibus fashion or to move each one of them individually.

The Chair: Well, if these relate to a common theme, why don't you just provide a bit of background, perhaps.

Mr. Denis: Okay. Each of these amendments is as a result of some discussion, obviously, that's occurred over the last few months here. The first one is to amend the bill to require custodians to maintain access logs for electronic health record usage. This is something that we had discussed and, obviously, is in the interest of privacy. I would move that.

The Chair: Okay. If you don't mind, just before you move them, my understanding is that these are intended to address the concerns raised by the Information and Privacy Commissioner.

Mr. Denis: That's correct. Yes.

The Chair: Okay. So why don't just you describe all of them, if you would, Mr. Denis.

Mr. Denis: Okay. Thank you. Dealing with the second amendment, it would amend the bill to reinstate the department's obligation to prepare a PIA when requesting health information from other custodians. Again, this is only in response to privacy concerns. It's in the interest of maintaining doctor-patient confidentiality.

Mr. Chair, the third one, finally, would deal with the reimplementation of concepts of expressed wishes and masking within the other EHR provisions. I think that our presenter had discussed a bit about the masking concept today as well.

The Chair: I think your suggestion is that we could discuss these sort of as a group.

Mr. Denis: That is my suggestion unless there's an objection.

The Chair: Okay. Just for the record, if I recall correctly, these were all things that in the bill as proposed are actually altered in some form or removed entirely, these sorts of privacy controls.

Mr. Denis: That's right.

The Chair: Okay. Just in terms of process – and, I'm sorry, perhaps I should have said something about this sooner – the idea behind this discussion is that if we're going to talk about some specific amendments now, these would be areas that we would highlight. Ms Dean as our Parliamentary Counsel would then take these and work with them prior to a subsequent meeting, in co-operation with counsel from the department, and actually, you know, based on what we discuss here and what we agree on, draft amendments in legal form, then, could form part of our report. Is that fair, Ms Dean?

Ms Dean: Yes, Mr. Chair.

The Chair: It's a little different than Bill 24. Bill 24, I believe, was a referral after first reading. Pursuant to the standing orders the first-reading referral allows us to deal with the concept generally and the principles in the bill. Referral subsequent to second reading restricts the committee to commenting or proposing changes on the specific provisions in Bill 52. It's what's proposed in Bill 52 specifically.

Ms Notley: Sorry. I thought I should jump in there before we vote on it. These are all three good amendments. As I've said, I think there are other issues which aren't covered under this, but these are a start to fixing, I think, a multiplicity of concerns.

My primary concern is with 3. I'm not clear from the information that we received today that the officials that were here today actually contemplated what I would characterize as a particularly effective system of masking within the system. So I'm a little unsure about how that would be done.

Then in terms of the other part of it, the concept of expressed wishes, am I assuming, then, that that's effectively returning the ability to withdraw consent? That's what is meant by that?

The Chair: Yes. I believe that's it. But if any of the officials from the department want to help us out, feel free to join us at the table.

Mr. Chamberlain: Thank you, Mr. Chair. If I understood the question correctly, the concept of masking is not withdrawing your consent.

Ms Notley: No. I'm sorry. I understood that there were two different elements to the third amendment, so I was talking about two different things.

8:10

Mr. Chamberlain: Yeah. Let me go to expressed wishes as well. In what we call the controlled arena, so when custodians are exchanging information, which is one of the things that the electronic health record facilitates – it's not the only way health information is exchanged – there is no consent requirement. Custodians can exchange information amongst themselves, and the rules that apply are the ones that Dr. Ausford talked about with respect to least information necessary; you have to require the information to provide some service, whatever it is you're doing. Those are the rules that govern how you collect, use, and disclose health information. In the controlled arena there is no consent requirement. That's not part of the act for purposes of care and treatment. For information used for research purposes, there is a consent requirement subject to some ethics board provisions.

Ms Miller: Perhaps I can explain as well your comment about expressed wishes. Expressed wishes is the concept in the legislation. It is fulfilled through a functionality within the system called masking. When you're dealing with the electronic world and with the EHR portal or Netcare, it globally masks using that tool. So a person expressly wishes to have their information globally masked; the tool, as was demonstrated tonight, has that capability to globally mask based on that expressed wish. That's how the two concepts go together.

Ms Notley: Oh. So they're not two different concepts.

Ms Miller: No. One is the way you enact the expressed wish in an electronic world.

Ms Notley: I'm sorry. Where did you refer to the part in the act?

Mr. Chamberlain: Section 58(2) sets out expressed wishes. As Ms Miller indicates, you won't find any reference to masking in there. That's the application of that section in the electronic world.

Ms Blakeman: Rachel, it actually says:

In deciding how much health information to disclose, a custodian must consider as an important factor any expressed wishes of the individual who is the subject of the information relating to disclosure of the information, together with any other factors the custodian considers relevant.

That's the section. That's it.

Ms Notley: Which page is that on?

Ms Blakeman: Well, I've got a downloaded bill, so don't trust me. It's section 58(2).

Ms Notley: I'm having a heck of a time finding that.

Ms Blakeman: Essentially, for anybody that really, really, really does not want a piece of health information out there, don't give it.

Mr. Chamberlain: I could help, Mr. Chairman. You won't find it in the bill because that section isn't amended by the bill.

Ms Blakeman: It's not in Bill 52, you mean. Yeah.

Mr. Chamberlain: It's not in 52.

Ms Notley: Oh. Okay.

Ms Blakeman: It's in the main act. Sorry.

Ms Notley: Sorry. Where was it that it was taken out in Bill 52?

Mr. Chamberlain: I'll explain that, but it's a somewhat complicated answer. It was not taken out in Bill 52. That section applies to disclosure. The electronic health record provisions in the proposed part 5.1 of the act make all access and uploading of data to the electronic health record a use. So in order to make the expressed wishes provision extend to a use, you would have to do something similar to what Mr. Denis proposed and actually add an expressed wishes provision to apply to the use in the electronic health record part.

Ms Notley: So just to clarify, we're not talking about recharacterizing something back to being a disclosure from being a use; we're talking about actually crafting another clause around expressed wishes.

The Chair: That's correct.

Just if I can sort of supplement, this was one of the major concerns expressed by the Information and Privacy Commissioner. The net effect of changing from disclosure to use was the loss of these privacy protections. The idea here is to apply them now specifically to a use so that people enjoy that same protection.

Ms Blakeman: But it's not contemplating reversing the section that changed it from a disclosure to a use. That's still staying in place. Have I got that straight?

The Chair: I believe so. Yeah.

Ms Blakeman: Okay. Well, I might have a bit more trouble with this than I thought I was going to.

The Chair: Okay. I'm going to suggest that rather than try to deal with all of them together, then, are there any comments or concerns around 1 or 2? We'll come back to 3.

Go ahead, Ms Blakeman.

Ms Blakeman: Thank you. So in 1 you're talking about the audit trail, and this is allowing both that it's recorded but also that individuals can get access to review who has accessed their logs. Is that correct, Mr. Denis? Is that the contemplation of 1? It's both things?

Mr. Denis: That's the understanding, yes.

Ms Blakeman: Both things? Okay. I'm good with it if it's both.

The Chair: Anything on 2? This is reinstating the privacy impact assessment. This was taken out in the bill as proposed.

Ms Blakeman: Yep. That's good.

The Chair: Do you mind if I sort of try to get some things off the table here, then? On 1 as moved by Mr. Denis – I'm not sure what the wording would be here. Could someone help me out a bit?

Ms Blakeman: That's close enough for Parliamentary Counsel to know what we intended, isn't it?

The Chair: That's the intention, yeah.

Ms Blakeman: Yeah. Well, then I'd let Parliamentary Counsel bring us back something. I'm sure they'll hit it right on the button.

The Chair: Okay. I think we'll do a little more than that. I think we'll ask for a motion to
direct Parliamentary Counsel to draft an amendment in accordance with 1 here.

Mr. Denis: I so move, Chair.

The Chair: Mr. Denis. Discussion? Those in favour? Opposed? Thank you.

Number 2, that the committee

direct Parliamentary Counsel, again, to draft an amendment that would reinstate the department's obligation to prepare a privacy impact assessment when requesting health information from other custodians.

Do you want to move that, Mr. Denis? Okay. Discussion? Those in favour? Thank you.

Okay. Then let's go back and talk some more about 3. Actually, I'm going to ask you, Ms Miller, just to comment on the effect of changing from disclosure to use and what the effect of this proposed amendment might be on that.

Ms Miller: On the rationale for it, as it exists today in the Health Information Act, every time a provider provides information from their source system, as we call it, a subset of that, to the electronic health record, that's considered a disclosure. Whatever provider then looks at that information subsequently is also considered a disclosure. Because Alberta Health and Wellness is managing the system, holding a lot of the applications, it also puts a responsibility on Alberta Health and Wellness for any subsequent action, anybody that looked at the data from the originating source. That means the originating provider is held accountable for those that look at the data later and what they've done with that information and decisions they've made as well as Alberta Health and Wellness.

That is not a workable model. People are putting up the information, recognizing that anybody that accesses it has the same level of security and expectations placed on them as does the provider. But to hold that originating provider accountable for all the subsequent actions of anybody that looks at the data later is unreasonable. That's why we want to change the notion from disclosure, once it's provided, to use. Anybody that's in that controlled arena would then be considered a use provision. You don't get into the controlled arena unless you have met all the tests in terms of passing security as defined in the legislation, et cetera, et cetera. That's the fundamental underlying reason for the change.

Ms Blakeman: But are we not considering changing who's in that arena with other clauses in this bill?

Ms Miller: Yes, we are.

Ms Blakeman: Well, then, who are they? That matters. Who else would get free access to the use of this information if that definition is changed to use from disclosure?

Ms Miller: True. We're trying to broaden the definition of custodian from what exists today, but whenever that broadened

definition is enacted, they would still be required to meet the same tests in terms of only looking at the information that they need to know based on the scope of practice that they provide and the highest level of anonymity needed to treat the particular patient that they are taking care of. They'd still meet the same tests. It would be just different kinds of providers added to what exists there today.

8:20

Ms Blakeman: I think this gets us into the area where we had questions like from the city of Edmonton. Would they now be considered a health service provider because that definition has changed? Am I way off beam here, guys? Help me.

Ms Miller: The ambulance maybe is what you're thinking of, Ms Blakeman.

Ms Blakeman: No. There was a submission from the city of Edmonton and some others. It was about who pays for health care and that anybody – it didn't have to be necessarily paid; they were now going to be captured. Come on, help me out, you guys. I'm not crazy here.

The Chair: Yeah. No, no.

Ms Blakeman: The chairperson is nodding his head.

Ms Miller: I was just informed that the city of Edmonton does have health professionals that provide health services. So it wouldn't be the city of Edmonton as a whole; it would be just those that work as professionals for the city of Edmonton delivering care and treatment to people.

Ms Blakeman: Yeah. See, I think we need to examine who else gets access to this information, even taking your point that they are subject to the same rules, before I'm comfortable making a decision that we can change. That's a huge move, and this was the move that the Information and Privacy Commissioner was most concerned about, moving from the disclosure to the use definition here.

The Chair: Did you want to reply, Mr. Chamberlain?

Mr. Chamberlain: Well, if I could just clarify, Mr. Chair, I think we're talking apples and oranges here. The collection and use/disclosure rules apply. If you expand custodians, you expand custodians. The use and disclosure rules will apply to all custodians. Whether it's a disclosure or a use isn't going to change the fundamental obligations for dealing with the health information and the overriding principles of least information and need to know. So while there is an issue and there was some discussion around the expansion of custodians, that is really, quite frankly, a bit of a red herring in the discussion of whether or not it's a use or a disclosure. The use and disclosure piece, as Ms Miller indicated, was simply because there are a number of obligations when you disclose information which are just simply not practical in an electronic world.

If you go back to the demonstration, there were a bunch of tests and other pieces that you saw that an emergency doctor might have to access. If that's a disclosure, then the original lab, the original doctor who put that information up, would have to consider each time that information was accessed whether it was the least amount of information necessary for Dr. Sherman in emergency to treat his patient. It's just not practical in an electronic world, which is why we move to the use concept.

The Chair: Okay.

Ms Pastoor, you have a question.

Ms Pastoor: Yes. I'm just trying to recall; I don't have it in front of me. It seemed to me that part of their problem, too, was how much of the personal records that they have as city employees they were going to have to share. It seemed to me that that was part of their concern.

Ms Miller: It probably was. I wasn't here when they presented. There's always a great discussion that occurs when you introduce a new type of custodian on what type of information, first, they'll have access to and what type of information they will provide. It does differ by provider type and somewhat by provider organization. That discussion happens long before the access is granted, so there's agreement up front before anybody sees anything. For these type of providers, they can see this kind of data and only this kind of data, and if they have an electronic system in their office or wherever they work, ultimately what kind of information will be pulled from their system into the electronic health record. That often takes several years of discussion before that is determined.

The Chair: Thank you.

Ms Notley: I'm still struggling with this somewhat. I mean, on one hand your explanation sounds quite reasonable, that, you know, if Dr. Sherman, who seems to be our example at all times – thank goodness he's on the committee – has to wait for a provider to go through the disclosure process, then it's unworkable. Yet I'm hearing that the system already works quite well. This sort of change of the sharing of information as though they were all uses as opposed to disclosure hasn't happened yet. So how is it that the system works so well right now and that our doctors are able to use it and get so much benefit out of it? That's my first question.

My second concern, around this idea that once you get into the arena, it's all use and it's no longer disclosure and we don't need to track it, goes back to the questions that I was asking Dr. Ausford. You know, a family doctor uploads a bunch of information, and specialist A uploads a bunch of information, and specialist B uploads a bunch of information. Then specialist C is asked to see the patient, reviews all that information. Then specialist C gets a request from a third party with a broad, broad consent saying: please prepare a report about all these different things. The way it was explained to me before was that, oh, specialist C would never, ever mention a single thing that specialist C had not himself uploaded onto that system. But now I'm hearing quite a shifting of the sands in terms of: once it's on the system, do we still own it, or is it now sort of used collectively? That's a concern. Those are my two questions.

Mr. Chamberlain: To try to deal with the second one first, the disclosure rules haven't changed. Disclosure is still disclosure. It's only within the electronic health record, Alberta Netcare, that the proposal, the amendment moves it to a use.

Ms Notley: No, I realize that, but I'm concerned that the person who is disclosing to the third party has way more information that they're compelled to disclose.

Mr. Chamberlain: And under the provisions of the current amendment, without any further amendments, the access of the health information on the electronic health record, the first access, when Dr. Sherman accesses the information in emergency, is considered to be a use, and the use rules apply. The least informa-

tion necessary, only if you need it: those kinds of provisions apply. Any subsequent disclosure by Dr. Sherman of that information is still a disclosure. It's only that first piece under the amendment that is deemed to be a use.

Ms Miller: I think your question, as I understood, was: today it works with disclosure the way it is and the obligation piece, so why do we have to change it?

Ms Notley: Yeah.

Mr. Chamberlain: Yeah. Part of the answer is that it is working, but it's actually not working as well as you would think it is because we're constantly having issues with specific questions around PIN, for example, the pharmacy information network, about whether or not it is in fact a disclosure and whether we can disclose the information and put the information on the system. We're starting to run into that problem as we begin to populate the electronic health record, and this is an attempt to get away from that and to enable us to move forward as the electronic health record expands and the usability of it expands.

The Chair: Okay.

Ms Blakeman: Are we talking about section 56.3 in Bill 52? If we're not, can you tell me what we are talking about?

The Chair: I believe so.

Ms Blakeman: Okay. This is basically going through a number of sections and saying – it doesn't say that this makes it a use; it just says it's not a disclosure.

(2) For greater certainty, the making of prescribed health information accessible pursuant to subsection (1) does not

- (a) constitute a disclosure of that information, or
- (b) require the consent of the individual who is the subject of the information.

This is how they make it a use, by saying it's not a disclosure, so you don't need to have consent of individuals. They don't know that that information is being shared about you. It is a shift.

Ms Miller: Under the current rules there's not consent for care and treatment purposes either with disclosure or use – for care and treatment purposes.

Ms Notley: But you're expanding it now from beyond care and treatment to . . .

Ms Miller: No. We're still talking care and treatment only.

Mr. Chamberlain: For clarity, Mr. Chair, there is no change to the consent status of the bill. This is all within the controlled arena, exchange between custodians. There is no consent requirement.

Ms Blakeman: Yup. Got that.

Mr. Chamberlain: There wasn't any change. The only change was in whether or not accessing the EHR was a use or a disclosure. That's the only change that that amendment you just read referred to.

8:30

The Chair: The intent, I believe, of this amendment is to reinstate the privacy controls that are available to individuals under disclosure and make them applicable to use. So that's the expressed wishes and

masking, recognizing that masking is a feature in the software, not a provision in the Health Information Act.

Ms Miller: Quite frankly, why we had it disclosure, you know, my recollection from back in 2001 was that most of what we knew at that point was based on our paper world. In a paper world it's hard to get sent from the point one doc – I'll use the physician as an example – to another physician. It's kind of point-to-point exchange, so it's best described as a disclosure. One physician is disclosing that record to another physician, and it works quite well in that kind of paper world.

In the electronic world, where the subset of that information is posted, if you will, in a secure information, there then are subsequent providers that access that information, so the originating physician doesn't necessarily know who will later access that because many people see many different providers, including many different general practitioners. Sometimes your main practitioner knows about that, and sometimes they do not. That's why it doesn't quite work in the electronic world, but it did in the paper world.

The Chair: What I'd like to suggest is this: recognizing that people may want to come back and talk about use and disclosure later, if we're in agreement with 3, at least, dealing with the expressed wishes and masking and putting them back in, I'm wondering if we could perhaps ask Mr. Denis to move that as a motion. Then we'll take this one off the table, recognizing that you may want to come back and ask some further questions later.

Mr. Denis: I so move amendment 3 as distributed.

The Chair: Okay. Those in favour? Opposed? I'm making a careful note here, Ms Blakeman, that you may have some further questions on that.

Ms Blakeman: Yup. Thank you.

The Chair: Okay. That one is carried. Thank you. We'll word it accordingly, a direction to Parliamentary Counsel to prepare the amendment "re-implementing the concepts of 'expressed wishes' and 'masking' within the EHR provisions."

I'm sorry. I just realized I kept everyone sitting for two hours. What's your pleasure? Would you like to take a five-minute break, or would you like to continue, committee members?

Ms Blakeman: Well, how much longer do we expect to be here? If it's two hours, I'm going to want a five-minute break now. What's the expected end time for the meeting?

The Chair: It's 9:30. If we finish earlier, that would be terrific.

Ms Blakeman: That's not going to happen. I'd go for the four and a half minute break. You can set the timer.

The Chair: All right. Let's take a quick break, and we'll reconvene in five minutes.

[The committee adjourned from 8:33 p.m. to 8:41 p.m.]

The Chair: Colleagues, we'll resume. Thanks.

Mr. Olson, you have some proposals for amendments as well, and I believe the clerk has just passed those around.

Mr. Olson: Yes, I do. Thank you, Mr. Chair. I think all of my

committee colleagues have a copy of this that they're probably now just looking at. I'll make maybe just a few introductory comments. There are actually a number of elements to this amendment, so several changes, really.

You know, much of what I've heard throughout this whole discussion has been about balance. I think we heard Dr. Ausford talk about balance again today, and we certainly heard it in some of the other submissions. I think there was some feeling that perhaps there was a bit of an imbalance in the power of the minister to compel the inclusion of information, so this is an effort to speak to that issue.

I think that there are two interests, obviously, that we're trying to protect. We're trying to protect people's privacy to the extent that we can and still maintain the integrity of the system. Here, I think, with these kinds of amendments we would include and involve the colleges of the regulated health professions more so in terms of deciding and regulating their own members in terms of inclusion of information for Netcare but still give the minister the possibility – if the colleges have not chosen to require the inclusion of certain information, the minister has the power to ask for that information but only after consultation with the affected colleges, consultation with the Privacy Commissioner, and the completion of a review by the Privacy Commissioner of an impact assessment.

This amendment also speaks of the appointment of a multidisciplinary data stewardship committee, which would include public members. This is a way of maintaining kind of a broad base of input from both those who are working on the front lines and the public in terms of what should be included in the system.

Finally, there is proposal to remove the offence portion for the custodians, which was a point of some contention as well. So a number of things that this amendment speaks to, but I think they respond to a number of the concerns that were heard through the consultative process.

The Chair: Just for clarity, then, Mr. Olson, these all address the proposed part 5.1 in the bill? That's my understanding.

Mr. Olson: I don't have it right in front of me, but yes, I think so.

The Chair: I imagine colleagues may have some questions for you or for the department representatives.

Ms Blakeman: Well, is it 5.1 or 6.1? Part 6.1 is the health information repository, and that also definitely contains section 107, which is amending sub (6).

The Chair: Mr. Chamberlain, do you want to clarify that for us?

Mr. Chamberlain: If I understand the amendments correctly, the bulk of this would speak to the minister's directing power, which is 56.3, I believe, in part 5.1. Ms Blakeman is correct. The reference to 107 is the offence section, which is in the next part.

The Chair: Okay. Well, seeing no hands, I'm just going to ask a couple of questions for clarity if that's all right. Mr. Olson, the first two paragraphs of this are addressing, as proposed in the bill, the directional authority of the minister to compel a custodian to share information with other custodians via the electronic health record. If I understand this right, the idea is to point to the colleges, which, you know, exist through legislation. They're public bodies with public representation, they set standards of practice and codes of conduct, and the idea is that the authority more appropriately resides in them.

Mr. Olson: That's right, and I think, you know, some of the feedback we heard was a feeling that there should be more input from those bodies.

The Chair: Conceivably, then, if this was to be adopted, you know, after our report goes to the House and so on, we would see colleges develop their own standards of practice and codes of conduct around the electronic health record.

Mr. Olson: I don't know if this is naive or not. I would hope that in a perfect world there would never be any need for the minister to get involved. The colleges would be requiring their members to provide that kind of information anyway. I think that would be the hope.

The Chair: If I just continue here – and if other colleagues want to get in here, just please indicate to the chair – you're saying that halfway through the second paragraph, in the event the minister determines it's in the public interest to have information provided and the colleges haven't taken steps, you're proposing sort of a filter here for the ministerial authority that involves consultation and so on.

Mr. Olson: That's right. I mean the minister can't trump the involvement of the colleges without any kind of a balance there. He still has to consult with the colleges. He has to consult with the Privacy Commissioner. The Privacy Commissioner would have to review the impact assessment, and only then, you know, would the minister be able to act. So there are a number of hoops he would have to jump through before he would override what the colleges had done.

The Chair: Just going a little further on, then, I just wondered if you could talk a bit about this data stewardship committee and how it works.

Mr. Olson: It's my understanding that the minister or at least the department already gets some input like this. I think this formalizes it and would require that interaction at the ministerial level rather than perhaps just within the department. I think the other important thing it does is specifically includes members of the public, and I think that, again, this is consistent with some of the input that we heard through the consultative process. I think that's also going to be a valuable resource for the minister.

8:50

The Chair: Okay. Then, finally, the offences that you're referring to here were the offences that pertain to failure of a custodian to comply with a ministerial direction as was proposed originally in the bill.

Mr. Olson: Yes. That was the one that had heavy financial penalties for failure to comply.

The Chair: Any discussion on this? Obviously, when it's drafted, there will be a fair bit of work that goes into putting this in legal form and referencing appropriate parts in the bill.

Ms Blakeman: Mr. Olson, do you have a reference for your data stewardship section in either the original Health Information Act or in Bill 52?

Mr. Olson: I think it was an informal thing. I don't think it's legislated. That was my understanding, anyway. It's formalizing something that was not legislated.

Ms Blakeman: Where would you be suggesting that it be inserted?

Mr. Olson: Well, again, as Mr. Horne just suggested – I haven't gotten so far as to figure out, you know, which section it should be in in the amending act or even really coming up with wording. It's kind of a proposal for the concept to be included.

Ms Blakeman: Okay.

Ms Notley: Just to get some background, can I assume this is designed to deal with that process where we're trying to decide what goes into the EHR that you described, Mr. Brisson, I think, with consultation with different health care providers, different physician communities, different players within the system in terms of what kind of information ultimately gets into the electronic health record? Is that correct?

Mr. Brisson: The process I describe would feed into the process that's being proposed here, so the technical details of the data, the systems, those types of things, are a different level of discussion, which would include those provider groups, Alberta Health Services, et cetera. That would then feed into the EHR data stewardship committee and the colleges in defining the access, use, roles, and responsibilities for that data now that it's going into the electronic health record. The college would be responsible for mandating the compliance with that data, and we're working with our members to do that.

Ms Notley: I'm just trying to distinguish between the concept of having the colleges enforce versus the concept of providing for more consultation and advice and committee work and all that kind of stuff for coming up with the content of the information that particularly physicians need to provide to Alberta Netcare. Is this both of those things, or is it just more enforcement?

Mr. Brisson: It's both of those things. The same providers will be at the table determining what information as well as the compliance and enforcement.

Ms Notley: Right. My understanding is that in some cases, for instance, the college of physicians has expressed some concern about, ultimately, physicians being directed under, you know, very strict circumstances to provide information when they either don't believe it's in the best interests of their patient or their patient has asked that it not be or whatever.

This question is to anybody. It's not just meant to you anymore. It's more of a discussion. Were we to go through this process and information were to be identified as necessary for inclusion in Alberta Netcare and that were to happen and there would be consultation with the college and ultimately the college was not prepared to go that extra mile and recommend that a certain piece of information be included and the minister then went ahead and ordered it, do you see there being problems with the college being required to enforce something that they, I think, have already suggested may raise ethical concerns for them? To anyone that wants to jump in.

Ms Miller: It likely could present a challenge for them. That is correct. I would anticipate, though, that this clause probably, if it has to be used for the compliance function, would more likely occur under the circumstance where an agreement has been reached by the college to direct their members to share this amount of information, whatever this is. But there are certain individuals out there that for

whatever reason decide they're not going to do it. You know, they just have their own opinion on these things. So I would envision that the compliance function that the college has with this proposed amendment is likely the area where that would be their role, and appropriately so, because there has been agreement to share X information, and certain individuals have chosen for whatever reason not to do it.

Ms Notley: Well, that's fine except I don't think that's what is actually in here. What's actually in here is the notion that there'll be consultation with the colleges and that there'll be consideration of a privacy impact assessment, but ultimately none of those are binding on the minister, so the minister could well proceed without the agreement of either the Privacy Commissioner or the college. Then what we're proposing here is that the college would be asked to enforce something that they wouldn't necessarily have agreed to. That's how I've read this proposed amendment. Was there consultation or discussion with the college about this proposed amendment?

The Chair: I'll answer that. Yes, my understanding is that there was considerable consultation.

Just sort of by way of background, there's actually a precedent for this kind of filter in other legislation. If you look at Bill 41, which was the Health Professions Statutes Amendment Act, 2007, I believe, that arose out of the concerns around infection prevention and control several years ago. The province came out with province-wide infection prevention and control standards. Government in its role of assurance for the safety and quality of the health system wanted to ensure that those standards would be binding for all professions across the province, that they would have total application. That particular bill provided the ability for the minister, with this sort of consultation that's here, to direct colleges to include those standards, those infection prevention and control standards, in their codes of conduct, standards of practice, governing sorts of documents.

My read of this is that it's a similar provision, but it includes the consultation. It adds the Privacy Commissioner given that keeping that balance is a main concern here for us as well.

Ms Notley: Right. I could see in that previous scenario that what you're dealing with is personal patient rights and that relationship versus the competing public health interest whereas this one wouldn't necessarily have the same sort of emergent nature to it that the example you're describing would have.

The Chair: Well, the staff may want to comment on it, but you know, what I would say in response, assuming that that's directed to me, is that the similar duty of assurance applies to the accuracy and completeness of information in the electronic health record in order that services of appropriate quality can be provided based on having the information available, that they can be provided safely so that missing information doesn't result in a contraindication of medication or some other intervention that may compromise patient safety. That would be my answer.

Ms Notley: Yeah. I would say, though, that you're still talking about patient safety within the context of that patient's care versus public safety to be weighed against an individual patient's rights and/or safety, which is all the one patient – right? – versus the competing ethical obligations of the physician vis-à-vis the one patient. I mean, I appreciate the information. It's important to know that this kind of model has at least been put in place somewhere. I didn't realize that.

9:00

The Chair: Dr. Sherman.

Dr. Sherman: Thank you, Mr. Chair. As I said, this is probably the most significant piece of modern-day health care legislation that can help to ensure the sustainability of the system by improving the efficiency of delivery of public health services in this province. I think this bill is in the public interest, and I'm glad that we're all discussing it. It's been great that we've actually taken time in deliberating these very important decisions.

Health care is evolving so rapidly that everything that we did yesterday we are re-examining. Everything has to be evidence based. We know we have a better way of doing things we did 20 years ago. There are better ways of doing things we did five years ago. It's in real-time clinical practice guidelines where we need to be able to educate the workforce and the front lines in this city and the rural areas. Communication of health information, I believe, is very important. That's in the public interest.

Netcare: I was the last physician in our group to get on it because I was morbidly afraid of technology. I was the last fellow to get e-mail as well. Netcare has evolved slowly. We protected privacy to get to the place where we have gotten to, and as it sits right now, it's an incomplete record; it's not the full record that we require. We need to get certain information from the GPs' offices. I had initially mentioned medications, problems lists, X-rays, ECGs, consultations with other specialists, interventions, and visits. However, we do need to satisfy privacy protection. We have a mobile population interprovincially and intraprovincially. We have duplicated labs and X-rays, duplicated care, incomplete information for patients. We have to balance the risks of privacy versus the risks of care.

From the physician's point of view – Dr. Ausford, for example: his patients have aged over 28 years. He has 2,000 patients. In fact, it was in the newspaper that he had to actually let go of 500 of his patients. He had to pick names out of a hat because he is unable to deliver that care to the same 2,000 patients that he inherited 28 years ago. As anyone knows, a physician's writing isn't that great in the physician's files, in the doctors' offices. When a physician retires or passes away, that information is lost or difficult to get. Those patients are older. They're sicker. They have complex health care issues. For many of them their health has deteriorated to the point where they don't understand or know many of their health issues, and their families are at different ends of the country. There's a glut of senior physicians who are going to retire, with a glut of senior patients.

From the patients' point of view, many patients for a variety of reasons, whether because they're working or from lifestyle issues or inability to access a doctor when they want to, visit multiple physicians and multiple pharmacies and multiple health care providers. From the institution's point of view, previously each hospital had a specialty. Health care is so subspecialized that it's simply not reasonable or practical or efficient to provide all of the care in each hospital let alone in each city and sometimes in each province. There are multiple health providers. We have nurse practitioners who have come online, pharmacists prescribing. We don't really have an efficient way to communicate with one another.

As a physician I am a proponent of the EHR and the EMR, and as you know, I was a critic of my own minister's bill because of some of the things that were in it. As someone who believes in protecting patient privacy, I believe that these amendments that we have before us – we've exhaustively consulted the professions and the colleges. I'm satisfied that if the Privacy Commissioner is satisfied that, with this amendment that is here, patient privacy is protected, and if the

colleges – it's the colleges' duty to the public to ensure standards of care. I'm reasonably satisfied with these amendments.

These are just comments that I wanted to make. Thank you.

The Chair: Thank you.

Well, that's the end of the speakers list. What I'm going to suggest is that if we propose a motion similar to the others, that would give Parliamentary Counsel the direction to prepare a legal amendment based on this. We'll get another chance to look at this, obviously, when it comes back to us in legal form. Would that be acceptable?

Mr. Olson, you're going to move this, then? I'll call the question. Those in favour? Opposed? What I'll say is that the motion is to direct Parliamentary Counsel to prepare draft amendments to the bill based on the document tabled by Mr. Olson marked as 2.

Is that sufficient for the record? Okay.

Just a couple of comments, then, in terms of where we go from here. I think we should have a bit of a discussion. I haven't been notified of amendments that other members may wish to propose for inclusion in the report. We can certainly still consider those. I have been told that it would be possible for counsel, working in conjunction with department counsel, to perhaps have these things we've agreed to drafted in legal form for us to look at potentially as early as Wednesday during nonsitting time in the House. I'm not sure that we actually have a need to meet tomorrow unless there are other things that people want to bring forward, but I am aware that a number of members aren't able to attend the meeting that's scheduled for tomorrow.

What I would like to suggest is that if you're willing, we will call another meeting for Wednesday during the dinner break, and we'll see what's been drafted for us by that point by Parliamentary Counsel and try to keep going. Otherwise, we're getting into constituency week next week, and I would hope that we could avoid a meeting. I suppose that if we needed a short meeting and people could participate by teleconference, we could do it that way as well. Most members I've talked to indicated an interest for keeping things going and trying to get as much done during the business week this week as we can.

Ms Blakeman: Just reviewing the notes again, a couple of issues seem to still be outstanding, and I wonder if there are any motions forthcoming. One is around that custodian issue that was raised by both the Calgary Chamber of Commerce and the city of Edmonton in their submissions around employers being designated as health providers because they're holding people's health records. That's still outstanding. Also, the Treaty 8 issues that have been raised are still outstanding. I personally am not clear in my head how the health information repository stuff works. I think there are some issues there, but it's a little hard to piece it together. Is the government bringing amendments on any of that, or have we seen what you guys are doing?

The Chair: I believe this is it so far.

We've got 20 minutes. Can we perhaps ask for some assistance from the department in just clarifying this issue with respect to employers? You might have to go back to actually how a custodian is appointed, a bit of a review, and then how this concern raised by the municipalities would play into it.

Ms Notley: Just on that issue – that's the only reason why I'm jumping in – I have a concern about how we define custodians in the future. You know, there are certainly the issues that were raised by those submissions, but I think that there are actually additional issues that need to be considered vis-à-vis the type of private-sector health

care providers who may or may not have interests; you know, insurance companies.

If we think through this whole issue of who is a custodian, I really need to see some more significant limits than what we've got right now. So if you're asking them to talk through that and think through how to respond to those concerned – I mean, whoever is let into that safe arena, as it's been described to us tonight, that's incredibly critical to how this operates. Right now this act has no limits on who the government by way of regulation can let into the arena. That is a fundamental concern that I have.

As I was saying to you earlier today, I'm just trying to refamiliarize myself with this, and I haven't had the chance to draft up any amendments, so I don't have any right now. But on that issue, if they're going to look into it, could you ask them to address it on a broader basis?

9:10

Ms Blakeman: Well, paid and unpaid: that's the other piece here.

The Chair: Excuse me. Is this on the same matter?

Ms Blakeman: Yes. It's about custodians, and it's about whether they're paid under the Alberta health care insurance plan to provide the health services or not. That's one of the pieces we're contemplating adding in, correct? Yes. This is the critical piece: who's allowed in, and what are the parameters around that custodian arena? Who's allowed to be in?

The Chair: Okay. Keeping in mind that our proposals here are restricted to the things that are proposed in Bill 52, do you want to take a run at this, Ms Miller?

Ms Miller: I think we'd better come back on that. I hear the concern. I think we need to come back to the committee on those comments.

Ms Blakeman: Okay.

The Chair: Okay. We'll ask you to do that in written form as well. I think that would be helpful given the complexity.

I should have said, Ms Blakeman, that we're keeping a running track up here of sort of outstanding issues that have been raised. Do you have a specific question around health information repositories?

Ms Blakeman: No. I'm sorry. I just haven't had time to do the work. There are issues there; I just can't remember what they are in the back of my head. I'll have to do the work before the next meeting.

Ms Notley: On that issue of the health information repositories I think there are a couple of issues around it. There were, of course, the health care professional groups that wanted access to those for the purposes of monitoring their own profession.

More of a concern for me was the idea of there being a more publicly accountable sort of model or board that oversees the health information repository and having that included in the act as well as there being some guidance around the issue of secondary use of information held by the health information repositories.

Just going back to what you were mapping out in terms of the schedule, there really are a number of issues that remain outstanding. I'm a bit concerned that the schedule that you're talking about isn't going to be able to deal with them. As I've already discussed, with three days' notice I'm unable to attend tomorrow. You know, I appreciate that we'd planned these evening meetings previously, but then it was decided that we were going to night sittings. I mean, this

is a very complex piece of legislation, and I don't want to be forced into a situation where in addition to the night sittings, we have to be here at 3 o'clock in the morning because we've decided we have to run this through with a very short lead-up.

I know you did a lot of work trying to get everything ready, but if we're suddenly having our meetings cut short because the Legislature is sitting when it wasn't supposed to be and then we suddenly don't believe that we can go into, you know, the next three weeks because the Legislature might end sooner than it's supposed to – I just don't think it's responsible to ram this thing through without a thorough discussion because there are several issues remaining around a very complex piece of legislation.

The Chair: Well, I'll just respond on the points with respect to process and probably take issue with a couple of things that you raised. First of all, the information that's been coming in in terms of the written submissions, the presentations, the summary report that was prepared by LAO research: all of that has been available to members of the committee for some time for their review. I think I asked or reminded members in a couple of the memos, at least one, the most recent one, that you please come prepared to begin deliberations on the bill as of this meeting. A fair bit of work, obviously, has gone into – I know you appreciate that – what we've put forward this evening.

In terms of the time that's available, that's a function of the availability of committee members. I recognize that we're all working very hard, and we've just come through estimates. Believe it or not, it's as tough a time on the government side of the House for a lot of members as I'm sure it is for those in the opposition parties.

I mean, my understanding is that these are the specific amendments that government members wanted to table with the committee. If there are additional ones, you know, we will need other members of the committee to come and present them, and we can have the same sort of discussion.

That being said, you know, as chair I do feel an obligation to keep things moving here. This bill came out in the fall session. We passed a motion in the House that was unprecedented, to bring it back into this next session of the Legislature, and there are steps to go through upon tabling our report, namely debate in Committee of the Whole. So it's not just a case of when the Legislature might stop sitting; it's also a question of all of the steps that take place that are depending on us tabling this report.

Ms Blakeman: Sorry. I didn't want to interrupt you. I just want to get on the list.

The Chair: You're on. Go ahead.

Ms Blakeman: Okay. I'm sorry; which memos? The only memo I can find from you is dated April 1. What other memos?

The Chair: No. I sent a memo to members last week, I believe, just reiterating what information had been posted and that the submissions had been posted as received, and please come prepared.

Ms Blakeman: Okay. Sorry.

The Chair: Obviously there's been some briefing with both Ms Pastoor and Ms Notley at least about these items before this evening. I'm quite comfortable that . . .

Ms Blakeman: Fair enough, but briefing my colleague this afternoon doesn't – given our House schedules and everybody else's schedules, I mean . . .

The Chair: Actually, there have been a number of discussions prior to today. I'll take no responsibility for people sharing information amongst themselves. I can assure you that I've provided any information I've had as it's become available.

Ms Blakeman: Okay.

The Chair: I guess the question then is: where do you wish to go from here? If members believe they're going to have other things to bring forward, I suggest we either meet tomorrow as planned or find another time this week to convene another meeting.

Ms Notley: This goes back to what I was saying. I mean, first of all, just to go back a little bit, as you know, I was briefed on these motions this afternoon at about 3:30 or 4, so it's not as though there's been a tremendous amount of opportunity. Now, when we thought about coming to this meeting to talk about and to deliberate on this bill and you asked us to be prepared, well, I think I have actually been fairly prepared up to this point on what we've had an opportunity to discuss.

Having said that, I also know that we've managed to cover about one-third of the issues. In terms of being prepared to go forward with additional amendments, my preparation schedule was premised on the schedule that was given to me about a week and a half or two weeks ago, that did not contemplate a meeting tomorrow morning that I can't make. It had contemplated two and a half or three hours Wednesday night, but now we can't do that. I appreciate that these are not constraints that the chair has put in place. I appreciate that you're operating under other constraints which are not yours, but I do think we need to take some note of the new constraints and that it's simply not reasonable for us.

I mean, you guys may have all talked about it and be prepared to call the question after it's been read once or twice, but this is a complex issue. We're opposition members on this committee. We're being asked to review this and deliberate this, and it's not unreasonable that it would take two or three meetings to go through this stuff and really, fully know where we're at with it. Unfortunately, due to situations outside of your control, we've now had to drastically reschedule. The difficulty is that with two days' notice or three days' notice, I can't be here tomorrow, and the dinner-break hour on Wednesday is not going to be adequate to be able to deal with the two-thirds of the issues that remain. I mean, I'm happy to move forward as quickly as possible, too, but it's just not realistic that we're going to get it all done by Wednesday.

9:20

The Chair: Any other comments on the process going forward?

I'm not going to go through the process of, you know, polling people on meeting dates and so on right here and now. I appreciate your comments. We're obviously constrained by night sittings in the House. The standing orders prohibit committees meeting while the House is sitting without leave of the Assembly. We're not going to ask for leave of the Assembly so the committee can sit while the House is in session. I don't think you'd probably advise us to do that either.

What I'm going to suggest is the following. We've tabled some things here that have been approved. There's some work that's going to begin now on drafting these amendments. We could proceed with the meeting tomorrow, but given that, I believe, all three opposition party members that are here can't attend, I wasn't planning to go ahead with that. I would like to see us at least devote some time on Wednesday to this. It might not be the final discussion, but I think we should try to keep things going. I'll wait for some other comments from the committee.

The other thing we could look at is meeting during constituency

week. Quite a bit could be accomplished in a half day or a day. Again, assuming members are prepared to come forward with specific proposals for the committee report, I think quite a bit could be accomplished, perhaps, in that regard. I could ask the clerk to poll members for their availability. I'm not sure the conclusion will be much different than people's availability tomorrow, but we can do that. Certainly, recognizing that the bill has some other steps to go through that are dependent on us tabling this report, you know, my view is that we should be looking to table our report on or about May 25.

Mr. Dallas: Well, Mr. Chair, I can only speak for myself, but my preference would be to continue to try and move the process, which would entail meeting on Wednesday. Certainly, I would be prepared to meet during constituency week. I would suggest a proviso to that, though, is that we could continue to kick the can around here. I think specifically we need to discuss only amendments that would be placed on the table, drawing those to a conclusion and ultimately preparing for the committee to provide a report. My suggestion would be that if we're compelled to meet during constituency week, the sole agenda of that meeting be to debate, discuss amendments that have been forwarded to the committee, with the idea that on conclusion of that discussion we would as a committee be prepared to make recommendations that would be included in the report.

Mr. Quest: I absolutely agree with Mr. Dallas. Why don't we get as much done as we can on this coming Wednesday if we go 11:30 to 1 or something like that and then just see where we're at? But if there's going to be more discussion and further discussion on these points, then, yeah, it should be in the form of amendments. If those amendments could be ready for Wednesday, we've got something on the table to talk about, and then we'll know where we're at.

Ms Notley: Sorry. I didn't quite understand that. You're talking 11:30 to 1 and then amendments being ready for Wednesday. I'm confused about what days we're talking about.

Then my second question was that the last I heard I thought we had meetings scheduled to discuss this – and I have to say that I did sort of plan things out on that premise – 9 to 11 on Tuesday, May 26, and then also in the afternoon of Thursday, May 28, that those dates were put out as meeting dates. So I'm a little surprised that now suddenly we're looking at actually having something submitted to the Legislature on May 25. I mean, this does seem to me like suddenly everything has gotten moved up.

The Chair: What I'm going to suggest is that the clerk poll members for their availability. We will attempt to meet on Wednesday, if people are available, for only a brief time. During the dinner break is what we were considering. Quite frankly, the other option was to go Wednesday morning as well, but a number of you are on Public Accounts. It's very problematic, but, you know, I do believe we've got a responsibility to move ahead in an orderly fashion and complete our work on this. Can we agree that we'll meet Wednesday during the break between sittings of the Assembly? It would be from 6:15 to 7:15. Let's reassess the situation at that point. We may have some draft legal wording come back from Parliamentary Counsel.

I'm going to ask that if there are other specific amendments that members want to have discussed, you forward those to the clerk prior to Wednesday, if possible, recognizing that people have busy schedules. Then perhaps on Wednesday we'll take a look at a subsequent meeting time.

Karen was just suggesting as well that, you know, another possibility, not palatable for some people, I'm sure, is to meet after adjournment on Thursday given that we adjourn at 4:30. We could look at that. We could look at constituency week. I'm going to ask you to think about it between now and then, and we'll have a chance to talk about this more on Wednesday night. But if I could just appeal to you. People seem to know what the issues are that they're concerned about. Again, if you have specific amendments, let's put them on the table in black and white, and let's have some discussion about it so we can give appropriate direction to Parliamentary Counsel.

Ms Blakeman: What I'm hearing is that if we don't have an amendment or don't have the time to come up with an amendment, we can't bring the issue before the committee for discussion. Is that correct?

The Chair: Well, my understanding is that you have raised the issues, Ms Blakeman, and the challenge before the committee now is to deliberate, prepare its final report, and table it with the Assembly. That's the stage we are at in these proceedings. We can certainly have discussion. My respectful suggestion is that unfocused discussion that's not addressing things that we may wish to include in our report is probably not a productive use of our time. I say that with respect. It's time to move here and address our report. That is our responsibility to the Assembly.

Ms Blakeman: I'm sorry. Was there a specific timeline that the committee was charged with to report back to the Assembly? Did it have to be before we adjourn the spring session? Was there a specific date?

The Chair: I'll ask Ms Dean on that one. I don't believe there is a specific date in the motion.

Ms Dean: No, there's not.

The Chair: Well, other members can comment, but I think you'll find that now that we're in our second session reviewing this bill – I'll speak for myself, anyway – there's probably not a lot of enthusiasm on my part to see this move into a third session.

Ms Blakeman: I see. Well, always nice to know.

The information that the departmental officials were asked to provide, need that also come in the form of an amendment, or will they be allowed to provide the information?

The Chair: Well, of course, if you can provide the answers to those questions by the next meeting, that would be appreciated.

Ms Blakeman: Good. Thank you.

The Chair: Okay. I don't know if there's any other business here. Tomorrow's meeting is cancelled due to the lack of availability. We will meet here again on Wednesday at 6:15. You know, we certainly appreciate the constraints that people are under with their time. We have been and will continue to do our best to accommodate as many people as we can.

Is there any other business?

Seeing none, could I have a motion to adjourn, please? Mr. Vandermeer. Discussion? Those in favour? Thanks very much.

[The committee adjourned at 9:30 p.m.]

