Medical Records Policy Framework

“Toward a Single Patient Record”

March 2015
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Preface

The evolution of eHealth in Alberta is an ongoing and complex process. There are many perspectives, and many context-specific factors which might affect the timing, adoption and utilization of eHealth tools to optimize the quality of health care delivery through the creation of a single, integrated patient record.

This document outlines the position of the College of Physicians & Surgeons of Alberta (CPSA) and recommended course of action to facilitate the adoption and use of electronic medical records (EMRs) and Electronic Health Records (EHRs), and the meaningful use of health information by physicians. It is intended to provide a starting point for consultations with physicians, to inform the development of standards of practice and advice for the profession as the eHealth environment evolves.

The CPSA also hopes this document will help clarify for other organizations and stakeholders developing eHealth tools and programs the advice and standards the CPSA provides to its membership.

CPSA Role in eHealth

The CPSA’s interest in eHealth reflects its mandate to ensure the quality, safety and continuity of patient care, to establish and maintain ethical and professional standards of care, and to advocate for public policy which contributes to the health of Albertans. The CPSA vision for eHealth is a health care system where:

- all medical records are fully electronic, with sufficient discrete data to enable an integrated and interoperable exchange of health information
- physicians and other health professionals have the training and support to use eHealth tools and processes effectively, appropriately and safely
- continuity of care is optimized by appropriate sharing and exchange of information facilitated by a single patient record
- the quality of care is optimized by appropriate access to information, and decision support and practice audit tools
- there is a comprehensive base of information which appropriately supports providers in the delivery of care to their patients, as well as management of the health system, research and other valid secondary uses of information

CPSA Rationale and Involvement in EMR and Alberta Netcare

The CPSA’s interest in the adoption and use of EMRs and Alberta Netcare (the provincial EHR) reflects the CPSA mandate to ensure physicians practice in a manner that enhances the quality of patient care, including patient safety and continuity of patient care. In addition, the CPSA establishes and maintains professional standards of practice which includes providing advice and direction to physicians on:

- the clinical value of medical record documentation for patient care, clinical and practice workflow / processes, practice analysis, research, regulatory and legal processes
- the use of electronic information
- transition to EMRs
- public policy development in the physician adoption and use of electronic medical and electronic health records
- the systematic integration and interoperability of EMR data with Alberta Netcare as a tool to advance patient safety and quality of care
1 CPSA Position

The CPSA supports the position that every patient in Alberta should have an integrated electronic record\(^1\) that is accessible by all healthcare providers involved in the patient’s circle of care, and by the patient as well.

Implicit in the CPSA position is that at some point in the future – timelines and dependencies to be determined – every physician practicing in Alberta will have:

- access to an EMR to document the patient’s history and working diagnoses, as well as the advice and treatment they have provided to a patient as a requirement of practice
- integration and communication capabilities to and from the EMR
- access to and use of relevant information in Alberta Netcare (the provincial EHR)\(^2\)

Medical records are an integral part of medical practice. Physicians have professional and legal obligations to maintain a record of their patients’ medical care. A physician may have exclusive or shared custody and control of a medical record, in all cases within a fiduciary relationship with the patient, and including the content, confidentiality, access, integrity and records management processes.

The past decade has seen a dramatic increase in the use of EMRs, the introduction of shared information in EHRs and the exchange of information using electronic communication tools, although there is significant variance in the deployment and use of these tools and processes. In addition, the physician’s role in stewardship of the supporting medical records is evolving.

1.1 How EMRs and Alberta Netcare are Changing Practice

The use of EMRs and development of shared medical records as integral communication channels within the health system represents an evolving and fundamental change to the practice environment. Patients and health system leadership have an expectation physicians will adapt and evolve with these cultural and procedural changes, and physicians have an expectation the CPSA will provide leadership and direction for the standard of care as it relates to medical records.

The adoption and use of EMRs is a core dependency in achieving aspects of the CPSA Vision for eHealth, specifically:

- **all medical records are fully electronic**, with sufficient discrete data to enable an integrated and interoperable exchange of health information

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1 An “integrated electronic record” is the concept of a seamless integration of information in an electronic format so that patients and their care team use the most up-to-date and readily accessible information to deliver the highest quality of care possible. There is a comprehensive base of information supporting an integrated care plan with full data integration for contemporaneous care.

2 The CPSA does not have a position on what product(s) (or sets of integrated products) are used to accomplish the goal of an integrated electronic record. The current architecture comprises multiple Clinical Information Systems (CIS), each with multiple vendors and software solutions, Electronic Medical Records (EMR) and an Electronic Health Record with an interoperability / interface infrastructure (Alberta Netcare). This architecture is expected to evolve, and the CPSA will continue to participate and contribute in its evolution, and adapt standards and advice for physicians as required. This paper uses the terms EMR and Alberta Netcare which reflects the systems in place today, but the issues addressed could reasonably apply to future technology-enabled systems of clinical documentation.
continuity of care is optimized by appropriate access, sharing and exchange of information, and decision support and practice audit tools.

The historical principles of medical record ownership (i.e., the physician/clinic/facility that compiles the physical record owns the physical record, and the patient owns the information contained in it) are well established within the profession and generally codified in legislation in terms of “custodians”. Implicit in “ownership” of the medical record is custody and control of the record, as well as access, use and disclosure of the information in the record. Another key principle is the duty of the physician to ensure the patient’s wishes regarding the sharing (or not) of his/her medical information are understood and respected.

However, the context of full physician custodianship of the medical record is changing with the emergence and growing utilization of EMRs and EHRs, specifically with:

- shared control of medical records
- consolidation of inpatient, ambulatory and office/clinic records

While the physical record may exist within a group or facility setting or under the management of an information manager, the custodial duties and ethical and professional obligations still apply to the individual physician. The traditional one-on-one relationship between the physician and the patient (and individual control of the medical record) is becoming less prevalent. Increasingly, there is shared custody of the record and therefore less control by the individual physician.

In addition to the traditional office or clinic based medical record, shared patient-centric records are emerging which are managed in central repositories and accessible to authorized healthcare providers involved in the patient’s care. The Alberta Netcare portal and underlying data repositories have been operational for almost a decade and achieved a high level of maturity and use. The technology platform, comprehensive clinical working groups and support programs for deployment, training and registration are all well established and functioning as an important information sharing conduit. Netcare has been deployed in over 1,100 medical practices, most community pharmacies, and most AHS facilities in Alberta.

There are increasing demands and pressures on the structure and use of EMRs for a growing number of purposes (e.g., record integration, automated health system processes, patient portals, etc.), and more stakeholders may contribute to the content and use the information in the medical record.

The implications for physicians managing the records in their custody are significant. Different physician specialties and groups can and will have medical records unique to their practice, specialization and patient population. There is significant variance in charting techniques and content due to the unique requirements and workflow of a practice, and the preferences and charting protocols of each physician.

The issue is not solely about the technology; just as important are expectations regarding the content of medical records and the communication and sharing of that information within the health system. The CPSA intends to provide direction and advice to physicians to address these changes and the changing obligations of this new environment.
2 Evolving Standards of Care

2.1 The Medical Record

The CPSA Patient Records standard of practice\(^3\) establishes current requirements for physicians to document and retain the advice and treatment of patients in a patient record. The standard establishes that the medical record must contain enough information for another physician or other regulated healthcare provider to be sufficiently informed of the care being provided to the patient and provides a set of minimum criteria regarding the content of the record. The standard is mainly principle-based, and applies to both paper and electronic records.

**Primary** purposes for a medical record today (irrespective of format) include:

- documenting the advice and treatment provided to a patient, in sufficient detail for another physician or healthcare provider to be informed of the care being provided
- enabling patient access to the information in their medical record
- supporting legal and regulatory processes and QA/QI reviews
- supporting analytical processes and medical research
- supporting billing and other practice management requirements, including reporting against defined outcomes or other measurements

The intended users of the medical record are the physician and their staff directly involved in the patient’s care.

**Emerging** purposes for a medical record (primarily in electronic format) include:

- systematic integration of medical information in EMRs to shared EHRs
- systematic integration of medical information in EMRs with automated decision support tools and health system processes
- systematic integration of medical information into shared repositories for primary and approved secondary uses
- patient engagement through the use of patient portals, email or other electronic and social networking tools accessible to patients (while still conforming to privacy regulations)

There is a broader set of intended users of the record (and subsets of the record) than the physician, and the information may be used in different settings than where the data was originally collected. Parts of a shared record may not have the broader context of the entire record.

2.1.1 Addressing the Gaps

The current Patient Records standard of practice does not address the emerging purposes of the medical record, nor the uniformity or consistency required for integration. Continuity of care requires:

- awareness and understanding of how information is stored, shared and expressly communicated

\(^3\) [http://www.cpsa.ab.ca/Resources/StandardsPractice/PracticeManagement/patient-records](http://www.cpsa.ab.ca/Resources/StandardsPractice/PracticeManagement/patient-records)
• a reliable, accurate information exchange in the circle of care, including patient access and contribution to the record
• continuity in the management of the patient’s condition
• clarity in the responsibilities of each provider
• patient awareness and handling of exceptional circumstances

As such, changing practice will require:

• medical records systems and applications capable of interoperability and structured information exchange
• uniform, standardized content in all medical records for any data that needs to be interoperable and fit for sharing, including discrete/textual data, semantics, coding, level of detail, etc.
• standardized terminology and coding that meets the needs of the treating physician, other healthcare professionals, and patients who may have limited capability/literacy to interpret medical terms and standards of practice
• charting protocols and data structures for dealing with sensitive information, unconfirmed or suspected diagnoses, non-compliance, differing clinical opinions, relevant non-clinical or situational data such as behavioural information and cultural bias, private “thought data” and mental notes, etc.
• data analytics to be available to physicians to support quality improvement, practice reflection and physicians’ understanding of their patient population

Health system processes that depend on standardized workflow (including the coordination and prioritization of care) will require:

• defined process steps with clear accountabilities and responsibilities, supported by interoperability standards
• coordination in the transfer of care and the management of shared information
• tracking and update of process steps/status
• common management of alerts and warnings
• physician and patient engagement

2.2 Shared Medical Records

The CPSA Patient Records standard of practice provides limited direction on the standard of care for the shared custody and control of patient medical records, including requirements to:

• have in place an information sharing agreement and an information management agreement
• have arrangements for ongoing custodianship of the records
• ensure physician access to relevant records, even if the physician is no longer participating in the shared record

The CPSA also contributed advice and direction on the development of the Information Sharing Framework between Alberta Health Services (AHS) and participating physicians, which provides the basis for defining the duties and obligations of all parties. Care must be taken to clarify and
separate the custodial roles and duties versus the roles and obligations of the Information Manager, who may in some circumstances act on behalf of the custodian.

2.2.1 Addressing the Gaps

The Health Information Act (HIA) does not include shared medical records in its construct nor does it articulate the legal obligations for physicians as custodians. The current definitions of custodian and affiliate are not adequate for this type of structure and may in fact complicate physician participation.

In a shared record environment, data stewardship may be governed by multi-disciplinary committees and legal agreements, which may limit the control of the individual physician. However, the professional obligations of the individual physician are not diminished as a result of shared custody. Different approaches and the commitment of individual physicians to accept and extend those obligations to others who share control in the group are required.

We believe it is critical to establish clear professional obligations which reflect and balance individual duties and shared control.

2.3 Use of Alberta Netcare

The patient information currently accessible in Alberta Netcare is passive in nature, and authorized users can use that information for purposes commensurate with their skills, comfort level and practice requirements. There is no regulatory framework for these purposes, other than the as-yet unused mandate of the CPSA to direct physicians to transfer prescribed data from their EMRs to Alberta Netcare.

The legal basis for these purposes is the HIA, and governance is exercised through the various bodies and committees of Alberta Provincial Health System IM/IT Governance Model. The College is a stakeholder member of these committees, but accountability and direct authority is primarily through the government. Enforcement of the legislation is through the Office of the Information and Privacy Commissioner (OIPC).

Patient information in Alberta Netcare includes:

- personal demographic information to uniquely identify each patient
- prescribed dispensed drugs
- known allergies and intolerances
- immunizations
- laboratory test results
- diagnostic imaging reports and images
- some event history, such as inpatient, outpatient, emergency ADT
- some other medical reports, including consultations, discharge/transfer summaries, admission history, etc.

2.3.1 Addressing the Gaps

Use of Alberta Netcare by physicians is currently voluntary and is not referenced in any existing CPSA standard of practice, but could potentially provide physicians with new tools and
information to enhance patient care. While not reasonable or necessary to expect physicians to access Alberta Netcare for every patient encounter (or for every patient), or to evaluate all the information available in Alberta Netcare, in certain situations Alberta Netcare may be the best and most timely source of relevant and critical patient information. There is an expectation physicians will use the best tools and information at their disposal. In the event of an adverse outcome, a physician might be required to justify why those tools or information were not used.

The deployment of a new information management tool or system, particularly one that can impact both an individual’s practice and the communication between other physicians, pharmacies and other health care professionals, requires a thoughtful and structured approach to maximize the chances of success and limit the risks to patient care.

The necessary changes to clinical and administrative processes will affect the traditional, well-defined and well-understood physician and staff roles, workflow, procedures, medical records and the patient-physician relationship, and pose a very real risk of impacting the quality of care and patient safety. Physicians have ethical and medico-legal obligations to protect the integrity of their medical records and the continuity of care during the transitional period.

2.4 Data Stewardship

In this context, data stewardship refers to the management of health information by health professionals, and includes the collection, use, disclosure, management and security of the health information in their trust.

While data stewardship is a system-wide issue that requires input and consistent policies from all professions and health delivery organizations, each aspect has legal, ethical and best practice considerations specific to physicians due to the fiduciary duties inherent in the patient-physician relationship.

Physicians have a professional obligation to create, use and maintain the patient’s medical record in the best interests of the patient. The rights of patients to privacy and confidentiality of personal information are well established in law. Hence, physicians have a well-established and accepted duty to protect the confidentiality of patient information – it is one of the fundamental tenets of the patient-physician relationship. There is also a legal obligation to protect the privacy of data collected related to the delivery of care.

The health needs of patients are by nature supported not only by the relationship of the patient and the physician, but also by the team-based and facility-based care delivery models of the health system as a whole. The CPSA also accepts that physicians have responsibility to support the overall health system with the use of individual information for health system management, and to support the public interest and need for ongoing biomedical and clinical research and other defined uses. Maintaining the public’s trust in both individual physicians and the health system is dependent on protecting the confidentiality of patient information while allowing reasonable access to and use of patient data for other purposes.

2.4.1 Addressing the Gaps

Creating policy and governance infrastructure that balances the obligation to improve public (population) health with the need to respect and protect individual patient autonomy is critical. In other words, a balance must be achieved between the patient’s rights to privacy and
confidentiality and the potential benefits to society. The costs and benefits implicit in the balancing of these competing interests must also be considered. Ethical use of information and the professional conduct of all the parties involved is fundamental, as is effective oversight of the entire process to ensure balance is maintained through appropriate controls and evaluation.

With the use of shared EMRs, systematic disclosure of information for primary and secondary uses and the growing accessibility of information for secondary uses, consistency in the application of rules across professions and organizational boundaries is essential. Regardless of who is responsible for information management, physicians need to be confident that whenever they share or disclose patient information, subsequent decisions about the use or disclosure of that information will be made on the same legal basis and principles and very similar ethical/professional bases they would have used.
3 CPSA Priorities

The CPSA believes critical next steps are:

- Design of principles, policies and regulatory processes to:
  - enhance the use of medical records to add value to a patient’s care
  - enhance the coordination of care amongst all care providers through the creation of a single, integrated patient record
  - ensure consistent and structured management of data in the medical record to enable appropriate information access, improved decision making and efficient communication (i.e., meaningful use guidelines to facilitate charting standardization for all systematic interfaces of EMR information)
  - clearly state the professional obligations within the physician’s span of control in the practice environment

- Development of a strategy that:
  - identifies the timing, conditions, dependencies and exceptions for establishing use of Alberta Netcare as a standard of care
  - identifies the timing, format, conditions, dependencies and exceptions for establishing use of an EMR as a standard of care
  - identifies the timing, format, conditions and dependencies for the systematic transfer of EMR data to Alberta Netcare
  - supports the transition to a new model of a shared, integrated record
APPENDIX: Toward Defining a New Standard of Care

The following represents the College’s perspective on the appropriate use of EMRs and EHRs to enhance patient care in a fully integrated eHealth environment. As eHealth evolves, this work will inform development of standards of practice and advice to support physicians in meeting their professional and ethical obligations. Any revisions to the CPSA Standards of Practice will undergo formal consultation with the profession, government and others, and require the approval of College Council.

1. Medical Records

The primary purposes of a medical record should be expanded to include:

- documentation of the advice and treatment provided to a patient, in sufficient detail for another physician or regulated health care provider to be informed of the care being provided
- facilitating patient access to the record
- supporting legal and regulatory processes and QA/QI reviews
- supporting analytical processes, medical and practice related research
- supporting billing or other practice management requirements including reporting against defined outcomes or other measurements
- systematic integration of medical information in EMRs to shared EHRs
- systematic integration of medical information in EMRs with automated decision support tools and health system processes
- systematic integration of medical information into shared repositories for primary and approved secondary uses
- patient engagement through the use of patient portals, email or other electronic and social networking tools accessible to patients (while still conforming to privacy regulations)

1.1 EMR Use

All healthcare providers who access and use the medical record have an opportunity to optimize practice procedures in the care of patients, as well as provincial health systems and processes enabled by Alberta Netcare. Physicians may consider using EMR capabilities to enhance practice management standards for:

- documenting a patient’s medical history
- collaborating on patient care
- requesting and responding to referrals and consultations
- managing shared information in active profiles
- managing transfers of care
- providing episodic care
- preventing follow-up care failures
- following up physician orders
- monitoring treatment outcomes
- identifying patient non-compliance and/or health system abuse
- managing direction and control of a medical practice
- protecting patient privacy and data security
- supporting patient awareness and consent management
Physicians using an EMR need to ensure:

- medical record transitions are managed:
  - patient information is secure
  - privacy of patient information is maintained
  - the integrity of the medical record is maintained
  - the integrity of clinical processes are maintained
  - continuity and quality of care is maintained throughout the transition period
- EMR interoperability with Alberta Netcare repositories is supported by:
  - data standards
  - structured practice processes
  - management of shared data and profiles
  - validation of the integrity of systematic transfer of data
- decision support tools are used appropriately where relevant
- structured document capture, test ordering and related scheduling/review are in place
- electronic messaging, eVisits, patient portals, email and social media usage is secure with appropriate clarity and understanding of the terms of use of the tools by all parties

Physicians participating in a shared medical record need to ensure:

- the custodial status of each physician is clear
- each physician understands data stewardship policies and the span of control of individual physicians
- specific procedures are in place for managing:
  - patient access
  - express wishes of the patient
  - third party disclosures
  - corrections and complaints
  - secondary uses of data
  - patient requests in conflict with the shared data stewardship policies
- appropriate information sharing agreements and information management agreements are in place
- roles and responsibilities are clearly articulated and separated into definable security and access profiles
- charting and coding schemes are in place:
  - uniform, standardized content for any data that needs to be interoperable and available for sharing (including discrete/textual data, semantics, coding, level of detail, etc.)
  - standardized terminology and coding that meets the needs of the treating physician, other healthcare professionals and patients
  - charting protocols and data structures for dealing with sensitive information, unconfirmed or suspected diagnoses, non-compliance, differing clinical opinions, relevant non-clinical or situational data such as behavioural information and cultural bias, private “thought data” and mental notes, etc.
shared workflows are supported by:
  o reliable, accurate information exchange in the circle of care (including the patient)
  o continuity in the management of the patient’s care
  o clarity in the responsibilities of each provider
  o patient awareness and handling of exceptional circumstances

referral and follow-up care is supported by:
  o clarity on the responsible physician, transfer of care, discharge
  o coordination and tracking of additional assessment and treatment
  o patient follow-up
  o findings and communication

consent management processes and patient awareness education are in place

2. Alberta Netcare

2.1 Alberta Netcare Access

If relevant information exists and access capability is reasonable, physicians and staff should have the clinical, technical and privacy training to access the Alberta Netcare portal at or near the point of care for all regular practice locations. If the portal is accessible within the practice, there should be systems and processes in place for:

  • privacy and security protocols
  • staff roles and access

2.2 Alberta Netcare Use

All healthcare providers who use Alberta Netcare have an opportunity to optimize practice procedures and enhance communication and continuity of care with other providers, as well as the provincial health systems and processes enabled by Alberta Netcare. Physicians may consider using Alberta Netcare to enhance practice management standards for:

  • obtaining a patient’s medical history
  • collaborating in patient care
  • requesting and responding to referrals and consultations
  • managing transfers of care
  • providing episodic care
  • preventing follow-up care failures
  • following up physician orders
  • monitoring treatment outcomes
  • identifying patient non-compliance and/or health system abuse
  • managing patient records
  • managing direction and control of a medical practice
  • conducting practice and care research
  • protecting patient privacy and data security
Physicians may also need to consider establishing new practice management standards for:

- managing shared information in active profiles
- managing errors and omissions in Alberta Netcare
- managing patient express wishes in Alberta Netcare
- receiving notifications from Alberta Netcare
- systematic transfers of data to Alberta Netcare

2.3 Managing Errors & Omissions

A physician reviewing a patient record in Alberta Netcare who recognizes a material error or omission of information, should, in addition to managing the patient’s care:

- explicitly assess the severity and risks of the error or omission (including the currency and subjective nature of the information, the relevance to current and future clinical decisions, and the express wishes of the patient)
- as appropriate, use the capability within Alberta Netcare to notify the Information Manager
- act to rectify the material error or omission by:
  - providing explicit instructions to the patient to follow-up with the original custodian
  - following-up directly with the original custodian
  - appending, updating or creating new information (if this functionality exists)

2.4 Integrating Alberta Netcare Data with a Medical Record

Physicians may at their discretion download or copy data from Alberta Netcare. This data should be limited to the scope of care provided by the physician to the patient. When data from Alberta Netcare is copied to a medical record created by a physician, it becomes part of that medical record. The physician is responsible to manage the chain of trust for the copied data. The physician should:

- ensure the source of the data is identifiable as an external record, or as a record of the care provided by the local physician
- ensure subsequent disclosures of the information respect the source of the data and the chain of trust implicit in the collection of that data

Physicians may at their discretion systematically transfer clinical information from their EMR to Alberta Netcare using accredited software that conforms to Alberta Netcare S2S (system-to-system) integration and messaging protocols as it becomes available, and maintaining an audit trail to the original record in Alberta Netcare. The physician should:

- ensure standardized content and format when posting information to the shared record
- ensure the accuracy of the information posted

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4 Most information currently accessible in Alberta Netcare is passive in nature, and individuals uses that information in a manner that is commensurate with their skills, comfort levels and practice requirements. An active profile is one that requires a standardized approach with consistent, ongoing management of the information by all parties, such as a shared medication profile.
- manage updates to previously posted information
- rectify material errors and omissions as they are identified

Physicians may at their discretion transfer unique clinical reports from their EMR to Alberta Netcare using accredited software that conforms to Alberta Netcare S2S integration and messaging protocols, and maintaining an audit trail to the original record in Alberta Netcare.

CPSA has the authority to direct physicians to transfer prescribed data from their EMRs to Alberta Netcare under HI Act Regulations but to date has not done so.

The directive to transfer prescribed data from an EMR, like all the CPSA Standards of Practice, would outline the minimum standard of professional behaviour and ethical conduct expected of all physicians registered in Alberta. Standards are enforceable under the Health Professions Act and are referenced in complaints resolution and discipline hearings.

Prior to any consideration to mandate the transfer of information, the following dependencies must be met:

- the technology to manage the transfer of information is available to all physicians and fully operational
- there are clear standards that identify the data elements involved in the transfer
- there are clear standards that articulate the content of each data element
- patient wishes for the sharing of information are respected (see section 2.5 below)

CPSA explicitly endorses the sharing of EMR data to Alberta Netcare to support patient care and improve clinical outcomes through enhanced communication. CPSA has previously provided endorsement as follows:

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<td>• Immunization Data</td>
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<td>• Patient &amp; Physician Identification</td>
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<td>• Public / Population Health Information</td>
<td>• Immunizations</td>
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Fundamental to the CPSA’s endorsement was the understanding Alberta Health would collaborate on developing education materials for both Albertans and providers, including an ongoing information campaign to advise patients of their privacy rights, the availability of masking patient information within Netcare and how to invoke that masking.

2.5 Managing the Express Wishes of Patients

In a patient-physician relationship, physicians have a duty to act in good faith vis-à-vis their patients and to protect the confidentiality of the information in their trust. The Health Information Act identifies explicit duties regarding management of the express wishes of patients, including requests to apply or rescind Global Person-Level Masking of the patient’s medical information in Alberta Netcare.
In the future, patients may have access to part if not all of their medical record, and so may request information be added, changed, withheld, or even removed. Policy to address these issues will be required.

Physicians are obligated to have a system in place for responding to and handling patient requests, working with the Information Manager.

This includes patient requests to:

- have their information in Alberta Netcare masked
- have existing masking removed
- have information corrected