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Chair

Mr. David Sweet

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● (1530)

[*English*]

The Chair (Mr. David Sweet (Ancaster—Dundas—Flamborough—Westdale, CPC)): Ladies and gentlemen, we'll call the meeting to order. We're continuing our study on the comparison of veterans services offered by members of the Commonwealth and the G8.

We have the great privilege of having Gail Graham with us. The U.S. Department of Veterans Affairs has been very gracious with their time with us. This is the third meeting, but as well, it's the second meeting for Ms. Graham since the last Parliament.

You've had a promotion, Ms. Graham.

Ms. Gail Graham (Deputy Chief Officer, Health Information Management, Veterans Health Administration, United States Department of Veterans Affairs): Yes, sir.

The Chair: You were the director of health data and informatics and now you're the deputy chief officer of health information. Congratulations.

Ms. Gail Graham: Thank you.

The Chair: It's good to have you here. I don't know if you remember how we conducted our meetings the last time, but—

Ms. Gail Graham: I do.

The Chair: —we allow visitors to present. If I look at this deck that you've given us, it looks pretty healthy. How long do you think you'll need for your opening remarks?

Ms. Gail Graham: What I can do is use this as a reference, just go over the electronic health record and the personal health record pretty quickly, and then open it up to questions.

The Chair: Would 20 minutes be sufficient?

Ms. Gail Graham: Sure. That would be fine. Why don't you just tell me when you want to switch over to the questions?

The Chair: That's fine. You go ahead. If you can contain it to 15 or 20 minutes, that would be great, and then we'll go through the rotation as we did last year when you were before us.

Ms. Gail Graham: Thank you, sir.

The Chair: Thank you very much.

Ms. Gail Graham: From our prior discussions, you're familiar with some of the background information that you see on slide 2. For the purposes of this discussion, it is important to note that we are a large training facility for medical residents and nursing and other allied health professionals throughout the United States. This means that these individuals are exposed not only to the veterans but to our electronic health record.

On slide 3, you see a screen capture of the face sheet of our electronic health record, the basis of which is known as VistA, the veterans health information systems and technology architecture. The computerized patient record system actually sits on top of this system called VistA, which we've had for almost three decades. The interface with the clinician and the electronic health record is about a decade old. This is available throughout the country. If a veteran is seen in New York and goes on vacation in Florida, the clinicians there can access the information, including images from around the country.

On slide 4, we have pictorial representations of the use of the electronic health record in place. In the upper right-hand corner is a cardiologist using the imaging component. Imaging encompasses not only radiology images but also cardiology images and waveforms. It could be a video of an entire procedure, for example.

On slide 5, we go into a little bit of what I referred to earlier as this availability of data no matter where the veteran presents. We have different applications that are used for this. The thing you might be interested in is that the component of VA that does the benefits determination for compensation also has access to our electronic health record. For example, when diabetes related to Agent Orange exposure in Vietnam is determined to be what we call automatically adjudicated if the veteran has diabetes and was exposed to Agent Orange, for those veterans that we treat directly, we can use the electronic health record to actually find that without bringing the veteran back in.

So there are uses for direct clinical care, for quality oversight, and for benefits determinations.

Slide 6 talks a little bit about that evolution I referred to and the fact that for almost three decades our practitioners have been able to look up lab results, radiology results, and pharmacy information in electronic format. Over time, really, what we've built on top of that is the clinicians actually ordering their own medications and seeing their own drug-drug alerts and other clinical decisions support that's presented to them.

Slide 7 shows some comparative statistics of the volume that we're talking about within our electronic health record system. It's just a point of reference. Because of the nature of how we provide care, which is much like a closed system such as yours, it means that we do reap the benefits of providers not reordering a lab test because the results were not available. Or it means referring a patient to a consulting physician and making sure that information is available without repeating radiology tests or laboratory tests just due to the unavailability of records and results. This talks about that economic benefit a little bit.

I want to touch briefly on our sharing with the Department of Defense. We have done this incrementally over time. It began with just the ability to view Department of Defense information. The most recent evolution is actually invoking clinical decision support on information from the Department of Defense in our system and the VA system and, in turn, the Department of Defense invoking clinical decision support. So it means that drug-drug and drug allergy interactions are performed not just on the information within the local database, but actually across the two organizations.

The "Quality Evidence" slide just talks about how our electronic health record has really been noted throughout the country, both in the private sector and in the public sectors, for the impact it has had in the area of economic savings, as I just discussed, but also in the area of quality and that ability to remind physicians of interventions for chronic disease patients or preventative medicine interventions such as influenza vaccinations or pneumococcal vaccinations.

● (1535)

The next slide, slide 11, provides a link to a demonstration site of our electronic health record.

I was also asked to cover the personal health record, which is a newer project for VA. The vision was that patients would be in control of their information, including information they record in this online database, but also that it would serve as a trusted source of health information. We collaborated with the Department of Defense to contract for a commercial health information module, and we actually augmented that with veteran-specific diseases, injuries, and mental health conditions. It has really evolved over time.

I'll talk about that a little bit. It was to improve access to services. It's also the way we provide for the veteran to communicate if they have external-to-VA physicians or want to look for assistance for a family member in the progress of their treatment. So we list some of those benefits here: improved communication and enhanced satisfaction with resources.

For example, in 2008 we added the ability for parts of the medical record to be available online to the veteran through this personal health record portal, so that they wouldn't have to come to the hospital to obtain a copy of their lab results or radiology results. This year, in 2009, we're adding the ability for veterans to communicate with their clinicians through a secure portal on My HealtheVet to ask questions or to clarify treatment requirements.

On slide 16 we've added some of the statistics about this. As we've added new functionality, it has encouraged more veterans to participate. For example, when we added the ability to refill prescriptions online, there was a large surge in the number of veterans who signed up online to participate in My HealtheVet. We anticipate a similar surge will come this year when we add the ability for provider-patient communications.

The next slide talks a little more about that. The veterans can also use this site to record military histories or personal histories, or as a diary to record their blood pressure, temperature, weight, anything that they may be tracking personally or that their provider has asked them to track.

The other things that we use both of these tools for are patient education and patient involvement. It's a big impact to the patient when you can show that a new medication or a change in lifestyle—weight loss or stopping smoking—reflects in their lab results or their spirometry results. To make that correlation between changes in behaviour in a positive or negative way has been another use of the electronic health record and the personal health record.

On My HealtheVet we also collaborate with research to make sure that veterans are aware of research opportunities specific to their disease or specific to veterans. This is another functionality that we use.

We talked earlier about the ability of veterans to refill prescriptions online through My HealtheVet, and we've depicted that here with the My HealtheVet pharmacy options. As I indicated earlier, this was certainly a highly requested feature. All of the features that we've added to the personal health record are determined by veteran focus groups and veteran advisory groups that tell us what they would like to see.

We believe these two tools are complementary. For example, we're doing more monitoring in the patient's home through our telehome health. So if we have a chronic disease patient with congestive heart failure and we want to monitor their vital signs daily and just generally how they're feeling, we transmit all of that information to a nurse, who may be monitoring 200 to 300 patients. She can intervene at any point when seeing any of the indicators going in the wrong direction.

● (1540)

Then they maybe contact someone else, the nurse picking up a phone and calling the veteran. We've found that this has avoided hospitalizations, has reduced lengths of stay, and has had a positive impact. It's possible because of these two technologies that support alternative treatment modalities, bearing on the electronic health record and the personal health record.

We also use this to remind the veteran when preventative services are due, and we find it to be an effective way to do these reminders — for vaccinations, or to remind patients to wear a seat belt or to quit smoking. We are adding reminders to the functionality.

The other thing we're adding to our electronic health record is an indicator to the provider. This way they know that the patient they're dealing with has a personal health record that can be used for communication, to examine results, or to access health information resources available through My HealtheVet.

Let me now turn to future releases. There is secure messaging, which has been highly requested. We had problems doing that via regular e-mail, so we looked in the United States and other places and found providers that were more experienced in using electronic communication with their patients, and we decided on the secure portal approach. We're also adding things like MyRecoveryPlan to use as an education tool between the provider and a patient recovering from surgery or other interventions. In the future, we hope to add components that will enable the patients to request appointments and do some other health care business online. There are some veterans who have co-payments that are due, and those co-payment balances can also be monitored online.

I'm ready to answer your questions.

● (1545)

The Chair: Thank you, Madam Graham. There's a lot in there, and I'm sure there will be quite a few questions, because it's quite robust.

We'll go first to Judy Foote of the Liberal Party.

Ms. Judy Foote (Random—Burin—St. George's, Lib.): Thank you, Ms. Graham. I appreciate the presentation. It's very comprehensive. As for being able to compare it with what we have here in our country, I don't think we can. So I'll start with some general questions.

How long did it take to put such a comprehensive system in place?

Ms. Gail Graham: It has taken between 30 and 40 years. About 30 years ago, we put into place the core systems of laboratory, pharmacy, and radiology, so that you could look up the results. About ten years ago, it migrated to the electronic health records system, which put a graphical user interface on top of the existing systems and their provider tools. At about the same time, the Institute of Medicine published information about errors caused by illegibility. It was a move to get rid of the problems we had with paper records.

Not all of our VA sites perform heart surgery, so we have a lot of referrals from the smaller clinics to the larger ones. A lot of it was born out of the inability to transfer paper records efficiently enough to keep up with patient care. In the beginning, it didn't have anything to do with being a luxury or being cutting-edge. It had to do with the logistics of not being able to move this paper quickly enough for patient care.

Ms. Judy Foote: On the technical aspect of it, I know there are still places in Canada where they don't have access to the Internet and access to the technology you would require to be able to access the type of information you're saying is available to veterans. So how does that work in the U.S.?

Ms. Gail Graham: For the personal health record, it would require Internet access. There are other initiatives—not VA initiatives—in the U.S. through the FCC, the Federal Communications Commission, to get wide-band access into rural areas across the country. So we're keeping a close eye on those initiatives because they will certainly benefit our veterans.

Our core system, the electronic health record, has not actually moved to the Internet. We have a wide area network in the United States that VA operates through commercial carriers, such as Sprint and others, to move the data in our electronic health record system. It does not depend on Internet access; it depends on connectivity that could be through a telephone line, for example. In some instances we have small clinics in very rural areas, and we have mobile clinics too, actually, that are hooked up via satellite technology to our electronic health record system. Certainly the Internet is a necessity in that connectivity for the personal health record, and we anticipate that future development of our electronic health record will have more Internet-based components to it.

But initially the phone lines were the way we used the electronic health record, through linkages back to the main site.

● (1550)

Ms. Judy Foote: How would the mobile unit work? Is that something that would go from community to community?

Ms. Gail Graham: Correct. In this past year there were two initiatives. I believe when we met last time we talked a little bit about the centres, which are really separate from the hospitals, where veterans can seek all kinds of assistance, whether it be mental health assistance or assistance with job placement. And they just recently purchased 50 mobile vans, equipped with satellite technology, that allow access when needed to the Internet, but access to the electronic health record as well.

We also have a pilot in our office of rural health, where certain areas have purchased mobile units to run mobile clinics. They might be in one city twice a month, or once a week, and the providers actually man a clinic within the mobile unit for those places that are not large enough for us to establish a physical presence in a clinic situation, for example.

Ms. Judy Foote: What would happen if a veteran, for whatever reason, had to go to a private clinic? Is there access to their records via that clinic? Is this something a private clinic can tap into?

Ms. Gail Graham: There are two models of that. We have situations where we actually contract with private clinics to run veteran clinics within their clinic. And in many of those they have chosen to have access to our electronic health records, so they would dial in through a T1 line or other connectivity and use that system.

But we also have a program where we actually pay for the services the veteran receives. In today's world, they have the option to go to any provider within certain areas, so we don't have that relationship of having them set up to have access to our electronic health record. But we're really hoping that the delegation feature in My HealtheVet and the personal health record can fill some of that gap, so the veteran can grant delegation access to private sector providers so they can see lab results or radiology results the veteran may have online with the VA.

That area is still a big challenge for us. And Alaska is probably one of the biggest examples we have, because a lot of our care in Alaska is actually done through what we call fee basis or purchased care.

The Chair: Thank you, Madam Foote. That's seven minutes.

Monsieur André, pour sept minutes.

[*Translation*]

Mr. Guy André (Berthier—Maskinongé, BQ): Good day, Madam.

Ms. Gail Graham: Good day.

Mr. Guy André: That is a very interesting health care system. I believe consideration is being given to bringing a similar system not only for veterans but for the general population as well.

Regarding confidentiality, to access client information, is a code required? Can anyone access a client's file?

Moreover, is there any type of information that cannot be included in a client's file because of its confidential nature?

● (1555)

[*English*]

Ms. Gail Graham: I'll answer the first question.

In the United States we also hope this technology is widely adopted and that it doesn't stay within the Department of Veterans Affairs or other large providers. We have a project that is similar to some of the initiatives you have, called the nationwide health information network, where VA would connect to this central system and share information across private sector and other federal agencies, for example. It is currently being done only with the authorization of the patients—in our case, the veterans.

I don't know if you want me to stop in between so you can translate.

[*Translation*]

Mr. Guy André: No, it's fine. We have interpretation services.

[*English*]

Ms. Gail Graham: Thank you.

So the access, for example, in our medical centres is actually governed by what your role is in the medical centre. It's done through a series of menus and keys for specific access. For example, only physicians who have medication ordering authority have a key to do medication ordering. So in many cases the electronic access gives us the ability to limit and control access in a way that we were never able to do in a paper environment. This comes not just with the technology, but we also do a lot of training with our providers on what is appropriate for them to access, what they need to know, how they determine the "need to know" of information, both by administrative staff and by clinical staff. So it's a combination of technology limiting access and educating those who use the system on what's appropriate to access.

We tried for many years moving the paper record around and trying to keep it secure, and in no way do I believe that this paper record was more secure than the electronic environment we're in today. So right now the access to the system would be limited to those who have a relationship with VA, either a VA employee or someone who's contracting on behalf of VA to provide those services. We do have mechanisms to control access down to individual patients. So for example, in this country veterans' service organizations assist the veterans in preparing their claim files, and that is done by issuing a power of attorney between the veteran and the veterans' service organizations. In those cases, they only have access to those veterans. The same is true for our quality and oversight groups. We will limit those to the "need to know", as is also the case for research. We can limit research down to those who are participating, for example, in a research study.

On the second question, on whether there are things that cannot be put into a client file, I know there are some organizations that do not put HIV results, for example, in their electronic health record. This is not the case for VA. We do include what we would call sensitive laboratory results or test results. One area in which you may not see all of the information is mental health. Mental health may put in summaries of information but retain detailed client notes separately from the electronic health records system. So this is an area that very likely may just have summary information and not all the details.

[*Translation*]

Mr. Guy André: If, as a client, I do not want certain information to be put into the computer system—for example, if I am HIV positive or if I've had psychological counselling as a result of a mental health problem such as PSTD, must I request that this information be withheld? How does it work? Do I have any control over the information that will be put into the computer system?

● (1600)

[*English*]

Ms. Gail Graham: Currently, in our verbiage, disclosure would mean that it was not for treatment, it was not for health care operations, which would be quality, for example. All of those disclosures would require a patient authorization, and the patient must specifically allow disclosures in those specific areas. In VA we would need a general disclosure, but for areas of drug, alcohol, sickle cell anemia, and HIV we would need a specific authorization from the veteran to allow that disclosure. That does not apply for those who are providing treatment, either on behalf of an employee of the VA or under contract to the VA.

So the veteran very much controls what we disclose externally, but does not have the same control internally of what other providers can see. If a patient in the VA is being seen in primary care, in mental health, and in orthopedics, those providers can see the information from the other sources.

The Chair: Thank you very much for your answers, Madam Graham.

Mr. Stoffer now, for five minutes.

Mr. Peter Stoffer (Sackville—Eastern Shore, NDP): Thank you very much, Madam Graham, for appearing before us today.

I believe the question from my honourable colleague was, if I didn't want to be part of the electronic system, if I liked the old system of paper files, warm bodies, and someone to talk to, could my records be taken out of this computer system and put into the manual method the way it was before?

Ms. Gail Graham: No, not if you're seeking treatment with NVA.

Mr. Peter Stoffer: You'd have no choice but to be in the electronic system?

Ms. Gail Graham: Right.

We have no way of processing, for example, laboratory or radiology orders in a safe manner outside of the system. We have paper contingency processes, but to revert to those on a case-by-case basis would be very difficult, and there would be a patient safety implication in trying to process that through a separate workflow.

Mr. Peter Stoffer: What do you do for those I would call the old school veterans, the World War II ones who are not adapted to computer technology, and their spouses?

Ms. Gail Graham: Actually, we haven't found this to be an age-limiting technology. The World War II veterans are just as happy when their provider is talking to them and showing them their laboratory results electronically, graphing them and really explaining them. We haven't really found that age gap. Actually, one of the largest cohorts of patients adopting our personal health record is patients over 65. Many of our veterans maintain a copy of their medical record on paper. Certainly, as they request it, we print the documents out for them so they can maintain their own information as well. But we really haven't seen that big divide among the age groups.

We also have libraries within each of the medical centres, and for veterans who may not have a computer in their home, we provide assistance and technology within the clinics and medical centres so they will have a computer available to them.

Mr. Peter Stoffer: I have two other questions for you.

It appears that you have a lot of fingers in the pie of a particular file—be it pharmaceutical, MRI treatment, a provider doing it. It appears that many people could be accessing one person's particular sensitive information. I'm wondering how you provide the security around that, if you could repeat that answer again.

Also, if a veteran dies, does the information die with the veteran, or is it still online and available for a spouse who may decide to use that information at a later date?

Ms. Gail Graham: I'll answer the second question first.

By law, our retention of records, paper and electronic, of the patients' medical records, is 75 years after the last date of inactivity. When patients expire, we have an obligation to retain their records for a period of 75 years. Much of this has to do with spousal requests for benefits and for research purposes. And much of that came after it was determined that ionizing radiation exposure, for example, had harmed individuals and that many of their records had already been destroyed. So for about the last 20 years, we've had a 75-year retention requirement for our medical records, regardless of the medium they're in, whether paper or electronic.

Our electronic system has a security foundation—we talked a little bit about this earlier—that works with a series of menus relative to the job within the facility. For example, the housekeeper doesn't have the laboratory menu and the nurse doesn't have the physician ordering menu. That's one level of the security that's applied. All the individuals who work for the VA or who have access to computer systems have background checks. They have to take privacy and security training. And then the system itself has security safeguards. The first level of that is the menus, subject to the job.

The second level of that security is known as security keys, specifically keys that have to be granted to you to do certain functions. The example I used was the ability to order medications. That has to match up with what you are authorized to do by your licence within the organization.

To speak to who's accessing, one of the advantages of the electronic health record is that it's not only in one place at a time. If you are an in-patient and your physician wants to review your chart, but you also are in radiology receiving a procedure, both of those providers could be looking at your record at the same time. So this multiple access was intentional.

We do lock the system in certain areas. Two providers cannot be ordering on one patient at the same time, so there cannot be conflicts between the orders.

The ability to access from multiple points is certainly a benefit. Also, the ability to audit who's accessing the record is another benefit of the electronic health record. You know who accessed the record and when it was accessed, along with the components of the record accessed.

● (1605)

Mr. Peter Stoffer: Thank you very much.

The Chair: Thank you very much, Mr. Stoffer, and thank you very much, Ms. Graham.

Now we'll go to Mr. Kerr.

Mr. Greg Kerr (West Nova, CPC): Thank you very much, Mr. Chair.

Welcome, Ms. Graham. It's nice to have you here with us.

Ms. Gail Graham: Thank you.

Mr. Greg Kerr: We appreciate the information.

Do I understand correctly that the Department of Defense does not keep electronic records?

Ms. Gail Graham: The Department of Defense has an electronic outpatient record known as AHLTA, and a few of the Department of Defense in-patient sites have a commercial product called essentris. Right now, VA is receiving information from both. The Department of Defense does not have a comprehensive electronic health record that spans all treatment areas.

One thing I didn't go into detail about is that the electronic health record I described to you is used for outpatient, in-patient, long-term care, and home health. In the VA world, it's used at all levels and settings of care.

Mr. Greg Kerr: The reason I asked—and I appreciate the answer—is this. Does that make it difficult to set up your records? Do you have to do a fair amount of research? Or does the information flow quite freely to you, even if it's not all consolidated?

Ms. Gail Graham: Their outpatient record does flow to us. For quite some time, we've received, for example, laboratory, pharmacy, and radiology information from the Department of Defense. They actually have an older system that was based on the original VistA system, which VA has used for some of those core functions, such as lab, radiology, and admission and discharge transfer files.

So we can view some of the information from the Department of Defense. For example, now we're able to view some of the theatre notes written in Iraq or Afghanistan, maybe when the patient was initially injured.

We also have some workarounds with them. For example, if a severely injured veteran or service member is returned to the United States at Walter Reed in Bethesda, we also get an indexed, scanned copy of their record for the polytrauma sites at VA to be able to access their information. That's certainly not the ideal, but at least the information is available to our providers when we assume care for some of these veterans.

We care for some of them while they're on active duty, as they actually go back to active duty.

● (1610)

Mr. Greg Kerr: So there is a pretty good interchange of information in regards to how it's done.

Ms. Gail Graham: Right. And for us, this is something that's monitored very closely by our Congress.

Mr. Greg Kerr: Now, I know that in any health system—and certainly I don't expect it to be much different there—amongst professionals looking at the information, there can be some difficulty in interpreting the information. Is that the case with you? By that, I mean it's been a tradition over years that a patient—in this case, a vet—often moves from one facility to another or has to go for a different kind of service. Does the new facility automatically accept the information flow, or is there a tendency to want to re-test and revisit the information?

Ms. Gail Graham: No, there's acceptance. Many of our providers have a bigger concern, when they start to participate in the nationwide health information network, with getting information from non-VA, non-DOD sources. That's probably a bigger concern to them. But we don't have a lot of issues with providers not trusting the information they're getting from another VA or the Department of Defense, for example.

Mr. Greg Kerr: That's good. That's really positive.

Basically, the information belongs to the vet. Am I correct? The file would belong to the vet.

Ms. Gail Graham: Correct.

Mr. Greg Kerr: We've heard questions about not only the confidentiality—which is a challenge in any electronic system—but also about the patient or vet's desire to control access to that information.

If the vet wanted to move into a non-VA facility, what happens? Do they have free access to take their records with them and transfer them, or is there some restriction on that?

Ms. Gail Graham: No. Actually, under the Privacy Act of 1974, the veteran can always have a full copy of their record. We can also download it electronically to different media, but we can certainly print out a paper copy for them to take with them.

We're also working with both Google and Microsoft on the ability for veterans in the future to actually take parts of their electronic health record and put them on the more generic personal health record portals that Google and Microsoft operate, so the veteran can then grant electronic access to other providers or other health care facilities. But right now, we would either print all of their record or we would download it to a CD or a thumb drive at their request.

Mr. Greg Kerr: Are we already done?

The Chair: You have time for one more question.

Mr. Greg Kerr: Well, I just have to ask about something I'm really interested in. Could you explain interoperability in regard to the My HealtheVet goals?

Ms. Gail Graham: Interoperability is actually what I just talked about. The veteran actually has the ability, if we put all of their lab results onto their My HealtheVet Internet site, to decide to send it to their Google health record or their Microsoft record and then share it with private sector physicians. It's partially that, and it's partially our participation in the nationwide health information network, under the auspices of Health and Human Services within the U.S. government. It's building a foundation for all health care providers to connect to this nationwide health information network, much like the U.K. Spine records service or some of the work you're doing, so that we can exchange information. All of that requires the veteran's consent and authorization to exchange that information.

So what we're doing with the Department of Defense is interoperability. We'd like to expand that out for the patient to control it and to exchange more routinely with the private sector.

● (1615)

Mr. Greg Kerr: Thank you very much.

The Chair: Thank you very much, Mr. Kerr.

Now we have Madam Duncan for five minutes.

Ms. Kirsty Duncan (Etobicoke North, Lib.): Thank you.

Good afternoon, Madam Graham, and thank you for your very comprehensive deck.

I do have some questions. You mentioned that the system can be used for preventive medicine, and I'm wondering if you can elaborate on that, please.

Ms. Gail Graham: Certainly. The system takes into consideration the veteran's age, sex, and chronic diseases. For example, just general preventative medicine may be reminders for the annual flu shot, or if they happen to know that this patient has congestive heart failure, it may also include their pneumococcal vaccination.

These reminders are shown to the clinician, and in My HealtheVet now, we also show them to the veteran if things are due. They also include things like talking to the patient about whether they smoke and, if they do, offering intervention to stop smoking. It may be the use of seat belts. It may be that they live in a certain part of the country and are exposed to different diseases in that part of the country. It can be logic based on any information about the veteran —their age, their sex, their personal health history, their family health history.

For example, we may do a preventative reminder for mammograms on women veterans over forty. If it takes into consideration your personal health history or your family health history, that you have a history of breast cancer in your family, it may do that reminder when you're thirty, for example.

It's the same thing with colonoscopy or colon evaluation after the age of 50, with those things that are recommended through different clinical means. We work with the Department of Defense and with the private sector on what are the interventions, at what time. This then expands into chronic care. For example, diabetics, under our quality measures, are required to have an annual eye exam and an annual foot exam.

Ms. Kirsty Duncan: Thank you, Madam Graham. That gives me some good idea.

On page 16, how were the conditions chosen? Maybe it's just examples, but on the ones that are shown, only colorectal cancer shows up. For veterans, I should think there would be other cancers you might be interested in.

Ms. Gail Graham: This is just an example.

Ms. Kirsty Duncan: Okay. You mentioned that the system could be used for research. Could you elaborate on that, please?

Ms. Gail Graham: We use it more in a way to inform the veterans about research opportunities for them, that there are research studies in PTSD, for example, and this is where they can make further contact if they'd like to participate in the research studies. We don't actually allow researchers to access the personal health record of the veteran, because we've made the commitment to the veteran that what they put in what's called their health vault actually remains at their discretion as to whether it would be shared.

We do, under certain circumstances, with approved protocols, allow some extracts of our electronic health records to be used for research. For example, if a researcher is looking for candidates for a PTSD study or cancers related to exposures or to military service, we would, under certain protocols, allow researchers to define their cohort of patients or to try to recruit patients in that manner.

Ms. Kirsty Duncan: Are the veterans made aware of that when they initially sign on to the system?

Ms. Gail Graham: Yes, they are.

Ms. Kirsty Duncan: What percentage of veterans use in the system and what are the barriers to use for them?

Ms. Gail Graham: Are you referring to the personal health record, My HealtheVet?

Ms. Kirsty Duncan: Yes.

Ms. Gail Graham: It's about 20% of veterans. I think some of the barriers are in largely rural areas—your colleagues brought it up earlier—where the Internet is not available or not available in an easy manner. That may be a barrier. We try to compensate for that with availability at the clinics and medical centres—for there to be computers and assistance available to them there. Certainly, we make an attempt to compensate for that. What we see is that every time we add a feature that may interest you, that would encourage you to sign up for a personal health record.

● (1620)

Ms. Kirsty Duncan: What are you trying to do to increase the percentage of use?

Ms. Gail Graham: We have the personal health record. My HealtheVet coordinators in each of the medical centres do a great deal of education. We use public service announcements. We work through the veterans service organizations to educate the veterans. The mobile units that I talked about earlier for the vet centres, and the mobile clinics, are all set up so that the veteran can access their personal health record from those locales. We do quite a bit of marketing to inform veterans that this service is available to them. But what really brings them in is when a feature is added that is of interest to them.

The Chair: Thank you very much, Madam Graham and Ms. Duncan.

I did give you an extra question at 5 minutes and 10 seconds. It's okay, because it was a good follow-up question you needed to get in. No problem.

[*Translation*]

Mr. Gaudet, for five minutes.

Mr. Roger Gaudet (Montcalm, BQ): Thank you, Mr. Chair.

Good day, Madam.

Surely there is a downside to this system. What might that be? Based on what you're telling us, it appears to be a sound system that relies on the Internet and the like, but surely there are some disadvantages for veterans, especially for those living in more remote regions.

[*English*]

Ms. Gail Graham: Did you want me to explore the negative aspects?

[*Translation*]

Mr. Roger Gaudet: Yes. It's important that we not make the same mistakes that you did.

[*English*]

Ms. Gail Graham: Sir, I certainly understand that. There have been large and published electronic health record implementation problems around the country. They've been in the newspapers and the trade magazines.

With VA, I think we started very small and very slowly. We started at one of our smaller, less complicated facilities when we went down the road of a true electronic health record, with the clinicians actually ordering through the electronic health record. I think that was an advantage.

It was also important not only that the nurses and doctors adopted this, but that administrators recognized that, for example, when we implemented the electronic health record in a medical centre or clinic, many times that required that the appointment time be extended from 20 minutes to 30 minutes, for example, because it took longer for the clinician to interact with the system, especially during the learning time.

We talked about these preventative reminders. All of those reminders come with some time impact to the clinician. We believe that impact is positive, that it maybe avoids illness or patients returning unnecessarily. So certainly that recognition that it requires time for the clinicians to adapt to this technology and that it may require longer time permanently is important. Many of our clinics still run 30-minute instead of 20-minute clinic appointments.

We had some pretty widely publicized problems a few months ago with the latest release of our electronic health record system—problems that were not found during testing. For example, we had a flaw in the latest release that changed the viewing of the discontinuation of medication orders, and nine patients received IV infusions and infusion heparin for hours after the physician discontinued the order. We identified the problem. We have mechanisms in place for the medical centres and the physicians and the nurses and the clinical application coordinators to report suspected problems immediately so we can research them.

Certainly you have to put in an infrastructure that allows providers to report problems with the system. For us, it created a whole new occupation called clinical application coordinators, who are available to help clinicians should they have problems with the system. I think that's absolutely necessary. We can anticipate that's going to be one of the challenges as electronic health records go into small physician offices that really can't afford full-time support.

We've had lessons learned in deploying slowly, giving time for clinicians to be trained and use the system, taking care and testing the system thoroughly, and making sure when we develop systems that we take heed that clinical practice is not uniform at every medical centre and clinic. It all requires that we do our due diligence and that we be good stewards of this technology. It's a tool, but it's just a tool, and it is still required to work well within the flow of clinical practice.

● (1625)

[*Translation*]

Mr. Roger Gaudet: Are new service members automatically signed up for this service?

[*English*]

Ms. Gail Graham: New recruits who come into the military are immediately entered into the Department of Defense system. VA has knowledge of them if they seek our services, but we could not access their records if they did not seek our services. There are some VA benefits available to service members before they become veterans. These may be non-health care benefits in the area of veterans' benefits administration—for example, there are some housing modifications they might be eligible for when they're still on active duty.

We have a new secretary—Secretary Shinseki. He has made a proposal that we do become informed of that service member upon entering the military. But at this time, unless they sought our services, we would not know about them.

[*Translation*]

Mr. Roger Gaudet: I have one last quick question for you.

When a service member retires, is his file forwarded to the Department of Veterans Affairs? I would appreciate an answer.

[*English*]

Ms. Gail Graham: Actually, there's still a fair amount of paper in the Department of Defense. VA is the custodian of the Department of Defense's paper records for those who are either separated or retired from the military. Those are sent to a place in St. Louis, Missouri, where if the veteran applies for a benefits claim or seeks health benefits from VA, those records are available to either be sent to Veterans Health Administration Benefits or to the veteran themselves. If that military person seeks care from us, then we can access those records, but if they do not seek care, we cannot access the records.

[*Translation*]

The Chair: Thank you very much, Mr. Gaudet.

[*English*]

Thank you very much, Madam Graham.

I put us out of rotation again, so I apologize. It will appear a little lopsided here because I missed a Conservative.

So, Mr. Clarke, for five minutes.

Mr. Rob Clarke (Desnethé—Missinippi—Churchill River, CPC): Thank you, Mr. Chair, and thank you, Ms. Graham.

I'm going to follow up on the question in regard to the electronic system that Mr. Kerr brought up here. You mentioned earlier Google and Microsoft. With the electronic system, in my personal experience when the Royal Bank—our banking system—shuts down, we don't have access to our records. Do you experience the same problems with your electronic system with the veterans right now?

Ms. Gail Graham: Sure. We've become very reliant on the electronic system, and if it's down for any length of time, while we have contingencies in place, it's still a very debilitating impact to our organization. Some of the contingencies we have, for example, are that we do a backup of patients' information for patients who are in the hospital, or for patients who have clinic appointments. Sites are set on routinely backing up a summary of information on those patients, but when the systems are down, our contingency plans are centred around paper and it's very problematic if they're down for any length of time. But we do have contingencies in place.

● (1630)

Mr. Rob Clarke: Is there another way to access the files when the system is down?

Ms. Gail Graham: There is. There are two things that happen.

One of them is that every day the system backs up summary information on in-patients and those who have appointments the next day. That information is kept separate from the mainframe of the hospital, for example, so that it can be accessed independently of the system being up.

We also have a read-only version of CPRS that can allow providers to look at information even if their local system is down for any length of time, but for it to carry on current work, it reverts back to a paper process of ordering laboratory, ordering radiology, in a manual process. We do have contingencies for looking up information should the systems be down, but it's a struggle. I'm not going to pretend that it's not.

Mr. Rob Clarke: With veterans and with the systems going down, sometimes information is lost, especially on veterans. Have you had any experiences where veterans have been lost due to system failure?

Ms. Gail Graham: We have not.

Actually, we've had the opposite. For example, during Hurricane Katrina when our hospital in New Orleans was evacuated, we took the backup tapes from the computer system and, within 24 hours, moved them to the Houston facility and had that information back up and online available for those veterans wherever they showed up. If they had a dialysis treatment on Monday, by Wednesday they were back online and their information was available. That has been our experience.

We had an experience about a year and a half ago where we had 17 systems on the same regional data processing system that went down. Providers did have access to read-only information, but they were down for about 17 hours, and there have been contingencies put in place since then that after five hours of downtime they would actually be reverted to a backup system. We're putting a lot of redundancy in place to make sure we don't have single points of failure for these systems.

Mr. Rob Clarke: When there are a lot of veterans going through the system on a daily basis, how many times a day or week is the system upgraded?

Ms. Gail Graham: Upgraded as a whole? We send out about 400 patches a year that upgrade some part of the system. Most of the upgrades currently, though, don't require that you take the system completely down. Those that do require the system being down are done off-hours and on weekends.

Mr. Rob Clarke: With the veterans and this electronic system, if they're sitting at home or are anywhere in the world, at the side of a lake or something like that, do they have access to review their own personal records to make sure they are up to date and well kept?

Ms. Gail Graham: If they're registered for the My HealtheVet personal health record and if they have authenticated in person, then parts of their medical record are available through My HealtheVet. That's the only electronic means by which the veteran can access their records. But that would be available regardless of where they were physically, as long as they were on the Internet.

For providers, it has been a tool that we've used. For example, we have a shortage of radiologists in this country. We have a central reading centre in California that, either as a contingency or a matter of routine because they can't hire a radiologist, does readings for different hospitals throughout the country. The electronic technology enables us to actually take the exam locally and communicate it to those radiologists, where they do the reading and transmit it back to the medical centre.

So there are other business reasons why it has been important to us to have this system.

● (1635)

The Chair: Thank you very much, Madam Graham and Mr. Clarke.

Mr. Lobb, for five minutes.

Mr. Ben Lobb (Huron—Bruce, CPC): Thank you.

It's been very interesting so far, Ms. Graham, that's for sure.

I noticed from your slide deck that there are 153 medical centres, 747 outpatient clinics, many long-term care and home-based programs, as well as 107 academic health systems that also participate with Veterans Affairs. Is your software system implemented in all those locations?

Ms. Gail Graham: It's not implemented in the academic affiliates, but it's implemented in all the VA locations, yes.

Mr. Ben Lobb: That's impressive. Do you have a rough idea of approximately how long it took to implement all that throughout the close to 900 locations plus the long-term care facilities?

Ms. Gail Graham: It is a two-stage approach. The initial implementation of the core system, the VistA system, happened almost 30 years ago. I'm not sure how long that took. I have a colleague in the room with me who may know.

A voice: It was incrementally dealt with, the core applications first and then additional applications built on top of that. It started in the early 1980s.

Ms. Gail Graham: Then the electronic health records system began in Tuscaloosa, Alabama, at a smaller location. Then during the next two years we rolled it out across the country using what we called key sites, which were divided into 22 veterans integrated service networks. I think Ms. Patterson talked to you about that. Each of those networks had a lead site or a key site where they had a clinical champion and a team that actually did the implementation.

So the complete implementation of our electronic health record was about a two-year timeframe. Then over the last decade it increased incrementally over time with the components that are used, until finally seven or eight years ago it was mandated for complete use. We had challenges. For example, it was easier to get the primary care and medical physicians using the system than it was to get the surgeons to use the system. We had different challenges in different parts of the medical centre itself.

Mr. Ben Lobb: There's an online for your medication and so forth through the pharmacists. Are the medications dispensed through Veterans Affairs, or are they also dispensed from a regular pharmacy?

Ms. Gail Graham: The majority of the medications that we dispense are for some of the veterans who are using contract services. They may get an interim dosage, such as an antibiotic that is needed right away. This is really a big area of cost savings for us. We disseminate medications either from the medical centre or, mostly, out of our consolidated mail-out pharmacies, where we process the refill prescriptions, and those are mailed to the veterans.

Mr. Ben Lobb: On the software, I'm reading between the lines here, but the government developed this software?

Ms. Gail Graham: Correct.

Mr. Ben Lobb: As time has gone on, have you had any third party affiliations? I notice your reference to Google and Microsoft. I just wondered if there are any other software vendors you've dealt with.

Ms. Gail Graham: There's actually a whole vendor organization called the VistA Software Alliance. Our software is available because it's in the public domain. This VistA Software Alliance and organizations that belong to that actually are resellers of our software. The big thing they offer is the support to install the software and maintain it. We have several state veterans homes in Oklahoma; there's a hospital in Midland, Texas; and Mexico has looked at our system. So there has been a fair amount of private sector interest.

● (1640)

Mr. Ben Lobb: I didn't quite catch it before. Is the software system real time? Is it a live software system? Or do you batch update at night or a couple of times a day?

Ms. Gail Graham: No, it's real time. The only batch processing we do is this. We have national databases in Austin, Texas, and some of the more administrative data are batch processed and transmitted to Austin. But everything else in the electronic health record is in real time.

Mr. Ben Lobb: I know this is the world of applications with your PDAs and so on. With the iPhones and the BlackBerrys of the world, do you have applications for either of those devices for your technology guru veterans?

Ms. Gail Graham: For the veterans right now, we're looking at some examples of using it, for example, with the home health nurses. The local medical centre in Washington, DC, is actually using BlackBerrys to transmit EKGs from the emergency room to the on-call cardiologist so they can do an immediate reading of the EKG and start ordering interventions before they can drive to the hospital. We're exploring a lot of those technologies right now, predominantly on the side of clinicians using those devices.

Mr. Ben Lobb: Interesting. Is there anything else new and exciting for either 2009 or 2010? And just to build on that, where is that driven? Is that driven by our users or your veterans? Is that driven by the clinical staff? Where do the new ideas come from?

Ms. Gail Graham: Both. When you have this many trainees coming through—new residents and nurses—they're living off their personal devices so they're always looking for different, innovative ways they can do their work. The veterans do keep us aware and alert of things they would like to see. Certainly a lot of them are happy that things can be accessed through a PDA or through an iPhone, for example. So we get them from both.

I wanted to address one of the other questions you had. Currently most of our system has been developed by VA. So many of the different medical technologies are becoming so specialized that, for example, right now we're looking at replacing our old laboratory system with a commercial laboratory system. In the area of the intensive care unit, we're looking at commercial intensive care unit software that would be interfaced into our system.

The Chair: There are two spots here and there are seven and a half minutes. If there's another Conservative with a question, you can go ahead and use the last two and a half minutes. No? You've exhausted all questions.

Okay, we'll move on now to Mr. Stoffer for five minutes.

Mr. Peter Stoffer: I'm okay, sir.

The Chair: All right, Mr. Dhaliwal, for five minutes.

Mr. Sukh Dhaliwal (Newton—North Delta, Lib.): Thank you, Mr. Chair.

I would like to welcome Ms. Graham on the teleconference with us today. I have a few questions, because I was going through this extensive document and I'm very pleased to see that the U.S. Department of Veterans Affairs is a world leader in the use of electronic health records.

My question to Ms. Graham is this. The Department of Veterans Affairs is working with the Department of Defense to make their health records interoperable. How will electronic records be reliably made accessible in challenging situations like theatres of combat across the globe?

Ms. Gail Graham: The Department of Defense probably needs to be the one to brief you on how they use their electronic health record system in combat areas. There is a component of their AHLTA system that actually has a theatre of combat component. At the VA, we can see the notes and documentation created in that theatre-based system, but really, DOD needs to be the one to speak to you directly about how that exactly works.

In those cases in which they do document electronically in combat zones, our providers and our adjudicators can actually see that information.

● (1645)

Mr. Sukh Dhaliwal: Electronic technology is progressing every second, and some doctors might be unable to adapt to this electronic system. Are you aware of whether there are some of those doctors? Or are all the doctors able to access this system, and are all parties fitting in with this technology?

Ms. Gail Graham: Actually, we don't have provisions today to have doctors who don't participate. This is how they access their results. This is how they order their medications. We gave them a period of time for the conversion, during which we accommodated both processing orders—non-electronically and electronically. But as I stated earlier, about seven years ago we really had to make the full conversion over to the electronic environment. A lot of that was prompted by physician colleagues. It was really a dangerous situation not knowing if what you were looking at electronically was complete or having to look at both the paper record and the electronic record. Really, when you make the conversion, you have a period of time with both, but to prolong that period of time really creates a very dangerous situation.

In this country, we have an oversight body called the Joint Commission. This is really an area they watch closely to make sure that as organizations convert to electronic situations, providers are well informed about how they access information.

I'm sure there were some providers who retired during this conversion, but to say that it was only our older physicians would not be the case either. What we see now is that it's a big recruiting tool for young physicians. Many of our physicians, when they go out into private practice, are very upset that they don't have access to electronic health records, as they did during their VA experience.

We see it today as more of a recruitment tool. As I said, during the last decade I'm sure there were physicians for whom it prompted retirement from VA, but it was not a mass exodus of clinicians. Some of that may be attributed to the fact that for two decades before we moved in the direction of their actually interacting with the computers to enter their orders and their progress notes, our clinicians had been accustomed to looking up information. We still allow, in some areas, some dictation of longer reports, such as discharge summaries or operative reports or histories and physicals. And some of our clinicians use voice recognition software to enter their progress notes, for example, so that you may see different flavours in how they interact with the computer.

Mr. Sukh Dhaliwal: As I mentioned in my preamble, the U.S. Department of Veterans Affairs is a world leader in the use of electronic health records. Why wouldn't other departments have followed that lead? Do you have any advice, not only for Veterans Affairs but for other health providers in general, such as provincial jurisdictions, if they go into a system like this?

Ms. Gail Graham: Other organizations similar to us, like the Indian Health Service, which provides care on reservations and non-reservations, have had an electronic health records system for some time. The Department of Defense was an early adopter of the core systems and has gradually moved to the electronic health records system. Organizations such as Kaiser Permanente and other large health care providers have seen that this enhances their ability to manage patient populations. We see the adoption more prevalent in organizations that reap the benefits in financial and quality performance.

I think in the VA there was a perfect storm of technologists who were interested and innovative, together with clinicians who saw that there was a better way of delivering care. Putting the two together created a perfect storm, out of which this system came. It wasn't perfect out of the box, but our providers know that it will be improved as time goes on and that we will listen to their input and make changes incrementally.

So I think it was all those things combined. In the long run, this is not easy. You have to think about the different ways clinicians practise and make sure that what you're introducing is a help and not a hindrance. You also have to educate patients. If this is something consumers want, they have to drive it. For those with chronic diseases trying to maintain continuity between physicians and carrying around boxes of paper documents, this is definitely something that will make their lives easier.

In the future, I think a lot of this will be driven by the consumer. But it takes care and planning in respect of how you want to roll it out. You have to determine the needs of the different specialties. Mental health, for example, was one of the first software packages we released, and that's not a common component in most electronic health records systems.

The seamlessness between in-patient, outpatient, and long-term care is also important. Many times we see that vendors are only selling outpatient records, in-patient records, or long-term care records. Integration, though, is really the key to both the usage and the continuity of care for the patient.

● (1650)

The Chair: Thank you, Madam Graham.

Mr. Dhaliwal, thank you.

I think everybody has stated that they have exhausted their questions. But I have a couple before we let you go, Madam Graham. I think you can tell by the questions that we commend you for the advancement in the area of electronic health records. I just wanted to make something clear. If I understand you correctly, there is not any state, federal, or municipal health care that's not integrated into a national electronic health care records system. Is that right?

Ms. Gail Graham: I don't know if I understand your question.

The Chair: I'm referring to Veterans Affairs, your department.

Ms. Gail Graham: Oh, for veterans. Yes, that's correct.

The Chair: And the other public health care agencies across the United States have electronic health records as well. Is that correct?

Ms. Gail Graham: Actually, the adoption is still pretty low. It's about 20% now. It tends to be concentrated in the large integrated health care organizations such as Kaiser Permanente or Intermountain Healthcare. The small practices have been slow to adopt the electronic health records system. We've done some things at the government level. There was a certification process established in which software had to go through a rigorous certification process to ensure that it met certain provisions of quality reporting or clinical decision support. That was established a couple of years ago. It was brought in to give providers who were purchasing these systems confidence that it would meet their needs. In fact, we're still not nationwide, or even past the 20% adoption rate of electronic health records.

The Chair: That's interesting. That limits your capability of dealing with outside clinics, then, obviously. If someone goes to a clinic that does not have the electronic health care records, then you'd have to manually upload that from the records that would be transferred to you on paper.

Ms. Gail Graham: Right.

The Chair: This gets back to the fact that it can also create serious errors. Thank you for that.

I wanted to ask you a question on the filling of prescriptions. Have you had much pharmacy fraud?

● (1655)

Ms. Gail Graham: We've had some. The Office of the Inspector General is probably a better one to comment, though I will tell you we've had—on the scale that we process pharmacy prescriptions—a very minute occurrence. We have had some instances internally of pharmacists diverting narcotics in very isolated cases. There are very few cases that I know of, but our Office of the Inspector General would probably be the one that could give you a more comprehensive response. I only know of those that were elevated to me.

The Chair: It sounds like, for the most part, it was internal, that it wasn't something where someone was actually able to create a false record and obtain pharmaceuticals.

Ms. Gail Graham: Right.

The Chair: Last, how many levels of redundancy do you have for your system? You were talking about what would happen where there was a natural disaster, that you'd move the records. Do you have several levels of redundance in terms of tape and hard drive backup?

Ms. Gail Graham: We do, and they're adding more all the time.

Currently the systems are backed up on tape, and those tapes are stored elsewhere so that they can be restored. But also, we're moving to regional data processing centres where several systems may be collocated, and they have established what they refer to as a hot backup for those systems. So if there were an outage over about five hours, I think it is, they could revert to the hot backup. There are the local tapes; there are the backup, full-redundancy systems; there are also the local measures that they take nightly to queue summaries of information for patients who are in the hospital or have upcoming appointments. Those are stored separately from the mainframe system. And then we also have a read-only system that's available nationwide, should there be an outage, that we can get to in the interim until the hot backup is restored.

Our uptime is pretty high, about 99.5%. But as many experts have said, when you convert to an electronic health record system, it almost needs to be at that Six Sigma level, with close to zero downtime, so it doesn't interrupt patient care. That's the direction we're moving towards, but we're not there yet.

The Chair: Thank you very much.

On behalf of the committee, I want to thank you. Your answers were very cogent and informative. We're going to have a lot of material for our report after this.

Again, if you could share this with the VA, this the third teleconference we've had, and you've been very gracious in your time investment with us for our study. Thank you very much.

Ms. Gail Graham: You're very welcome. I wish I could have seen you, but it was great to hear from you again.

Thank you.

The Chair: All right, ladies and gentlemen, we'll now go into some committee business.

Is there any need to go in camera for this? If there's someone who would like to, I will, but other than that we'll just move forward with it. Is everyone okay with that?

Some hon. members: Yes.

The Chair: The first item we want to deal with is our schedule to Ste. Anne's. I understand there's some discussion to be had around that.

Monsieur André.

[*Translation*]

Mr. Guy André: I looked at the schedule. I had asked that we meet with a union representative from Ste. Anne's Hospital. Also, Ms. Magali Picard, the Vice President for Quebec of the Union of Veterans' Affairs Employees, is prepared to meet with the committee. It would be interesting to hear what she has to say.

It's no secret that the next budget will call for cuts to the operating budget of Ste. Anne's Hospital. The minister shared some highly relevant information with the committee. He maintained that the cuts would not necessarily compromise the quality of services provided to veterans.

I've looked at the schedule and I think we should meet with the members of the administration team at 10:35 a.m. It is critically important, to my way of thinking, that we meet with the administrators and examine the research activities taking place at Ste. Anne's Hospital.

According to our schedule, we are slated to hear a presentation on Epikura, a nutritional program of texture-controlled foods for patients with dysphagia. Because this is a more specialized subject, I think that instead we should meet with Ms. Magali Picard, or extend our meeting, despite our already tight schedule.

That is my suggestion. I feel it's important to meet with union officials.

● (1700)

[*English*]

The Chair: Mr. Stoffer.

Mr. Peter Stoffer: I tend to agree with that.

You're also having a lunch at 12:05. It wouldn't hurt to invite the president of the veterans association, who is at Ste. Anne's, to join you. He could give you first-hand knowledge from their perspective on how the treatment is going there and how these proposed changes to the contract workers will affect them.

He wrote a letter outlining their concerns. I believe Mr. Kerr and Mr. Thompson have received it, because we received a copy. He was quite concerned about what may happen. As a courtesy—he is the president of the veterans association there—it would be a nice gesture on the committee's part to invite him so you can have a friendly chat to discuss that and other issues within Ste. Anne's Hospital.

The Chair: Just to clarify, he's the president of the Ste. Anne's veterans association.

Mr. Peter Stoffer: Yes. His name is Raymond something. I don't have his last name.

The Chair: I think we'll be able to source that.

Mr. Peter Stoffer: He's a really nice guy.

The Chair: Is there any other conversation around this issue?

Monsieur Gaudet.

[*Translation*]

Mr. Roger Gaudet: Will there be some interpretation?

The Chair: Yes, sir, there will.

[*English*]

Mr. Peter Stoffer: I'll interpret.

Mr. Greg Kerr: Having the chair of that association to lunch is a good idea. It's a good courtesy.

To the other point, I don't see any difficulty if we want to add somebody to discuss the union perspective. But I wouldn't want to take an already prepared part of the agenda out of there. It's okay if it's a matter of adding a few minutes or whatever at the end. These are all fairly restricted times, so I don't think it would be a problem if we wanted to add a bit of time there. I would rather not take anybody out of the agenda who's already there.

The Chair: Madam Foote.

Ms. Judy Foote: I concur with that as well. It's important that we meet with everyone we possibly can, but I think we need to add it to the end of the schedule.

[*Translation*]

Mr. Guy André: As I said, either we add it on to the end of the schedule , or we. . .

[*English*]

The Chair: May I make a suggestion that we have an extended working lunch. We'll include the president of the veterans association first, as Mr. Stoffer suggested. Then we will invite the union representative at the end of our lunch. We'll extend it by maybe 20 minutes. Most of the things we're investing in are 20 minutes at a time, so that should work out.

I've been on this trip before. You'll want to get out of Montreal as early as possible to beat the rush, so that will extend our visit to around 2:30 p.m. Is everybody all right with that, provided we get hold of these folks to make sure they're going to be available?

[*Translation*]

Mr. Guy André: I have the telephone number.

[*English*]

The Chair: Is there any conversation about any other issue?

I will remind the committee that our next meeting is in this room at 10 a.m. on Thursday. We don't have a meeting on Wednesday.

Go ahead, Mr. Dhaliwal.

● (1705)

Mr. Sukh Dhaliwal: Is this letter just for circulation, or is it an action item?

The Chair: Mr. Dhaliwal, if you'd like to talk about an action item, I would be prepared to entertain it.

Mr. Sukh Dhaliwal: We have a letter from Mr. Anthony Rota to the clerk of the Standing Committee on Veterans Affairs. The letter requests that Mr. Cotter be given another opportunity to address the standing committee. I would like to see the point of view of the committee.

The Chair: Go ahead, Mr. Kerr.

Mr. Greg Kerr: I have no particular difficulty, but we've agreed to finish certain studies first, so I think we should stick with what we're trying to get done and add this later on. In other words, we're having these various presentations to finish up our review process. I think we should get that done first. I'm sure there will be a lot of requests for individuals before we're through. If we could put it later on, until after we finish the study, it might be for appropriate, Mr. Chair.

The Chair: Go ahead, Mr. Dhaliwal.

Mr. Sukh Dhaliwal: Mr. Chair, at least we could have a commitment by the committee that after we finish the business the committee is working on, we would bring Mr. Cotter. Is that the consensus?

The Chair: Go ahead, Mr. Gaudet.

[*Translation*]

Mr. Roger Gaudet: Does Mr. Cotter live in Ottawa?

[*English*]

The Chair: I'm not certain of that, Mr. Gaudet.

[*Translation*]

The Clerk of the Committee (Ms. Erica Pereira): I'm not sure, but it's in Mr. Rota's riding.

Mr. Roger Gaudet: That's in Timiskaming. It isn't exactly next door.

Thank you. That answers my question.

[*English*]

The Chair: There seems to be consensus that it would be after we're finished our current study. We also have the Dominion Institute after that, and a trip to P.E.I. to visit the headquarters of Veterans Affairs Canada.

Madam Sgro is not here today, but I can assure you that she would speak vehemently about this next matter. She and I both wanted to put on the schedule an organization that has developed a DVD that celebrates the Royal Canadian Air Force. We met the producers at the Dominion Institute when we went there for the breakfast, and I asked them to submit a letter to me regarding it. I have it in front of me here. They also sent a copy to Madam Sgro. She's not here to speak to it, but if there's no objection, we will add it to the schedule after our study as well.

Ms. Judy Foote: Mr. Chair, does that mean we'll get a letter back to Mr. Rota indicating how we will follow up on this matter and when Mr. Cotter can expect to appear before the committee?

The Chair: The appropriate steps will be taken. The best step, in my mind, would be to contact Mr. Rota to ask for the contact information for Mr. Cotter and then invite him.

Mr. Sukh Dhaliwal: Thank you, Mr. Chair, and thank you, committee members, for considering this.

The Chair: Is there any other new business?

The meeting is adjourned.

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