Maximizing the value of EMRs

With almost 65% of eligible physicians having adopted an EMR in their practice in British Columbia, several trends are becoming clear. As discussed in previous articles, the 65% of physicians who have adopted EMRs are heavily weighted toward non-urban physicians in group practice, and particularly physicians in communities that have established divisions of family practice and EMR communities of practice. Urban solo and small clinics trail well behind and make up most of the remaining 35%.

It has also become increasingly evident that there is extensive variation in the levels of EMR use, with many different contributing factors. Even within a single town, a single group practice, and among users of the same EMR system, the level of effective use of the EMR can vary significantly. The reasons may include an individual's basic computer and typing skills, time spent learning the new EMR, quality of training, willingness to adapt, and flexibility and ease of use of specific templates and tools in the EMR. Adopting EMRs is a complex change. Everyone adopting EMR goes through similar cycles of progress and barriers—the important part is having the time and support to break through the barriers.

Looking close to home, we have seen the highest levels of effective use where physicians participating in local EMR communities of practice (COPs) have established EMR user groups and a network of physician and medical office assistant peer mentors, and more effectively engaged with their EMR vendors for training and support.

Looking further afield, we see countries such as Denmark and New Zealand that have enjoyed ubiquitous use of EMR for several years but have also run into similar challenges during their journey. Physicians had adopted the EMR, but had not learned the more advanced functionality or started to use the EMR to support proactive care (e.g., chronic disease management) or quality improvement efforts. Denmark, for example, established the role of "data consultant." These individuals visited clinics to help alleviate gaps in training, configure the EMR for efficient use, and support the clinic in establishing patient registries in the EMR so that they could begin to assess their practice population proactively and evaluate how they were doing. Like BC, these other jurisdictions made effective use of peer support, user groups, and vendor support—all with a strong focus on quality improvement and stronger health system integration.

"We cannot grasp the complexity of our chronic complicated patients by piles of pieces of paper. We need the EMR to help us... there is no other option."
—Dr Lianne Lacroix, Kelowna

Acknowledging these experiences, PITO is now expanding its support for clinics already on EMR to make the most of their investment. This new Post Implementation Support Program is being pilot tested in five communities across the province this fall/winter, while preparations begin to expand support across the province. Building on what has been effectively proven in the COPs, and lessons from other countries, the support mechanisms include:

- Local physician and medical office assistant peer mentors—"super users" on their particular EMR available to assist other clinics in their own, or other, communities.
- User groups—EMR-specific local user groups where physicians and MOAs can come together to learn from one another and their EMR vendor in a collaborative setting.
- Practice automation coaches (PACs)—individuals with EMR and office management experience who can provide more in-depth follow-up, such as addressing workflow or training barriers, and assist in setting up condition registries and templates for the first time.
- Advanced vendor training and protected time—funding for physicians to purchase advanced training and support, and use protected time from practice to make changes.
- Coordinated support with General Practice Services Committee (GPSC) and Specialist Services Committee (SSC) initiatives—coordinated learning sessions (e.g., chronic disease management and practice efficiency using an EMR), in-practice support, and evidence-based templates/tools built into the EMRs.

These support mechanisms are available equally to both GPs and specialists; however, the focus or approach will vary depending on the spe-

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cialty or type of practice. While GPs may be more focused on chronic disease management, specialists may be more focused on enhancing the referral/consult process or surgical booking process.

To measure progress toward more comprehensive use of EMRs, PITO has established a model for assessing the level of use of the EMR (often referred to as "meaningful use"), and associated clinical value, based on a generally accepted international framework (see the **Figure**). The goal is to support all clinics in getting to Level 3 ("Full EMR"), and ready to make use of the EMR for proactive care and quality improvement (Level 4). The specific definitions of Levels 3 and 4 vary between full-service family practices, consulting specialists, surgeons, walk-in clinics, and others. The Figure is a simplified summary of this model. Concurrently, PITO is working to strengthen the connections between the EMRs to support these goals:

- General practice: Ensuring that the EMR workflow, templates, and other tools are optimized for the Guidelines and Protocols Advisory Committee and GPSC/PSP priority areas and guidelines (diabetes, COPD, CHF, etc.).
- Specialty practice: Enabling electronic referrals and consultation letters ("e-referral") between GP and specialist, and enabling electronic OR booking for surgeons.
- Shared care: Using the e-referral mechanisms to support exchange of information between providers in support of shared care such as maternity care or COPD.

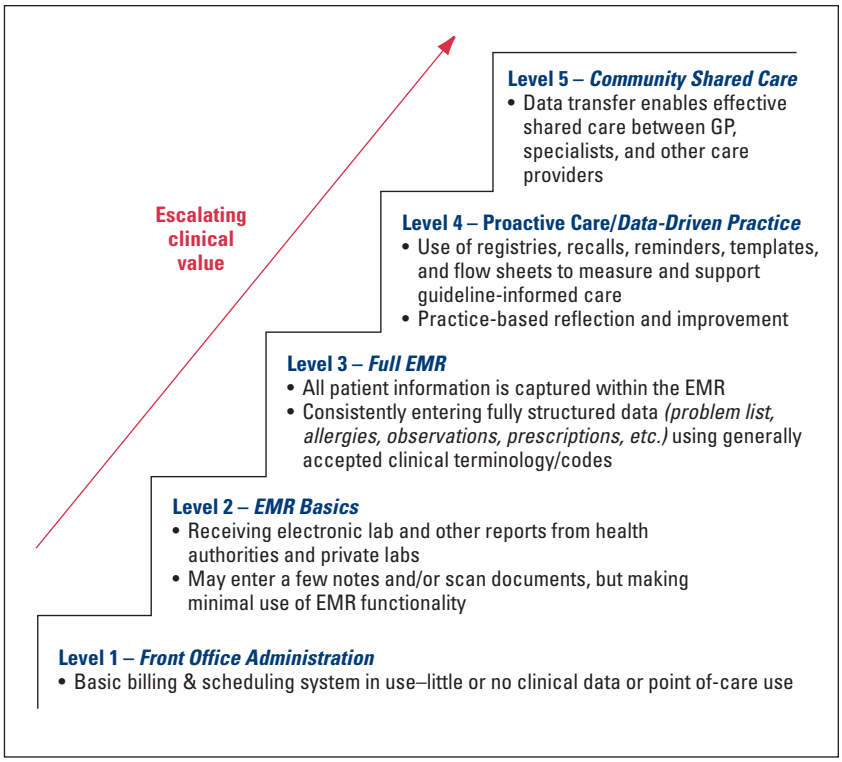

Figure. EMR "meaningful use" and clinical value model.

If you are currently using an EMR and would like to learn more about this advanced support, please contact your PITO local relationship manager (see www.pito.bc.ca for contact details).

—Jeremy Smith
PITO Program Director