



Improved Patient Outcomes through Meaningful Use of EMRs by Ontario Physicians

Toronto, November 17, 2010 – Ontario physicians using Electronic Medical Records (EMRs) are reporting that EMRs enable them to improve patient care and operate more efficient practices.

“Ontario’s doctors know firsthand the important role that EMRs can play in supporting the advancement of our patients’ care,” said Dr. Mark MacLeod, President of the Ontario Medical Association. “Physicians using EMRs report that patient safety has improved and continuity and overall quality of care has improved. We will continue to work hard to achieve our shared goal with the provincial government of ensuring every patient has an electronic medical record.”

OntarioMD has been funding and supporting over 5,000¹ community physicians to adopt EMRs since April 2005 as part of eHealth Ontario’s EMR Adoption Program. OntarioMD collects EMR user surveys to evaluate the success of the Program and identify areas for improvement. Since 2008, more than 2,000 surveys have been collected.

Dr. Stephen Chris, Board Chair, OntarioMD, said: “There is a lot of discussion about meaningful use and EMRs right now. Physicians participating in Ontario’s EMR Adoption Program have eagerly adopted EMRs, and shown remarkable levels of meaningful use of EMRs since we first measured use in 2008. The latest 2010 survey results show further improvements in patient outcomes and even greater EMR use.”

Greg Reed, CEO of eHealth Ontario, noted that, “Considering that the majority of your health information is collected and managed by your family doctor, it is an absolute must that physicians successfully adopt EMRs within their practice in order for ehealth to be a success. Working closely with our partner OntarioMD, Ontario now has more physicians using EMRs than any other Canadian jurisdiction combined.”

The latest survey results for 2010 clearly illustrate that physicians using EMRs are producing positive results including:

- 90% are using EMRs regularly to write and renew prescriptions;
- 90% are regularly receiving and managing lab results electronically, up from 82% in 2008;
- 92% are using their EMRs to enter their encounter notes, eliminating the need for paper records;
- 73% felt they were primarily paperless, up from 60% in 2008.

OntarioMD is a subsidiary of the Ontario Medical Association. It manages the EMR Adoption Program on behalf of eHealth Ontario, which oversees and funds the Program.

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¹ Only community physicians funded by OntarioMD. eHealth Ontario also funds physicians separately.

Background – Measurement in Ontario’s EMR Adoption Program

In 2008, OntarioMD and eHealth Ontario commissioned and competitively procured an independent evaluation of physicians participating in the EMR Adoption Program. 1,200 physicians were asked to answer a survey about their EMR use and its impact on their practice. Two hundred and sixty-eight responded.

Beginning in 2009, physicians are required to submit the EMR Usage Survey when they apply for a Performance Recognition Bonus once they have established electronic medical records for 600 of their patients with EMRs or two-thirds of their roster. OntarioMD has collected surveys from 1,750 physicians between February 2009 and September 2010.

Ontario’s approach to meaningful use is set out in the EMR Funding Program Terms and Conditions, which define eight meaningful use criteria in two broad categories:

Practice Management	1. Scheduling patient appointments 2. Billing for services
Clinical Support – Electronic Medical Record (EMR)	3. Entering encounter notes for patients seen 4. Entering problem lists for patients seen 5. Making new prescriptions/renewals 6. Generating automated alerts/reminders to support care delivery 7. Receiving lab results electronically, directly into the EMR from private labs supported by the EMR Specification 8. Storing patient care related information and documents within the EMR that originated from another healthcare provider/organization

Most community physician practices use computers for scheduling and billing, the key difference with the EMR Adoption Program usage criteria is that the patients’ information must be integrated with their clinical electronic medical records. The *Clinical Support* criteria above define core functionalities that enable EMRs to support improved health care delivery.

The following charts show the progressive improvements in patient outcomes and use of EMRs by physicians participating in the EMR Adoption Program as measured by the 2008 and 2010 survey results.

Patient Care Outcomes

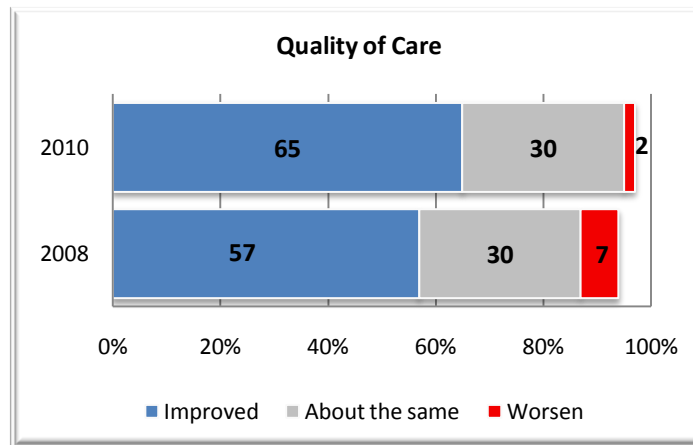
The majority of physicians report that EMRs enable them to improve patient care outcomes.

The most notable improvement was centred around quality of care improvements. In 2010, 65% of responding physicians felt that EMRs helped improve the quality of care delivered to their patients, up from 57% two years prior. The number of physicians who felt that EMRs negatively impacted the quality of care that they provided also dropped in the same period.

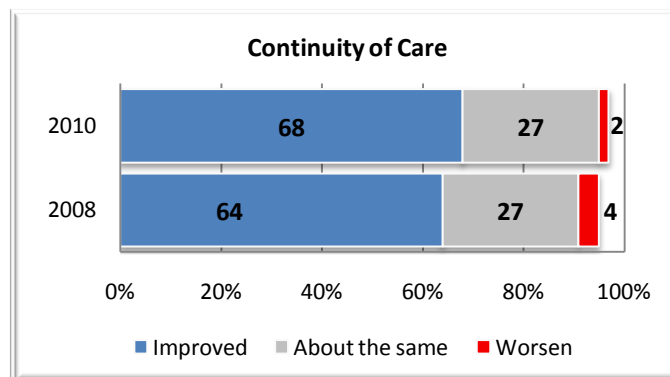
Dr. Sol Werb of Toronto says: *“The EMR has made the quality of my practice much better, especially with chronic disease management, like diabetes and hypertension.”*

Dr. Elliot Halparin of the Halton Hills Family Health Organization and Halton Hills Family Health Team says: *“An EMR makes you smarter. It makes you more efficient, and you can search through your notes. Once you switch to an EMR, it becomes clear what are the pitfalls of using paper records.”*

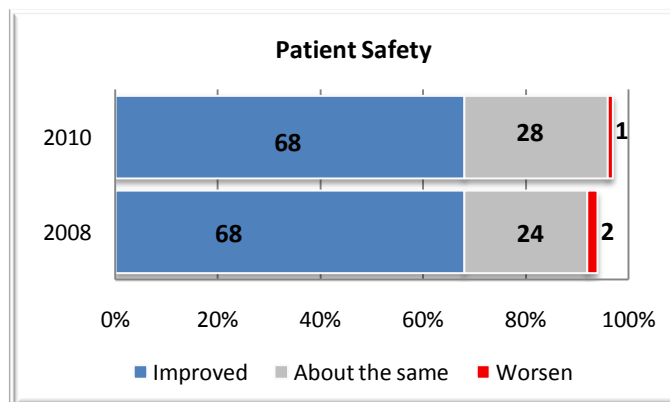
Between 2008 and 2010, nearly 7 in 10 physicians felt that EMRs helped improve the continuity of care and the level of safety provided to their patients.



268 respondents in 2008 and 1,092 respondents in 2010



268 respondents in 2008 and 1,093 respondents in 2010



268 respondents in 2008 and 1,089 respondents in 2010

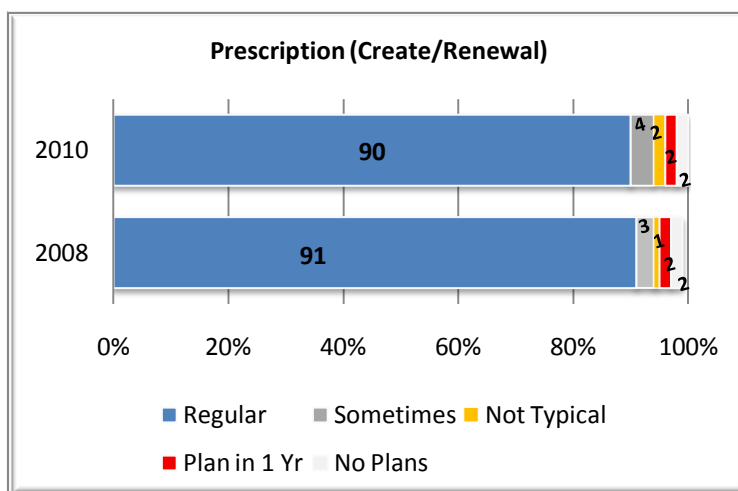
Clinical Support Use

The use of EMRs for regularly writing and renewing prescriptions has remained high at 90% of surveyed physicians. This supports patient safety by checking for adverse drug interactions and by eliminating hand written prescriptions.

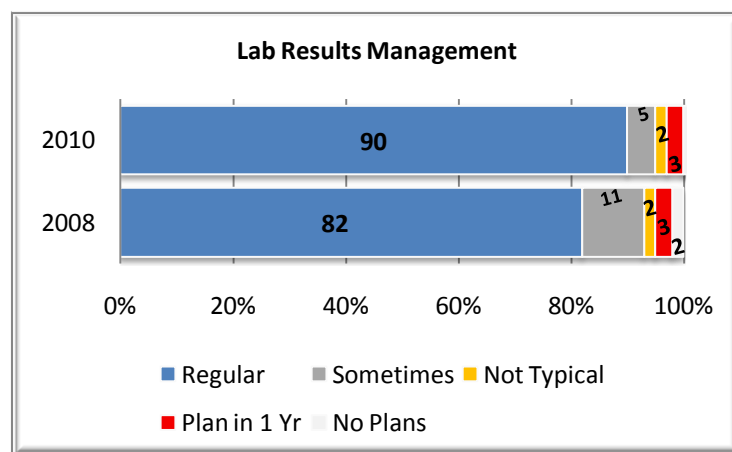
90% of surveyed physicians are regularly receiving and managing lab results electronically, up from 82% in 2008. These physicians are able to receive lab reports in minutes versus days, and are able to avoid having to scan paper records into their EMRs.

53% of surveyed physicians are leveraging their EMR to remind them of any overdue or upcoming Preventative Care and/or Chronic Disease Care event. This is up from 41% in 2008.

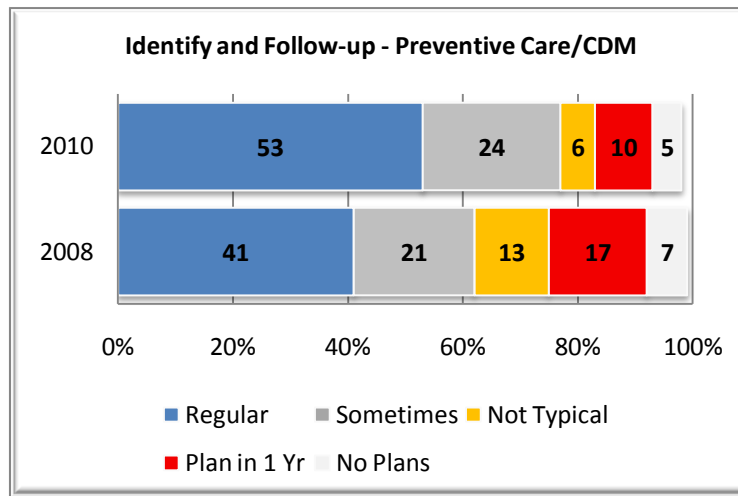
Once physicians have moved to an EMR, more than 80% use it as their primary source for patient information, the Cumulative Patient Profile (CPP) - 83% in 2010, up from 81% in 2008. The CPP is the part of a patient chart with summary information on a patient's personal and family characteristics as well as ongoing health conditions and treatments, which is separate from continually updated information on short-term problems.



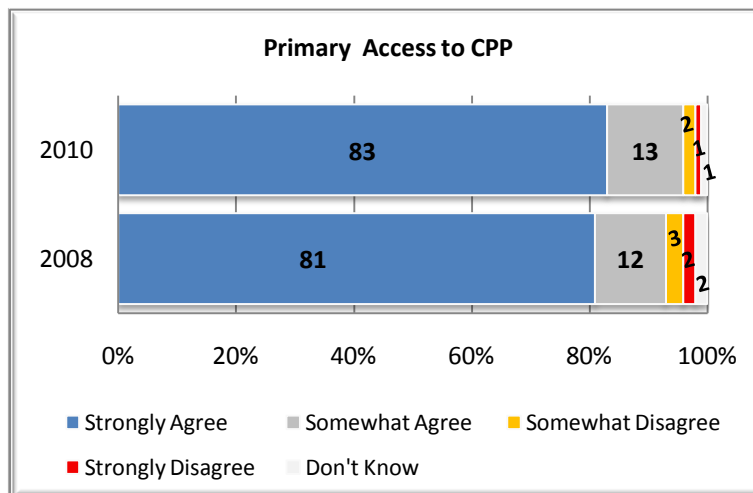
268 respondents in 2008 and 930 respondents in 2010



268 respondents in 2008 and 937 respondents in 2010



263 respondents in 2008 and 950 respondents in 2010



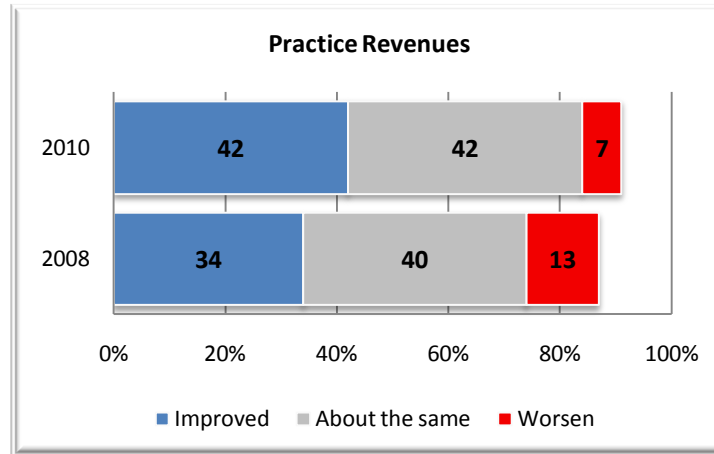
263 respondents in 2008 and 936 respondents in 2010

Practice Impact

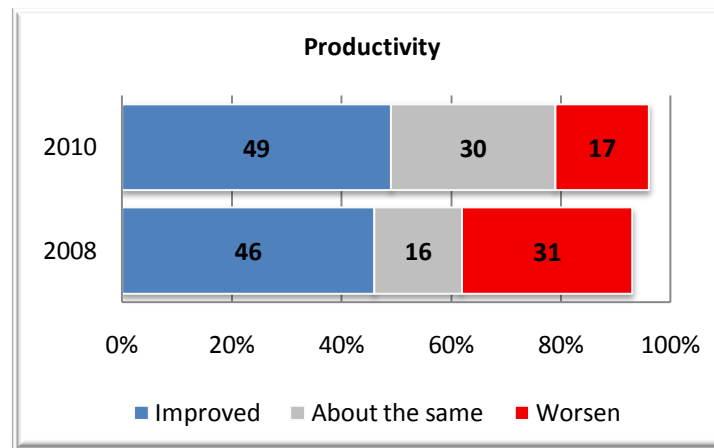
A key concern with physicians adopting an EMR is how it will affect their practice – especially their productivity and revenues.

- In 2010, 84% of physicians reported improved or the same revenues, up from 74% in 2008;
- In 2010, 79% reported improved or the same productivity, up from 62% in 2008.

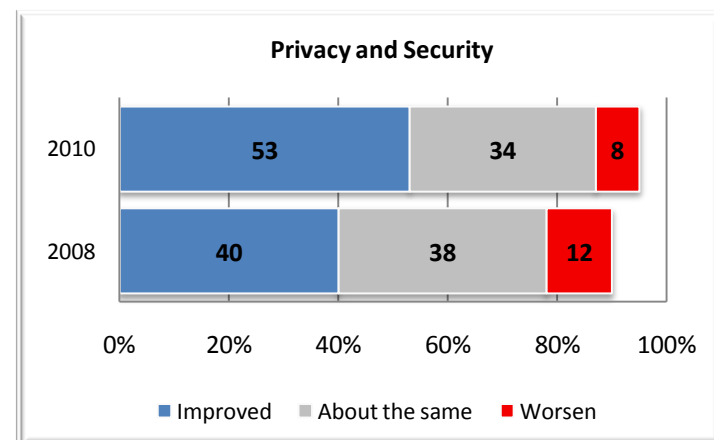
A majority of physicians (87%) also felt that the privacy and security of patient information on an EMR either improved or remained the same over paper records, this was up from 78% in 2008.



268 respondents in 2008 and 1,084 respondents in 2010



268 respondents in 2008 and 1,091 respondents in 2010



268 respondents in 2008 and 1,087 respondents in 2010

Moving Away From Paper

A long-term goal of using EMRs is to minimize the need for paper records. Physicians are well on their way to achieving this as 92% in 2010 are entering their encounter notes only into their EMRs. In 2010, 73% felt they were primarily paperless, up from 60% in 2008.

