Beyond the EMR tipping point

Over the last few decades, our ability to make improvements to health care delivery has relied largely on the benefits of technology. Technological advances have brought us many of the tools that physicians rely upon today, such as MRIs, fibre optic endoscopes, telehealth conferencing to bring health care to isolated areas, and greatly improved medications.

One of the largest areas to benefit from this technological revolution is our ability to gather information and improve communication. Because of the Internet, never in the history of the world have patients been more empowered to help themselves and participate in their medical care.

For physicians and other health care providers, the use of electronic medical records (EMRs) has been just as revolutionary. Designed to replace and improve upon the traditional paper chart, EMRs capture data and accurately represent a patient's status at all times. EMRs enable physicians to improve the quality of patient care significantly by:

- Allowing for an entire patient history to be viewed without the need to track down the patient's previous medical records from other health care providers.

- Reducing the chance of data duplication, as there is just one modifiable file.
- Eliminating the problem of lost forms or paperwork, and assisting in ensuring that data is accurate, appropriate, and legible.
- Making it possible to search a chart to examine possible trends and long-term changes in a patient's health (now a quick and effective process, as all the information is contained in a single file with the ability to highlight and graph relevant data).
- Improving communication among members of the care team, as well as communication between providers and their patients.
- Improving the quality of consult request letters.

In the bigger picture, EMRs seamlessly connect physicians to the broader health care continuum by better coordination with hospitals and community care outlets, and through increasing efficiency and performance across regions. This technology has an exciting future, and physicians will see many benefits as EMRs progress and become more connected, improving our ability for shared care.

With such obvious benefits, it's a wonder that when compared with other developed countries, Canada's EMR adoption rate lags significantly. Although Canadian EMR adoption rates have risen from 23% in 2006 to 56% in 2012, countries such as Australia, New Zealand, the UK, and the Netherlands have adoption rates above 90%—especially among family physicians.

However, the BC story is quite different from the national one. BC physicians have adoption rates close to 80%, and will likely reach 85% or more by 31 March 2014. With PITO (Physician Information Technology Office) having set a deadline of 30 September for one-time EMR adoption funding applications, we had a flood of late adopters. Although we still have inroads to make, the large number of physicians already using EMRs means BC's early adopters are reaching further to optimize their EMR system. BC leads the way with tools and resources developed to optimize EMR use and accelerate quality-improvement initiatives. It's important to note that EMR adoption and optimization are but one component of continuing quality improvement, which also includes physician connections to PharmaNet and PLIS (Provincial Laboratory Information Solution), enabling access to a patient's complete medication profile and lab history directly from within the EMR.

For physicians set to retire in the next couple of years, it may make sense to forgo the expense and time-consuming learning curve of adopting an EMR. However, physicians who are years away from retirement and choose not to adopt EMRs will find it increasingly difficult to access patient information. Recently, the Fraser Health Authority, Vancouver Coastal Health Authority, and the Provincial Health Services Authority announced that by the end of 2014 they will be phasing out distribution of lab, medical imaging, transcription, and other reports via fax or mail in favor of electronic delivery. Reports will be delivered directly into either EMRs or an Internet inbox for practices without EMRs.

For those who have adopted EMRs, there are a host of resources available through PITO and GPSC to make the most of the technology. These include:

- Practice automation coaches help

physicians move from simple charting to more complex chronic disease management and shared care.
- Physician and MOA peer mentors provide hands-on support.
- Vendor training.
- Communities of practice (18 in the province) and local user groups.
- PSP clinical modules designed to incorporate EMRs, with practice coaches to assist with change.

I hope that all BC physicians adopt EMRs into their practices in the near future. The bottom line is EMRs are here to stay—they are the future of health care. Physicians who use EMRs lead the way in providing exceptional patient care. In fact, physicians involved with shared care will know that it is next to impossible to practise in a shared care model without an EMR and interoperability. Wouldn't it be great if all emergency departments provided family doctors with the patient's typed emergency record the very next morning?

In this issue of the *BCMJ* you can read more about this topic and about some BC physicians who are at various points in their EMR journey. Find out how both family and specialist physicians have adopted and customized EMRs to their specific needs.

Many years ago—in 1991, amazingly—my office converted to a paperless system, and the quality of care I was able to provide to my patients improved dramatically.

—William Cunningham, MD
President

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Letters for Personal View are welcomed. They should be double-spaced and less than 300 words. The *BCMJ* reserves the right to edit letters for clarity and length. Letters may be e-mailed (journal@bcma.bc.ca), faxed (604 638-2917), or sent through the post.

Re: Pressed to test

Dr Richardson asked if one would order cortisol levels because a patient told her that her naturopath said she needed them checked, order hormones for someone who wants to start bioidentical hormones, order X-rays of the back because someone's chiropractor wanted them ordered, or order a cervical MRI because someone's massage therapist wanted the imaging done [Pressed to test: How should GPs respond? *BCMJ* 2013;55:312].

What I would do for each of these patients is to try to generate a SOAP note for the original problem, then review what tests, if any, I would order for that particular assessment. I intervene (that is, order a test, request a consult, or even ask a question) if I am pretty sure the intervention is going to help the patient. If I don't think the intervention is likely to help, I don't intervene. If the patient described in the above four scenarios is healthy, I probably would not order the test. I would review with the patient that testing can cause harm. For example, if we find something on testing and the patient has a new diagnosis, we may feel obliged to follow up with more testing and perhaps also treatment. I don't need to order a lumbar radiograph on a 60-year-old to know that he or she probably has disc space narrowing and osteophyte formation. Why give the patient a label that may cause worry, and which will not lead to useful treatment? If a patient insists I order a test that I don't think needs to be done (commonly, PSA or lipids), I fill out the requisition for the test and mark clearly, "patient to pay."

GPs in British Columbia have great freedom of professional action. Our colleagues in the United States express frustration because they are allowed to order a narrow range of tests and therapies for disease-related categories. It is not sustainable for health care spending to increase with every provincial budget. If we in BC manage patients in an empathetic, elegant, and slightly frugal manner, we can provide good care and hopefully not contribute to a situation in which the legislature feels compelled to limit the action of doctors in arbitrary and unhelpful ways.

—Robert Shepherd, MDCM
Victoria