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CMA and a smart strategy for health IT
Anna Reid, MD, CMA president

Doctors and data stewardship: a murky proposition

Public leery of sharing medical information without consent

Plugged-in patients: new tools allow doctors to connect with patients

Did you know your EMR can do this?

Patient engagement is big!

The EMR, all grown up

Correction:
In the March 2013 issue of Future Practice Emailing Patients: Time Save or Time Bomb article, the website “Healthy Debate” was wrongly identified.
CMA and a smart strategy for health IT

Anna Reid, MD, CCFP(EM)

Implementing an electronic medical record (EMR) in your practice is not the end of the journey but just the beginning.

By all means pat yourself and your practice partners on the back for making the move to an EMR and dealing with all of the challenges of adjusting your workflow and training your staff to accommodate the new system.

But frankly, using an EMR is fast becoming the standard of practice in medicine and to take full advantage of the new electronic environment to improve patient care and implement practice efficiencies there is a lot more you need to do.

This is part of the reason the Canadian Medical Association (CMA) is working with the provincial and territorial medical associations (PTMAs) to revise its strategy on health information technology. In addition to emphasizing some of the basics that physicians need to remember when working in an electronic environment, the CMA wants to ensure our members are getting the best use out of their EMRs to benefit themselves, their patients and the health care system as a whole.

The issue of Future Practice profiles some of core elements of that revised strategy.

We have taken this opportunity to provide an update on the protection of patient health information and the views of the Canadian public on this issue. It should come as no surprise that those views have remained fairly constant in recent years — Canadians expect the privacy of their health care records to be protected and they see physicians as the natural stewards of that information.

The CMA and others have provided sound principles for how physicians can and must fulfil this role. We feel this is so important that it cannot be emphasized enough — especially as certain jurisdictions try to access patient information without proper safeguards or permissions.

Two articles in this issue deal with how physicians can obtain assistance from their peers in making the best use of their EMR and outline the framework — or “maturity model” of EMR use — that has been developed to help practices measure how effectively they are working in an electronic environment. Peer-to-peer is a well-accepted learning environment for physicians in clinical medicine, and much work has been done in recent years to translate this into the EMR environment. Now, almost every jurisdiction in Canada has networks using local physician experts and supported by Canada Health Infoway. The maturity model of EMR use pioneered by OntarioMD is just a roadmap for how physicians can move along the continuum from being basic users of the system to taking full advantage of all the benefits that the EMR can offer to improve care.

Finally, we have a feature on how several physicians are taking new and exciting approaches to engaging patients in their own care using electronic tools. This highlights another important part of the CMA strategy, namely encouraging innovation by our members to improve health care by using EMRs and the other electronic tools now available.

I hope you enjoy the issue and in doing so gain a better perspective on how CMA continues to support approaches that make sense for you in dealing with the new electronic environment.
Physicians know the paramount importance of protecting the privacy of their patients’ medical records. They have long regarded it as a sacred trust, articulated in landmark documents such as the Canadian Medical Association’s Code of Ethics.

But the family practice physician in a solo or small group practice, who has a waiting room full of patients, wouldn’t be alone in feeling pressured when a patient asks pointed questions about the security of her personal health file in the current electronic environment.

Consider this scenario: Your patient is being treated for HIV and lives in a small community. She worries that if her HIV status became public knowledge it could subject her to stigma and impair future employment prospects. She asks to have that part of her medical record “locked down” — and you wonder if your electronic medical record (EMR) system enables such selective non-access. If it does, do you or your staff know how to do it? If the EMR only prohibits access to the full record, does that put you in conflict with any data-sharing agreements you’re party to?

Confidentiality/privacy ≠ stewardship
Dr. Patrick Ceresia, managing director of corporate services and privacy officer with the Canadian Medical Protective Association (CMPA), notes that thanks to the advent of electronic technologies — including the EMR — when it comes to privacy the rules are changing.

“We now have (e-health) tools … that have all kinds of potential but still have challenges and a down side.”

Jean Nelson, the CMA’s privacy officer, elaborates: “(These systems) make medical records potentially available to a wider range of people (such as hospital administrators, clerks and policy-makers in an electronic health record [EHR] environment), and wider availability means greater risk of invasion of privacy. It also means greater audit capacity to see who has been looking.”

The College of Physicians & Surgeons of Alberta states:
“Data stewardship refers to the collection, use, disclosure, management and security of health information by a health professional. Within each of these aspects, there are legal, ethical and best practice considerations for how physicians manage the health information in their trust.

“Maintaining the balance between patient confidentiality and the reasonable use and access to individual patient data for other purposes is critical to maintaining public trust in physicians and the larger health system…”

The definition of data stewardship that appears in the College of Physicians & Surgeons of Alberta’s (CPSA) 2012 Vision for eHealth makes it clear stewardship is more than keeping records confidential within the confines of an individual practice.

The vision articulated in that document talks not only about protecting the privacy of individual patient records in an electronic environment but also about ensuring physicians and others are properly trained to use e-health tools and processes appropriately, and that the quality of care is optimized by appropriate access to information.

Lots of interest in EMR data
The wealth of information residing in patient medical records has huge value for those shaping policies for future population health, health care system planning and medical research, according to Hutchison. This increases the pressure on physicians to enter into data-sharing agreements, where they must take time to understand how information is:

- masked to protect patient privacy
- managed (and by whom) and stored
- handled when a complaint is raised or a privacy breach occurs

And there’s another wrinkle: “Who is going to be responsible for physician compliance?”

Why everyone needs to be at the table
Ultimately, key stakeholders have the same goal, Hutchison states. The governance and responsibility for data stewardship is changing, and all parties must collaborate to find alignment and develop “a reasonable framework that can be consistently applied.” She says there’s a danger that physicians will be overburdened with administrative duties when “we want doctors to be able to focus on practising medicine.”

Experts in this area agree that every stakeholder has to be participating in the discussion as privacy policies and legislation are developed. Physicians need to understand how care roles and responsibilities are shifting, and other stakeholders need to hear the physician’s perspective and challenges.

In the interim, Hutchison notes, “we’re in policy-by-project mode (regarding decisions being made)” as technologies advance and shared-care projects for special patient populations emerge.

Where to find guidance?
Assistance is available from many sources, including CMA, CMPA, provincial regulatory colleges, provincial/territorial medical associations and government privacy offices. (See Recommended resources.)

In its e-health paper, the CPSA states that it considers as part of its mandate:
“… encouraging the adoption of (EMRs), ensuring the clinical value and appropriate use of EMRs and enabling the connectivity...
of tools and information to support patient care and health system management via the Alberta (EHR). … Maintaining the trust and open exchange of information between patients and physicians is fundamental to these interests.”

The OMA has a similar view in its policy documents.

Among ways CPSA is implementing this direction: developing an information-sharing framework where there is shared control of patient medical records, having representation on provincial EHR design teams and governance committees, and contributing to establishing the criteria by which physicians can manage privacy expectations while appropriately sharing information with the EHR.

Who educates the patient?
As trusted advisors, doctors are often asked to counsel patients about privacy decisions. But the primary care physician no longer has sole jurisdiction over how patient medical information is being used or managed, and experts say physicians should not be the patient’s only information source. The CMA’s Nelson believes regional health authorities and the medical organizations are looking to governments to take on more of this role.

Patients should know that they can ask for their personal medical record and make corrections or additions to it, but also that there will be a cost involved — and that care provided outside their primary care physician’s office may not be reflected there. Asks Nelson: “Who’s telling patients they can do that?”

Ceresia calls for increased education at all levels, and observes that many patients assume there is far more sharing of patient information among various health care systems and providers — and privacy protection — than is presently the case.

1. Privacy, confidentiality and trust are cornerstones of the patient–physician relationship.
2. Patients have a general right to control the use and further disclosure of their personal health information and a right of reasonable access to the information contained in their medical record.
3. Physicians must handle personal health information in compliance with the applicable federal and provincial privacy laws and professional regulations.
4. Physicians play an important role in educating patients about possible consensual and non-consensual uses and disclosures that may be made with their personal health information.
5. Security safeguards must be in place to protect personal health information to ensure that only authorized collection, use, disclosure and access occur.

Source: CMA Principles for the Protection of Patients’ Personal Health Information
FOUR IN FIVE OF CANADIANS POLLED IN A RECENT online survey would agree to sharing of their health information electronically, but only if they provided consent to do so. The survey findings also reinforce the important role the public believes physicians have with respect to protecting patient medical information.

However, the poll also showed a surprising ongoing lack of knowledge about the growing environment of collecting and sharing patient medical information in an electronic medical record. Fewer than half of the respondents (40%) in the Ipsos Reid survey conducted for the Canadian Medical Association (CMA) said they know what an electronic health record (EHR) is or understand how it impacts on the privacy of their personal health information.

The poll was conducted in December 2012 and involved 2,015 respondents representing a cross-section of Canadian adults. It is the most recent in a series of polls in this subject area that Ipsos has done for the CMA since 1998.

A report from Ipsos on the survey results noted: “Given the widespread use of online platforms to facilitate sharing information and executing transactions, it’s remarkable that there has been such little movement (in survey results over the past five years) — awareness has not climbed dramatically and views are relatively static — when it comes to EHR.

“However, general awareness may not breed enough familiarity … to garner more acceptance of EHR and increased sharing of health information.”

Who to trust?
The survey results underscore an interesting contradiction. While as a society we’re increasingly comfortable socializing and conducting some personal business online, we’re not eager to share something as sensitive — and important — as individual health information beyond our own health care team members.

More than four in five Canadians (82%) believe physicians keep confidential the information they’re given by patients, and most respondents said they don’t hold back information because of concern that a health care provider might share their health disclosures with another party. Nevertheless, the percentage of people who did feel anxious about that has risen from 11% in 2007 to 14% in 2012.

Informed consent appears to be key. More than 80% of survey respondents agreed or strongly agreed that they’d be willing to have personal health data shared with governments and researchers if their consent was asked first. This is a 7% increase over the 74% who were willing to release their health information in this way five years ago.
Whether the health information is “delinked” so it cannot be associated with a specific individual seems to make little difference. Survey respondents were split on whether they’d share or not share — as has generally been the case over the past four Ipsos Reid surveys.

However, there’s strong resistance to patient information such as prescription details — even if aggregated — being sold to data-mining companies and used for commercial purposes, such as marketing targeted pharmaceuticals to doctors. In 2007, 75% of survey respondents said they would be concerned with such a practice; this rose to 90% in 2012.

An EHR system managed by local or regional health authorities and third-party providers is also unpopular. Just 34% of survey respondents indicated support for this kind of health information storage/sharing, a 9% drop since 2007.

More than half (57%) of survey respondents strongly agreed that only a limited number of health care team members should have access to some parts of a patient’s medical record — whether electronic or on paper. Those who were familiar with EHR systems felt even more strongly, with 64% strongly agreeing. Among those unfamiliar with EHR systems, though, just 50% strongly agreed with limited access.

In the same vein, four in 10 respondents (40%) strongly agreed that government civil servants and hospital administrators should be able to see individual patient health information — but that figure was 47% for those familiar with EHRs and 35% for those not familiar with the electronic records systems.

Perceived health care benefits
When patient data is stored in a provincial EHR, respondents agreed that they felt confident that they’ll get the care needed when they’re ill. More than 70% indicated some level of agreement, a 6% hike since this question was asked in 2010.

Familiarity breeds suspicion
More than half (57%) of survey respondents strongly agreed that only a limited number of health care team members should have access to some parts of a patient’s medical record — whether electronic or on paper. Those who were familiar with EHR systems felt even more strongly, with 64% strongly agreeing. Among those unfamiliar with EHR systems, though, just 50% strongly agreed with limited access.

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More than six in 10 respondents (64%) oppose governments having the power to force doctors to provide medical information about their patients, but that figure was higher (69%) among those familiar with EHR systems.

Attitudes affected by age, education, tech awareness
Close to half (46%) of survey respondents reported using social media at least once a week, and these people were least cautious about sharing personal health information with researchers and governments. For example, while 42% of respondents overall expressed faith in their provincial government’s privacy protection of personal health information, this was less evident among those who never use social media (36% agreed) and more evident among those who use social media daily (47%).

Respondents from Quebec also expressed less concern about how EHRs were managed and whether government and hospital administration staff had access to personal health information.

MANAGING PATIENT HEALTH INFORMATION

A system where a patient’s personal health record is stored and managed by their physician and no information is released without the patient’s express consent.

Very acceptable Somewhat acceptable

80% 26%

A system where the patient consents up front to their physician to allow electronic access to their information to others for the purpose of diagnosis/treatment by a specialist or in necessary situations such as hospital emergency rooms.

76% 33%

A system where some of the patients’ core clinical data elements from their personal health records are centrally stored and managed by local regional health authorities or third party service providers.

32% 26%

Base: All respondents, excluding don’t know. Source: Ipsos Reid
ENCOURAGING PATIENTS to become more engaged in their own care has become central to health care delivery. This can range from using a secure email system to allowing patients to access and maintain their health care records through a patient portal.

While these approaches offer benefits touted by patient advocate groups, data is still sparse on whether using the new technologies in this way actually improves health outcomes.

The most noteworthy recent study of relevance was a retrospective cohort analysis of adults enrolled with Kaiser Permanente Colorado, Denver. It compared health care utilization for patients who had online access to health records and email communication versus those who did not. The study, by Dr. Ted Palen and colleagues and published in the Journal of the American Medical Association in November 2012, found having online access to records and clinicians was associated with increased use of clinical services.

The researchers speculated there may be several reasons for this finding — which is counterintuitive to many — including the fact that online access identified additional health concerns requiring more in-person care. Alternatively, selection bias may have meant those likely to request more services were also more likely to sign up for online access.

An accompanying editorial described the findings as “sobering for patient portal enthusiasts.”

Despite the study findings, Dr. David Bates and Susan Wells wrote in their editorial that “personal health records are here to stay and ... electronic access to personal health records (PHRs) represents an extremely powerful tool from a variety of perspectives and can help empower and engage patients.”

Another recently published study compared care for sinusitis and urinary tract infections managed by either in-person visits at four primary care practices in Pittsburgh, Pa., or electronic visits in which patients accessed a secure portal and answered questions about their condition. The system would then make a diagnosis and respond online.
Innovation in Halifax

When you talk to Halifax family physician Dr. Ajantha Jayabarathan, the sense of being part of a revolution to seriously engage patients in their care is palatable. Jayabarathan is part of a pilot project launched by the Capital District Health Authority giving approximately 3,000 patients secure access to their medical records using RelayHealth, a service of McKesson Canada. The two-year project will involve 30 physician offices in the Halifax region. Patients will be able to access their medical information and test results and book appointments. Jayabarathan said her office was the first to enrol patients in the project, beginning in late January.

All patients, when they come to Jayabarathan’s clinic, are asked about participating in the project. If they agree, an invitation is sent — and she said about 140 of her 1,400 patients had been signed up by the end of March, with 98% of those approached agreeing to take part.

She explained that the patient portal is on a platform separate from her electronic medical record system, but there are plans to integrate the two by this summer. However, the PHR is controlled by the patient, who determines who can access the data and who can audit who has reviewed the information.

Jayabarathan said she inputs laboratory results, along with her consultation notes, into the patient’s PHR and then sends the patient an email noting that the results are available. While patients can book appointments through the system she has not yet enabled allowing patients to communicate by secure messaging. There is also a broadcast messaging function to send the same message to all patients and capacity to upload patient handouts and videos.

Younger patients are especially enthusiastic about the new tool, she said, and are keen on being able to access their health information when travelling.

Physicians often don’t give enough credence to the patient’s perspective on his or her condition, she stated. “People do a lot of things for their health that they had not been disclosing until now,” but with the PHR they can enter much more information — such as symptoms.

“Eventually the test is going to be: do I rely on the information that a person is putting into their record and how reliable is that information? If the PHR is launched and physicians say ‘this is not reliable information’ it becomes a bit of a futile exercise.”

Jayabarathan added: “I think this is going to change the provision of care and … cause a lot of patient empowerment,” which may initially drive up the use of resources. She also predicted this new approach could upset many physicians used to the older model of care.

Hospital PHR

The hospital-based PHR system at Sunnybrook Health Sciences Centre, Toronto — arguably the largest of its kind in Canada, and launched in 2006 — continues to expand.

Most recently, Sunnybrook’s MyChart has added online appointment scheduling and online consultation assessment questionnaires for patients enrolled with the family practice unit. MyChart consists of two main components — data from the hospital including test results, discharge summaries and medication use plus personal information the patient chooses to enter on symptoms, health monitoring data and subjective information. The potential for secure email communication is another part of the system.

In an email after an interview, Sarina Cheng, director, Information and Telecommunication Services & eHealth Strategies,
described the functionality of the hospital’s PHR as follows:

“Mychart online access is available for all records in Sunnybrook’s electronic patient record system — over 1.4 million patient records. Through the patient, their personal health participants and clinical care teams such as family, friends, caregivers, physicians, pharmacists, dietitians (and others) can be granted access to all, some or no information. It is controlled and managed by the patient. (It) supports patients who travel, seek care out of country, live out of country, (or are) caring for a family member.”

Feedback from physicians, patients and their families has been “extremely” positive. “It’s a good news story,” Cheng said. “Physicians would like to see this leveraged more for outcomes, which is… where we are heading with this now,” she added.

For example, quality-of-life questionnaires have been implemented for cancer patients even before the patients are seen. “We’ve included the whole circle of care through the patient,” she said. “There is nothing like it. This is all about the patient and their personal health record.”

Cheng explained that Sunnybrook is partnering with other health institutions in Toronto, so data from these centres is integrated into MyChart.

Secure email
Dr. Maria del Junco is part of the Taddle Creek Family Health Team in downtown Toronto. Since last summer she has been using Wellx, the product of a small Toronto-based company that allows secure email communication between herself and her patients.

The secure email function is an addition to existing Wellx functionality the practice was already using, and del Junco said when first asked she was reluctant. “Initially, I said I don’t want to do that because I will be inundated with emails,” she recalled in an interview.

As a result, del Junco said she only invited about 100 patients to participate last July. However, she quickly decided to send invitations to all 1,000 patients for whom she had email addresses; about 400 signed up to participate.

Patients registering to use the system go through a consent process that includes reviewing an acceptable use policy modelled on one suggested by the Canadian Medical Protective Association. Del Junco and her patients then access Wellx through a secure website.

Del Junco said she only gets one or two emails daily from patients requesting prescriptions, or asking questions that can often be answered without seeing the patient — an “extremely useful” feature. She said she can also securely send test results to patients with an attached note.

“It has completely cured me of my paranoia about email communication between doctor and patient.”

In addition to facilitating online doctor–patient communication, the system has a broadcast function that allows del Junco to send out information to all registered patients. She said she used this function last summer to tell participating patients when she would be on vacation.

While the tool is also intended to allow patients to book appointments, del Junco said this function has been disabled because the system is not connected with the practice’s electronic medical record (EMR). It would presently be impractical to schedule with it.

West Coast connections
Dr. Christopher Collins, a family physician in Nanaimo, BC, has been using an Internet-based portal that allows patients to make appointments online and access information contained in their clinical record. The Access portal used by Collins is part of the Intrahealth electronic medical record system.

Collins said he has been using the portal with patients since November 2012, with positive results. “I think it works exceptionally well (and) my patients love it.” To date he has logged in about 250 of the 1,600 patients in his practice, and almost every one of those patients has used the portal.

He only enrols patients when he sees them face-to-face, and notes he has patients
from late teens to those in their 80s participating.

“I got Accession because I wanted patients to be able to see their (test) results, and we both make a decision together.” As a result of using the system he has started to annotate test results specifically for the patient’s benefit. Another benefit, he said, is that patients often give much more detail when requesting an appointment through the portal.

With appropriate permissions, access to patient information can also be given to caregivers or other health care providers, he said, and patients who are more tech-savvy can enter their own blood pressure readings.

Collins said he has not yet enabled functionality that allows patients to contact him through the portal.

Another test of the Accession software was reported by Dr. André Bredenkamp from the White Rock-South Surrey community of practice, as an official patient portal pilot conducted for the Physician Information Technology Office in British Columbia.

In this project, 51 patients participated in a six-week assessment of the portal to book appointments, review test results and communicate with their physician.

Patient feedback was positive, with most saying they preferred using the tool to book appointments, request prescription refills and update their own health information. Reviewing test results was the most-used function while communication with the physician was the lowest-rated function.

Overall, patients said the portal was “easy to use” and that using it was “more valuable than direct clinic communication.”

**Mobile mental health**

In London, Ont., a pilot project is exploring whether accessing personal health records via their mobile phone will improve quality of life for patients with mental health disorders and save the health care system money.

The Mental Health Engagement Network (MHEN) project is a longitudinal research study involving 400 patients with mood or psychotic disorders currently living in the community and working with 55 mental health care providers in London and the surrounding area.

Participants have been randomly assigned to either an early or a later intervention group.

Subjects in each group receive an iPhone and the Lawson SMART record, a web-based application that provides a PHR and tools to help manage personal health. The Lawson SMART record was developed in partnership with Telus Health Solutions, using a consumer platform powered by Telus Health.

Participants in the early group received the tools in July 2012; those in the later intervention group serve as controls for the first six months of the project.

Through use of the PHR, subjects can store, maintain and manage their own health information. This may include medications used, family history, caregiver contact information and care plans. The record being tested here also provides health management tools such as a mood monitor that allows individuals to track mood electronically in real time, as well as tools to track physiological measures such as blood pressure and weight. The record also allows participants to set prompts and reminders about upcoming appointments and when to take medications.

Cheryl Forchuk, professor and associate director of nursing research at the Arthur Labatt Family School of Nursing, Western University, and group leader of mental health/health outcomes research for the Lawson Health Research Institute, London, is head of the MHEN project. In an interview, she noted the data stored in the record is behind the hospital firewall but incorporates information from community health providers. In addition, she said, patients are entering a large quantity of monitoring data themselves. Information in the record can be accessed by health care providers and others, provided permission is given by the patient.

Forchuk said use of the PHR appears to be well received. Participants and those in focus group discussions have documented numerous cases of how well the intervention is working.

Because the record promotes a holistic approach and allows patients to record or monitor a number of health measures, many participants are reporting improvements — in activity levels or weight, for example — as a result. In addition, she said, the mood monitor has proven effective in demonstrating to subjects that their depression may not be as pervasive as they thought.

“I think this has the potential to be a real game-changer,” said Forchuk, and if the intervention can be shown to reduce one day’s hospitalization per person per year “it pays for everything.”
Did you know your EMR can do this?

The value of peer-to-peer networks

Pat Rich

MENTORSHIP IS IMPORTANT TO MEDICAL EDUCATION, and a big part of helping Canadian physicians learn how to use electronic medical record (EMR) systems more productively.

In Canada, almost every jurisdiction now has a peer-to-peer network for education on the use of electronic records, with support from Canada Health Infoway. There are well-established programs in Ontario and British Columbia, and programs have been re-initiated in Nova Scotia and Newfoundland and Labrador.

As Infoway notes on its website, “regional peer-to-peer networks have been established under the national Clinician Peer Support Network program to respond to local clinician needs. Each network is aligned to the national program objective to sustain and accelerate clinical engagement with a focus on supporting one or more specific initiatives.”

The peer-to-peer networks across Canada have similar goals, namely to link experienced physicians and other health care professionals with their colleagues to support them in using an EMR and integrating it into practice.

The number of physicians serving as peer mentors varies, depending on jurisdiction. Based on data from a year ago, for example, 72 physicians were serving as peer leaders in British Columbia while just two doctors were doing this work in Newfoundland and Labrador. Data collected in Alberta over a 26-month period (to March 2012) detailed a peer network consisting of 26 physicians and 22 other health care providers who provided EMR demonstrations and post-implementation mentoring to 1,189 participants.
“I’m pretty passionate about EMRs … and most days it (the EMR) works extremely well for me,” says Dr. Christopher Collins, a family physician in Nanaimo, BC, who has assisted as a peer leader for the provincial Physician Information Technology Office (PITO).

In a telephone interview, Collins said many physicians have “massively raised” expectations when they first implement an EMR system. He said these doctors believe “it will solve your worldly troubles, double your billings and help you get home on time. “Then you enter the ‘trough of disillusionment’ that most people are in for about six months,” he said, when the reality of actually having the practice operate with the system sets in. Collins said his practice also had this experience. Although he was working hard to make the system work better and be more functional, nobody else was benefiting from his experiences.

“I felt obliged to try and share that information, because if I’m investing all this effort and energy and someone else was (doing the same)… they might know something I don’t and … I would definitely know something they might not know.”

As a result, Collins said he offered to become a peer leader for PITO and, in the process, help provide useful information to other physicians while improving relations between the profession and the program office — which had something of a reputation as “the big bad wolf.”

Collins described working as a peer leader as being “really satisfying” because it allows him to educate other doctors about making relatively small changes in how they use the EMR that can bring “significant increases” in functionality.

“There’s a big light bulb that will go off in their heads, and it will save them five minutes a day. Or I can set something up for them in a few seconds that would have taken them a couple of hours of figuring around or working on.”

Not only does he have the satisfaction of knowing he has saved colleagues from initial frustration in learning something about the EMR, such as he experienced, but Collins also noted he is remunerated for doing so.

Originally, he said, PITO concentrated on helping physicians who were “in crisis” with their EMR and struggling to use the technology. However, Collins also helped launch a user group in the Comox Valley for physicians who are more familiar with EMRs.

“It’s really helpful to be shown (one-on-one) what you don’t know,” he said. But he has found it’s more productive to disseminate the information throughout a community by communicating with several doctors at once.

Collins admits he has sometimes been frustrated when working with physicians who don’t appear to be committed to improving their knowledge of the EMR, but even these doctors seem to get some value from the meeting.

“PITO has done a good job of advocating to help physicians set up their systems well,” Collins said, applauding PITO’s commitment to the peer mentoring program. He noted the number of physicians working as peer mentors in his province far exceeds participation in some of the larger provinces.

Calgary pediatrician Dr. Neil Cooper has served for some time as a peer mentor in Alberta. With plans to wind down the Physician Office System Program (POSP) in the province, Cooper says there will still be a need for some sort of peer support program. Even among physicians with established EMRs, he said, there is much to be gained from meeting with other physicians to discuss issues related to EMR use.

“We’re still at the ‘replace your paper record with an electronic version’ stage,” he said. “I am just now starting to get into ‘how can this system make me a better physician?’”

Last spring and summer, Infoway surveyed participants in the peer-to-peer networks in Alberta, British Columbia, Manitoba and Ontario. Of the 73 participants, 44 were physicians. Overall, 96% of respondents felt they had positively influenced colleagues in understanding and adopting an EMR system or other technology in their practice setting.

These peer leaders said they derived great satisfaction from interacting and building relationships with colleagues. They also reported enjoying being able to mentor their peers in adopting and optimizing the use of the EMR to improve patient care.
Involving patients in their care by providing them with access to their own electronic medical records (EMRs) — and by other strategies — was a major theme at this year’s HIMSS meeting in New Orleans.

The emergence of patient engagement as an important discussion area can be attributed to legislative requirements under the “meaningful use” provisions of the HITECH Act (Health Information Technology for Economic and Clinical Health) and the growing e-patient movement.

During this year’s HIMSS conference a special forum (with three separate sessions) was dedicated to patient engagement, but several other speakers also referred to the topic.

As Gabriel Perna, associate editor of Healthcare Informatics, wrote in a blog following the conference:

“At approximately 2 pm on Tuesday, as I was going from interview to interview, and following HIMSS13 on Twitter, I came to a realization. Patient engagement … had arrived. Although I didn’t get a chance to check out too many education seminars on the topic, I was told that every single one was standing-room only. As I walked through the exhibit floor, vendors as far as the eye could see were touting their ‘patient engagement’ solutions. Some … were telling me they had done ‘patient engagement’ before it was cool to say you were doing it. Everyone has a plan, or is in stages of developing a plan. We have no idea where this movement is headed, but if you were at HIMSS13, it’s hard to call it a stagnant issue.”

Another post-meeting blog, from Chilmark Research, had a slightly different take:

“Despite the quite vocal efforts of ONC (US Office of the National Coordinator for Information Technology) to push patient engagement to the forefront, I still see most programs at health care institutions being funded by marketing departments. It is not about engagement, it’s about loyalty. Even HIMSS seems to recognize this as they had a number of screens scattered throughout the convention center that flashed four screens:
1. Healthy patient
2. Connected patient
3. Informed patient
4. Stronger patient
which left me wondering … “Where is the engaged patient? “Without engagement … we are dead in the water for only an engaged patient will take the necessary steps to actively manage their health.”

For physicians and hospitals in the United States wanting to take advantage of federal government funding for investing in health IT, they must meet meaningful use provisions in the first stage of funding that include a section on patient engagement.
To be eligible for funding, physicians must:

- ensure 50% of all patients who request an electronic copy of their health information are provided it within three business days
- provide clinical summaries for more than 50% of all office visits within three business days
- ensure 10% of all unique patients seen are provided with timely electronic access to their health information, subject to the physician's discretion to withhold certain information
- provide patient-specific education resources for more than 10% of all unique patients

In addition, hospitals wishing to receive funding must provide an electronic copy of the patient’s discharge instructions at discharge.

These requirements have added a tangible business case for doing something that many physicians and patients say should be standard behaviour anyway. At the New Orleans conference, the high-profile presence of two icons of the e-patient movement — Dave deBronkart (e-PatientDave) and Regina Holliday (The Walking Gallery) — testified to the desire by HIMSS to embrace participatory medicine. HIMSS also used the meeting as an opportunity to release its own book on patient engagement, Engage! Transforming Healthcare Through Digital Patient Engagement. The book sold out during the conference.

One of the book’s editors, Dave Chase, founder of patient relationship management software company Avado, spoke about the business case for patient engagement.

He noted physician practices can save money by engaging more patients electronically. Administrative savings can be realized through dealing online with appointments, referrals, prescription requests and the delivery of laboratory test results.

Despite the growth of patient portal solutions in the U.S., Chase said the main sites used by patients remain Google, WebMD and Wikipedia.

At the same session, Dr. Jonathan Wald, an instructor at Harvard Medical School, referenced four core concepts of patient engagement identified by the Institute for Patient- and Family-Centered Care:
- dignity and respect
- information-sharing
- participation
- collaboration

He also quoted the ONC (U.S.), noting the need to shift the mindsets of health care providers and patients alike “so that participation by patients, families, caregivers and each provider becomes routine rather than the exception.”

Eric Manley, eHealth system manager, Mayo Clinic, spoke at an educational session that focused on case studies in patient engagement.

He made it clear that just putting in place the technical infrastructure to allow patients to access their own medical or health information electronically was not sufficient. Patient engagement requires much more work.

Manley said many patients turn down the opportunity to access their medical record through a patient portal because they don’t understand what this means — e.g., that they would be able to see their own laboratory results. In addition, he said, passively marketing services such as online appointment booking “doesn’t cut it.” Patients need to be explicitly made aware that such services exist.

Manley suggested telling patients about online services at the time of the office visit.

He quoted a number of patients who had come to recognize the value of online communication with their physician.

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**The Walking Gallery**

This jacket is an example of a phenomenal experience in patient engagement that has become a fixture at health IT conferences in North America. The art, painted onto jackets or lab coats, is created by artist and activist Regina Holliday as a way to graphically represent patient stories. The inspiration for the Walking Gallery came from Holliday’s experiences struggling to get health records for her husband, Fred, during the final year of his life. More than 250 jackets have now been painted by Holliday and others. The jacket pictured belongs to Dr. Sue Woods, a general internist at the Portland VA Medical Center, Seattle, researcher and member of The Society of Participatory Medicine.
The EMR, all grown up

Are you making the best possible use of your electronic medical record (EMR)?

Pat Rich

Now that EMR implementation and adoption has become widespread, this is the question increasingly asked of Canadian physicians.

The challenge has led to the development of theoretical constructs and practical survey tools to map out clinicians’ progress in using the EMR’s full range of capabilities, from basic record-keeping to more sophisticated integrated care. Importantly, these maturity models are able to measure levels of EMR adoption and use, so the tool’s clinical value can be clearly identified.

While Ontario is one province that has taken the lead in developing and testing such a model for EMR use, other jurisdictions have been involved in similar exercises. COACH — Canada’s Health Informatics Association — recently published a white paper on a maturity model based on the experiences of four provinces.

As COACH CEO Don Newsham noted in a news release about the white paper, “the journey in adopting EMRs can leverage this model to provide the fidelity needed in measuring EMR adoption and to foster clinical value in Canada.” He said jurisdictions less advanced in implementing EMRs would find the document “extremely useful.”

The Ontario EMR maturity model was developed by OntarioMD in 2010 as part of its change management support, to help existing EMR users maximize their use of electronic records.

As Dr. Darren Larsen, senior physician peer lead for OntarioMD, explains, the model allows doctors to take an iterative approach to periodically assess their progress in achieving the full benefits of an EMR. This maturity model was validated in pilot projects involving family physicians and other health care providers who had been using an EMR for different periods of time.

Larsen said the tool is designed to measure progress in practices in which EMRs have recently been implemented, but also to identify gaps in the use of technology with well-established groups.

The maturity model developed in Ontario and reiterated in the COACH white paper talks about six levels of EMR use:

1. Level 0 – Paper-based
2. Level 1 – Basic record-keeping
3. Level 2 – Established clinical processes
4. Level 3 – Advanced disease management support
5. Level 4 – Integrated care
6. Level 5 – Population impact

For example, when a practice is at the first stage of EMR use it has a hybrid billing schedule in place and prints bills daily, although the EMR is used to communicate within the practice. At this level, the EMR is used to input patient demographics, the patient visit and the encounter notes. At Level 5, the most mature degree of use, appointments are managed online and linked to an EMR scheduler. The system autopopulates billing codes based on encounter notes. Physicians also communicate with other providers through the EMR. At this level, the EMR is used to co-manage and reconcile patient enrollment and send/receive individual patient records data from one EMR to another.

In discussing how the model should be used by physicians or practices, OntarioMD outlines the following steps:
1. raise awareness of the model
2. conduct an assessment of current EMR use
3. determine gaps and opportunities for change
4. develop an action plan
5. implement improvement projects
6. evaluate the impact of the changes
7. review, and move to the next assessment phase

In a video produced last year, Larsen said the OntarioMD maturity model “can be used today by groups to improve office efficiency, identify productivity gaps, optimize their EMR systems and better connect with provincial services as they become available.”

Most recently, Larsen reports the maturity model has been converted to an online questionnaire which provides metrics in real time to physicians, and can be used to zero in on practices that need help getting “from good to great.” A soft launch was scheduled for early April, with a provincewide launch expected around May 23.
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