Ontario Medical Association

Community-based Physicians' Priorities for EMR Functionality

A collaborative project of the OMA Community-based EMR Working group (General Assembly, Priority and Leadership Group, ACE Panel) and OntarioMD

June 2026

Contents

Executive summary

Background:

- In 2024, the Priority and Leadership Group (PLG) of the OMA General Assembly identified the following priority for the Advocacy, Communications and Engagement (ACE) panel: **improve the functionality (and usability) of out-of-hospital certified EMRs to help physicians work more efficiently.**
- EMR usability sits at the intersection of physician well-being and healthcare sustainability: 46% of physicians report burnout (Canadian Medical Association, 2025), driven in part by rising administrative burden, including after-hours EMR use increasing from 36% in 2017 to 64% in 2025; family physicians are especially affected, spending ~19 hours/week on administrative tasks.
- This burden reduces patient time and challenges comprehensive community-based care and patient attachment; poorly designed health IT—often lacking physician input—can add inefficiency, making EMR usability improvements essential for reducing burnout, retaining physicians, and ensuring timely, high-quality care.
- The OMA, in in conjunction with physician leadership of the ACE Panel partnered with OntarioMD to design and conduct a study to address this priority. The findings were intended to inform both the OMA's advocacy activities and OntarioMD's ongoing EMR work with physicians and vendors.

Methodology:

- A mixed methods approach was used.
    - Quantitative: A survey was administered in Spring 2025 with 545 physician responses included in the analysis.
    - Qualitative: Seven focus groups were conducted in Fall 2025 with specialists and family physicians drawn from OMA membership.
- Key topics included: priorities for EMR functionalities; intuitiveness; extra hours worked outside of patient time; experiences with vendors; and frequency of disruptive technical issues.
- Following completion of both the survey and focus groups, key findings were reviewed with a group of expert EMR users convened for the purpose of developing key themes and recommendations.
- These themes were later rated for importance and feasibility, as well as ranked during a dedicated session of the OMA General Assembly in November 2025; the resulting set of priorities was then organized by theme for this report.

Results:

- The top two ranked functionalities in an ideal EMR were:
  - **The ability to quickly document patient visits in desired format.**
  - **The ability to quickly retrieve all relevant patient data during a visit, with** minimal clicks to complete common tasks and an intuitive user interface.
- The bottom two ranked functionalities in an ideal EMR were:
  - **The ability to track and audit time spent on specific tasks** to inform practice and system improvements.
  - **Customizable dashboards for different roles.**
- Only 49.6% of physicians in the survey reported that their EMR was ***Mostly*** or ***Very intuitive***. 34.7% reported their EMRs were ***Somewhat intuitive***, while 16% selected either ***Not very intuitive*** or ***Not intuitive at all***.
- Two-thirds of respondents (67%) reported spending at least two additional hours per day on their EMR outside of patient-facing hours. Of the 27.2% doctors who reported working "more than 3 extra hours per day", the average extra hours worked was 4 per day. Extra hours were reported as consumed with writing notes for patients, billing, documentation, following up tests, and prescription refills.
- Over half of respondents ***Strongly agreed*** or ***Somewhat agreed*** that their vendor responds quickly (57%) or provides good support (52%).
- Vendors fared less well in terms of their helpfulness with workflow requests (35%) and whether their product provides good value for money (36%).
- Focus group findings:
  - Prioritization of ideal functionalities largely aligned with the survey results. Discussion with mid ranked functionalities revealed considerable variability across physicians reflecting differences in their practice models and workflows.
  - Discussions revealed key pain points with EMRs and vendors, including concerns about non-intuitive interfaces, low value-add upgrades, hidden costs for dubious return, and concerns regarding vendor support (timeliness, and an inability or unwillingness to fix known issues).

Themes:

Health System

- Advance meaningful interoperability across digital health systems.
- Align with broader efforts (e.g. nationally) to reduce fragmentation and promote consistency.
- Recognize and address the impact of EMR-related burden on physicians' capacity to deliver patient-centered care.

Core EMR Requirements (presented to physicians in the study as "Standards")

- Set a higher bar for certified EMRs. Establish clearer, more rigorous core requirements for certified EMRs.

- Modernize core requirements to ensure essential functionalities are consistently available across all certified EMRs.
- Define requirements that enable/support safe and efficient delegation within clinics while maintaining privacy and security.
- Advocate that physicians are not required to pay add-on costs for functionalities deemed essential.

EMR Vendors

- Design easy workflows and usability features that facilitate accurate and consistent data entry, enabling reliable downstream use of data.
- Increase flexibility and customization to better support real world clinical workflows.
- Continue modernizing EMR platforms to support emerging capabilities, including AI enabled tools.

AI Enablement

- Integrate AI tools within EMRs to support clinical workflows.
- Develop AI tools with physician input designed to reduce clinical burden and maximize impact on patient care.
- Develop AI tools that elicit relevant clinical information quickly and efficiently.

Next Steps: Recommendations

Recommendations for OMA:

- **Leverage these findings to support advancing acceleration of digital innovation in healthcare.**
    - Ontario has a comprehensive digital health strategy. A coordinated approach is essential to improve access to patient records, enable centralized referrals, modernize EMRs and integrate AI to improve care delivery and system efficiency.
    - Support physicians to adopt EMRs that best suit their practice and improve patient outcomes.
    - Reduce barriers to care – through advocating for internet connectivity across the province to support the use of EMRs and access to care for all patients.
- **Advocate for government investment to improve and modernize EMRs.**
    - Current EMRs often lack interoperability, create administrative inefficiencies, and require costly upgrades and maintenance that are largely paid for by individual physician practices.
    - Priority investments should include: EMR modernization and interoperability improvements, integration with provincial digital health infrastructure, cybersecurity and data protection upgrades, workflow optimization and usability enhancements, and ongoing technical support and maintenance
    - While it may not be realistic to implement fully funded EMR implementation and ongoing support, other models could be supported by Ontario government and health sector partners e.g. targeted grant programs, matching funds, or phased

cost-sharing. This strategic investment will enhance patient care, reduce administrative burden, and strengthen system-wide integration.

- **Strengthen access to care.**
    - Leverage EMRs to improve referrals and enhance access to specialists by centralizing referrals and implementing coordinated care.
- **Develop a Provincial AI strategy with system partners.**
    - Identify tools that best support physicians and their practices.
    - Support safe adoption and integration into clinical workflows
    - Improves efficiency while maintaining quality and patient safety
    - AI must be implemented in ways that reduce administrative burden, not add to it.
- **Support physician wellness.**
    - We know that having digital tools that are effective and integrated into clinic workflow supports physician wellness. Improving EMR usability could:
        - Reduce administrative tasks and the "second shift" of after-hours charting contributing to physician burnout.
        - Decrease burnout.
        - Enhance recruitment and retention.
- **Align advocacy efforts for EMR Systems with OMA Digital Health Principles.**
    - Advocate for the integration and functionalities to enable digital health solutions that are:
        - Seamlessly integrated
        - Co-developed with physicians
        - Interoperable
        - Focused on usability and patient centered care
    - Engage the Ministry of Health and Ontario Health on EMR-related challenges in the trilateral Digital Health Advisory Table.
- **Coordinate advocacy efforts nationally.**
    - Digital health challenges extend beyond Ontario. The OMA should collaborate with provincial-territorial medical associations (PTMAs) and the Canadian Medical Association (CMA) to coordinate advocacy efforts across Canada, to:
        - Decrease physician administration burden
        - Improve portability across jurisdictions
        - Strengthen patient care and safety
    - Continue to support pan-Canadian advocacy efforts such as Bill S-5 (formerly Bill C-72), the *Connected Care for Canadians Act* and sustain membership in Renew72 coalition to become a fully digital health sector.

Recommendations for OntarioMD:

- **Inform internal priorities** (Managed digital services program, vendor engagement, core EMR requirements, certification program)**.**

- **Support strategic decision making** by conveying Ontario physicians' perspectives at advisory tables, working groups and committees).
- **Drive system level advocacy (influencing provincial and national policies, requirements and funding).**
- **Translate recommendations for digital tools into actionable initiatives** by identifying projects to test, pilot or implement with tangible system-wide improvements).
- **Extend best practice principles across digital health** (guiding principles across the range of digital health solutions, not just EMRs).
- **Enable seamless, reliable, and cost-effective data migration between EMR systems.**

Acknowledgements and Project Team

This work was a joint venture between OntarioMD and the OMA completed under the oversight of the Community-Based EMR working group (made up of former and current members of the ACE Panel).

Working Group Members

Dr. Julie Kovacs, M.D., F.R.C.P.C.

Dr. Julie Kovacs completed her medical degree at McGill University. She did her internal medicine and rheumatology residency training and subsequently a lupus fellowship at U of T.

She has participated extensively in undergraduate rheumatology teaching at U of T in the *Foundations of Clinical Practice* course, as a Rheumatology Physical Examination Skills instructor in ASCM 2, and as an ASCM OSCE examiner.

She has also served for years as a clinician teacher in the rheumatology clinics at St. Michael's Hospital and Wellesley Hospital.

Dr. Kovacs has held numerous leadership positions within the OMA Section on Rheumatology, actively and passionately advocating for her peers. She served as Rheumatology Chair of the Section for six years and currently holds the position of Vice-Chair. In addition, she was Chair of the Ontario Rheumatology Association (ORA) OMA Committee for six years, served on the ORA Board of Directors, and the ORA Therapeutics Committee.

Dr. Kovacs is currently in her second term as Vice-Chair of the OMA ACE Panel, formerly known as the Advocacy Panel.

Dr. Rayudu Koka, MBBS, DPM, MRCPsych, FRCPC (Vice-Chair)

Dr. Rayudu Koka is a Consultant Psychiatrist who has practised in Sudbury since 1986. He is Medical Director for the Mental Health & Addictions Program, Health Sciences North (HSN). He is also Professor of Psychiatry with Northern Ontario School of Medicine (NOSM). He also served as Section Chair Psychiatry for NOSM. He is with Ontario Medical Association (OMA) as OMA Chairperson for District 9 and OMA Section of Psychiatry Member at Large, Academic Medicine Forum Member at Large. He has many years of experience as a Hospital Board Member. He also served as CPSO Council Member for 10 years and as CPSO President 2008-2009.

For 25+ years, Dr. Koka has been actively involved in the Multicultural Folk Arts Association of Sudbury (SMFAA) since his arrival to Sudbury. He is currently Vice-President. Dr. Koka is

currently President of India-Canada Association (ICA) of Sudbury where he promotes the East Indian culture and educating the broader community.

Dr. Gareth Seaward, MBBCh, MMed(O&G), MSc(CE), MSc(QIPS), Dip Mid COG(SA), FCOG(SA), FRCSC-MFM, FACOG (Chair)

Dr. Seaward is a Professor Emeritus in the Department of Obstetrics and Gynaecology and Professor (Status) with the Institute of Health Policy, Management and Evaluation, Temerty Faculty of Medicine, University of Toronto. He completed 12 years of service with Ontario's Provincial Council of Maternal Child Health in 2023, providing provincial leadership in obstetric health care, including initiating and guiding the expert panel that developed obstetric care guidelines during the COVID-19 pandemic.

Dr. Seaward has been a member of the Fetal Medicine Unit at Mount Sinai Hospital for 28 years and served as Deputy Head of the unit for 20 years. He has authored over 100 publications and has received numerous awards recognizing excellence in research, teaching, and administration. In 2025, he was awarded the Temerty Medicine Dean's Alumni Award for Lifetime Achievement. His leadership roles with the Ontario Medical Association have included Deputy Chair of District 11, ACE Panel member, and currently Chair of the EMR Working Group.

Dr. Dannica Switzer, **CCFP(EM)**

Dannica Switzer is a rural generalist working as a locum throughout Northern Ontario. She is involved with the Rural Medicine Forum and District 9 and was part of the Advocacy Panel from 2023-25. Dannica is a strong advocate for Northern and Rural health.

Staff Team

Mavis Jones, Phd

Mavis Jones (Phd) is a Manager of Policy, Evaluation and Corporate Performance at OntarioMD. She and her team at OntarioMD provided the methodological contribution to this study, including survey design and deployment and focus group facilitation, as well as analysis and synthesis of findings.

Timothy Jason

Timothy Jason, is a Senior Advisor in Business Insight and Analytics, OntarioMD, who contributed to research methods and design, questionnaire development, quantitative data collection, data management, analysis, reporting, and overall report development.

Christina Jones
Christina Jones is a Senior Policy Analyst at OntarioMD involved in evaluation and research of clinician use of digital health technology. Prior to this, she studied abroad at the University of Birmingham earning an MSc in health economics.

Dr. Chandi Chandrasena, CCFP, FCFP

Dr. Chandrasena has been the Chief Medical Officer (CMO) at OntarioMD since 2021. She is a family physician practicing in Ottawa, and former OMD Physician Peer Leader who has mentored many of her colleagues to use EMRs and digital health tools effectively to enhance patient care. Dr. Chandrasena has provided expertise and leadership across this entire project. As CMO, she provides clinical advice at provincial and national tables and clinician advisory groups and is instrumental in forging system-level partnerships.

Nina Palikuca

Nina Palikuca is the Coordinator, General Assembly with the OMA's Governance and Physician Leader Engagement Team. She provided administrative and logistical support to this study and the EMR Functionalities working group. In addition, Nina supports the prioritization and idea submission process and other GA activities.

Katina Kominos

Katina Kominos is a Senior Manager at the OMA, where she plays a key role in advancing strategic initiatives and evolving General Assembly priorities. Katina played a key role in participant recruitment and communications with this research work.

Joanne Thanos, MHSc

Joanne Thanos is Senior Director of the General Assembly at the Ontario Medical Association (OMA). Joanne provided support to the panel and working group to undertake this work, including cross-functional engagement and leadership across staff teams.

Background

Physician burnout remains a system-wide problem with consequences for physicians and healthcare delivery in Canada. The Canadian Medical Association's 2025 National Physician Health Survey found that 46% of physicians (n=3310) reported symptoms of burnout [1] , defined as high levels of at least one indicator of depersonalization or emotional exhaustion using the Maslach Burnout Inventory. The survey identified a growing administrative burden as an important contributor to burnout. Across the three survey iterations (2017, 2021, and 2025), the proportion of physicians reporting that they spent an excessive or moderately high amount of time on their electronic medical record (EMR) outside regular working hours increased substantially, from 36% in 2017 to 49% in 2021 and 64% in 2025. The burden is particularly pronounced in family medicine, where one study[2] found physicians spend an average of 19 hours per week on administrative tasks. This administrative workload reduces time available for direct patient care and contributes to challenges in maintaining patient attachment due to reduced clinical hours or leaving the profession due to burnout.

At the same time, EMRs have become indispensable tools for modern clinical practice. When designed and implemented effectively, EMRs support continuity of care, improve access to patient information, facilitate clinical decision-making, enhance communication among care providers, and help meet regulatory and quality improvement requirements. EMRs have the potential to improve both physician efficiency and patient outcomes by reducing duplication, streamlining workflows, and providing timely access to critical health information. However, these benefits can be undermined when systems are difficult to use, poorly integrated with clinical workflows, or require excessive documentation and administrative effort.

[1] Canadian Medical Association. National Physician Health Survey 2025. Ottawa: The Association; 2026. Available from: https://digitallibrary.cma.ca/viewer?file=%2Fmedia%2FDigital_Library_PDF%2F2026%2520National%2520Physician%2520Health%2520Survey%2520EN.pdf#page=1 [accessed Apr 24, 2026]

[2] Ontario College of Family Physicians. A Profession in Crisis: The survival of family medicine in Ontario. Toronto: OCFP; 2023. Available from: https://ontariofamilyphysicians.ca/wp-content/uploads/2023/09/ocfp_member_survey_report_2023_05.pdf [accessed Apr 24, 2026]

[3] Ontario Medical Association. Healing the Healers: System-level soutions to physician burnout. Toronto: OMA; 2021. Available from: https://www.oma.org/siteassets/oma/media/pagetree/advocacy/issues/burnout/burnout-paper.pdf [accessed Apr 24, 2026

[4] Peccoralo LA, Kaplan CA, Pietrzak RH, Charney DS, Ripp JA. The impact of time spent on the electronic health record after work and of clerical work on burnout among clinical faculty. J Am Med Inform Assoc England; 2021 Apr 23;28(5):938–947. PMID:33550392

[5] Shanafelt TD, Dyrbye LN, Sinsky C, Hasan O, Satele D, Sloan J, West CP. Relationship Between Clerical Burden and Characteristics of the Electronic Environment With Physician Burnout and Professional Satisfaction. Mayo Clinic Proceedings 2016 July 1;91(7):836–848. doi: 10.1016/j.mayocp.2016.05.007

[6] West CP, Dyrbye LN, Shanafelt TD. Physician burnout: contributors, consequences and solutions. Journal of Internal Medicine 2018;283(6):516–529. doi: 10.1111/joim.12752

While workload, administrative burden, and insufficient time with patients are frequently cited contributors to physician burnout, the electronic systems used to collect, share, and manage patient information—has introduced additional challenges.[3-6] Paradoxically, technologies intended to support physicians can also contribute to workload and frustration when they are not designed with end users in mind. Family physicians, specialists, and hospitalists are adapting to a growing number of expensive, complex, and largely unregulated platforms while often having limited involvement in their design, procurement, and implementation. As a result, physicians may spend considerable time navigating systems that do not align with clinical workflows, creating inefficiencies that detract from patient care. [3-6]

Recognizing both the importance of EMRs and the challenges physicians face in using them, the Priority and Leadership Group (PLG) of the OMA General Assembly identified a key advocacy priority in Spring 2024: improve the functionality and usability of out-of-hospital certified EMRs to help physicians work faster and better. In response, the OMA, with physician leadership from the Advocacy, Communications and Engagement (ACE) Panel of the PLG, partnered with OntarioMD to develop a study addressing this priority. Following membership transitions within the ACE Panel, a Community-Based EMR Working Group was formally established to provide continuity and sustain momentum for this work.

> "Ask a hundred different doctors the same question, you'll get a hundred different answers…"
> *- Focus group participant*

Regardless of differences in physicians' experiences with digital health, common themes emerged regarding priorities and frustrations. While other studies have identified physician challenges with digital health tools[3] [4] [5], this study aimed to go further: not only to identify the

[3] Borges do Nascimento, I.J., Abdulazeem, H., Vasanthan, L.T. *et al.* Barriers and facilitators to utilizing digital health technologies by healthcare professionals. *npj Digit. Med.* **6**, 161 (2023). https://doi.org/10.1038/s41746-023-00899-4
[4] Rodrigues DA, Roque M, Mateos-Campos R, Figueiras A, Herdeiro MT, Roque F. Barriers and facilitators of health professionals in adopting digital health-related tools for medication appropriateness: A systematic review. *DIGITAL HEALTH*. 2024;10. doi:10.1177/20552076231225133
[5] *2024 National Survey of Canadian Physicians | Barriers and Challenges to Digital Health Technologies.* (2024, September 9). https://insights.infoway-inforoute.ca/2024-cma-barriers-challenges-digital-health-technologies/

EMR functionalities that doctors need, but also to document what works well and what does not. These insights are intended to inform and strengthen discussions among the OMA, OntarioMD, health system decision makers (Ministry of Health, Ontario Health, OHTs), EMR vendors, and physicians themselves – with the shared goal to develop a clearer, more actionable understanding of how to make EMRs work better for physicians and their clinics.

Objectives

The primary objective of this research project was to understand physicians' current experience with EMRs including key challenges, perceptions, and the perceived value of existing and potential EMR functionalities.

Secondary objectives included identifying factors that may influence EMR use, challenges associated with EMR use, and physicians' preferences for EMR functionalities. Additional objectives included exploring physicians' satisfaction with their EMR vendors, and to develop recommendations to advance EMR improvements at the health system, clinic, and vendor levels.

The study was guided by the following questions:

- **What do physicians like or dislike about their EMRs?**
- **What do they want in an ideal EMR?**
- **What can we learn about physicians' experience with their EMRs that can help us advocate for systems that will help them work faster and better?**

Methods

Survey

To address the research objectives, a survey instrument was designed using best practices and expert input. A review of relevant EMR literature, and previously used internal research questionnaires was conducted to identify validated and/or published scales and other questionnaire items to incorporate into the survey. Key stakeholders and subject matter experts including OntarioMD's corporate chief medical officer, peer leaders and staff provided feedback on the survey's structure, design, and wording used in draft questionnaire items to ensure clarity and validity.

The final questionnaire, vetted by the ACE Panel/ Community based EMR working group, consisted of 43 questions across five sections (see Survey at a Glance box for details). Two open text questions were added at the request of physician leaders involved in reviewing the survey:

SURVEY AT A GLANCE

- 43 questions
  - 8 single-choice
  - 3 multiple-choice
  - 26 scaled
  - 6 open text
- 5 sections
  - You and your EMR
  - EMR Usability and Satisfaction
  - Your Current EMR Functionalities
  - Your Ideal EMR Functionalities
  - Your EMR Vendor
  - Extra hours spent on your EMR
- In field May 27 - June 10 2025
- 545 responses included in analysis

"What other functionalities do you find valuable in an EMR?" and
"What don't you like about your EMR?"

Answers to these questions were assessed via qualitative coding for themes.

Customer Voice was used to design the questionnaire and included conditional branching to streamline flow of questions and screen participants for survey eligibility. This study focused on community-based EMRs, however physicians who reported working exclusively in hospital settings were directed to the end of the survey, where they were given the option to comment on their hospital information system (HIS).[6]

An invitation email was drafted by the research team which included the survey link. The content was reviewed by OMA Communications, and initial distribution was carried out by OMA district leads. The survey in-field period was May 27 – June 10, 2025, with one email reminder sent during this period. Due to a suboptimal initial response rate, the survey was redistributed via the OntarioMD CRM, supported by additional promotional efforts. Survey participants were informed that results would only be reported in an aggregate and a de-identified format, according to OntarioMD's privacy policy[7].

[6] Of the 57 who identified as hospital-only, only 19 chose to provide comments. Given the small numbers these are not addressed in this report but retained in the study archive.
[7] Although we have included limited qualitative material – extracted from open text survey responses or focus group participants – in this report for the purposes of illustration, identifying information is withheld.

A total of 695 Ontario clinicians completed the survey. After cleaning and processing the data, 666 responses remained for preliminary analysis. 64 incomplete responses were excluded due to a survey branching error that was detected and corrected on the first day of deployment. 57 hospital-based physicians, who were eligible only for the optional open-text HIS question were excluded from the community-based data analysis. Further data cleaning and processing identified and excluded duplicate responses and non-EMR users, yielding a final sample of 545 eligible clinicians for analysis.

Data was downloaded from Customer Voice into MS Excel spreadsheets and transferred to a custom-built data model. Power BI was used to further process, model, and visualize the data. IBM SPSS Statistics was used to analyze the data according to direction from the project team.

Responses to two optional open-text questions, "What other functionalities do you find valuable in an EMR?" (323 responses) and "What don't you like about your EMR?" (408 responses), were analyzed using an inductive (i.e. bottom-up) coding approach to identify themes. Responses often included more than one reference requiring coding (e.g. "I don't like that navigation requires too many clicks and also my vendor is really slow to respond"), the total number of references coded was higher than the number of responses received. 439 references were coded for the first question and 598 references for the second.

Preliminary findings from the analysis indicated the need for follow-up focus groups to explore emerging themes. Focus group participants were recruited through the OMA, and focus groups began three months after the survey closed.

Focus groups

The mixed methods approach used in this study included a qualitative method to unearth and further detail broad or high-level findings yielded by the initial quantitative methods. Focus groups capitalize on the collective meaning-making possible through discussion on shared experiences - in this case EMR use – such that group members can emphasize or contest points that are brought up by others, as well as articulate more detail on the "how" and "why" of their perspectives.[8]

For this study, we deliberately recruited from the same population as the survey (i.e. community-based Ontario physicians; two groups of medical specialists; two groups of surgical specialists; and three primary care physician groups). For the primary care/family physician groups, each group was limited to users of one EMR: one for each of TELUS - PS Suite, QHR - Accuro, and WELLSTAR - OSCAR Pro EMRs. These three EMRs have the greatest industry market share; therefore, they were the most represented EMRs among survey respondents. The intent was not to exclude EMRs with a smaller user base, but instead to allow more productive within-group conversations given shared tacit knowledge across systems. Furthermore, any solutions

[8] This also resulted in a few serendipitous instances of teaching between users of the same EMR, where one user had a persistent problem that could be addressed by a workaround used by another.

to improve the most widely-used systems would serve to improve the experience for all EMR users.

The resulting seven groups were recruited via the OMA, and participants were compensated for their time. Groups were conducted virtually via Zoom between September 9, 2025 and October 6, 2025, and recorded for the purposes of analysis.

From the survey findings, we identified three main areas or themes in which qualitative methodology could enrich our understanding. These themes, along with focus group material provided and discussion prompts, are listed below.

FOCUS GROUPS AT A GLANCE

- Tues Sep 9 – Surgical Specialists (4)
- Thurs Sep 11 – Medical Specialists (6)
- Mon Sep 15 – Surgical Specialists (3)
- Tues Sep 16 – Family Physicians, TELUS PSS (4)
- Thurs Sep 25 – Family Physicians, OSCAR Pro (4)
- Thurs Oct 2 – Medical Specialists (4)
- Mon Oct 6 – Family Physicians, Accuro (4)

Theme 1: Ideal EMR functionalities

Focus group material:
Participants were shown a visual summary of 10 ideal functionalities in final ranking order from survey respondent ratings. We conducted an adapted sorting exercise to drive discussion around group preferences and reasoning, asking group participants to group the functionalities under *Most important*, *It depends*, and *Least important*.[9]

Prompts:
- Do these findings reflect your experience?
- What would you change?
- What are the reasons why some of these are more important to you than others?

Theme 2: Intuitiveness of EMR

Focus group material:
Participants reviewed a data visualization of aggregated responses to the survey question "How intuitive is your EMR system's interface?" and quotes from open text questions where respondents volunteered non-intuitive aspects of their EMR. We asked the group to review this material while reflecting on their own experience with their EMR's intuitiveness.

Prompts:
- What is your experience with your current EMR's interface? (likes, pain points)

[9] Outcomes of this exercise were captured visually and are retained in the detailed focus group report, available in the study archive.

- Are there examples of intuitive interfaces from other parts of life where you have thought, "I wish my EMR could do that?"
- What would you like to say to your vendor if they were here right now, about your EMR's interface?

Theme 3: Extra hours on EMR

Focus group material:
Participants reviewed a data visualization of aggregated responses to the survey's multiple-choice question "How many hours do you spend on your EMR outside of patient time?" Group members were then polled on where they see themselves reflected (i.e. how many extra hours per day they personally spend on EMR tasks outside of patient time.)

Prompts:
- What are the tasks occupying you during this time?
- Which of the ideal EMR functionalities (referencing the earlier list) would most reduce that extra time?

Findings

Survey participants offered a mixed portrait of their relationship with their EMRs.

- Two-thirds reported that their EMR has a **positive impact on patient care**
- Fewer (60%) reported a **positive impact on workflow efficiency**.
- Only 6% and 2% reported a very negative impact on workflow efficiency and patient care, respectively.

Across both the survey and focus groups, physicians agreed that an EMR's greatest value is for its ability to manage patient data.

Even physicians who viewed their EMRs positively identified ways in which their EMR experience could be improved. Many had quite a bit more to offer on what is needed to make EMRs work better for physicians. This report aims to capture what physicians said works well in their EMRs, what doesn't, and the overall experience of managing EMRs with or without vendor support.

Findings below are organized under four subheadings. The first three reflect the structure that shaped the focus groups, and the fourth highlights a sub-theme (under intuitiveness): **EMR Functionalities, Intuitiveness, Extra Hours,** and **Vendors and their EMRS**.

EMR Functionalities

To develop the survey items on *current* and *ideal* EMR functionalities, we used an iterative process of consultation with physicians and EMR experts through OMA and OntarioMD channels.
These included:

- The ACE panel of the General Assembly/OMA
- OntarioMD Practice Enhancement Consultants (PECs)
- Clinical experts in EMR applications across EMRs (i.e. those involved in building and using OntarioMD's EMR Lab)
- OntarioMD Peer Lleaders.

This process resulted in two lists:

- 11 current functionalities
- 10 ideal functionalities

Each item was assessed for validity, legibility, and ease of understanding.

From these lists, survey respondents were asked to rate each item on a scale of 1 (***Not at all important)*** to 10 (***Extremely important)***. They were instructed that they could assign the same rating as often as desired (i.e. they could rate all items a '10' if desired).

Analysis confirmed a high to low ranking based on respondents' ratings (Figures 1 & 2).

Figure 1. Current EMR Functionalities in ranked descending order of importance.

1. **Patient charting -** Ability to see all relevant up-to-date information on a patient in one place (e.g. CPP, last notes)
2. **Ordering medications** (e.g. sending Rx/refills to pharmacy, calculating quantities based on strength and prescription instructions)
3. **Reviewing outstanding tests, reports, referrals and follow up care**
4. **Billing**
5. **Managing medications** (e.g. managing questions/changes from pharmacy, deactivating meds after proposed consumption period, updating and flagging data from external sources such as DHDR)
6. **Seamless information sharing with circle of care partners** (e.g. hospitals, specialists, labs, diagnostic facilities, allied health, home care, LTC) **without manual data re-entry**
7. **Online booking/calendar management** (e.g. appointment information, appointment booking, tracking schedule)
8. **Collecting and updating clinical information digitally in advance of the patient visit** (e.g. intake forms, pre-visit questionnaires)
9. **Creating, managing and running efficient processes** for hitting performance bonuses and improving clinical outcomes (e.g. preventative care and chronic disease reminders, recalls and follow up)
10. **Digital patient communication after the visit** (e.g. post-visit education and links, follow-up on next steps in care)
11. **Easy data extraction and reporting from EMR for QI** (e.g. hitting CPSO requirements for QI, patient panel management, required reporting for provincial/funded projects)

Following this ranking, additional analyses yielded the following results for **current** functionalities:

- In comparison to starting and early-career clinicians, mid-to-late-career clinicians tended to value the following significantly more:
    - patient charting
    - reviewing outstanding tests, reports, referrals, and follow- up care
    - seamless information sharing
    - creating, managing, and running efficient processes
    - easy data extraction
    - billing
- Rankings changed according to career stage. For example, later-career clinicians tended to value reviewing outstanding tests, reports, referrals, and follow-up care more than billing. The opposite was observed with earlier-career clinicians.

Figure 2. Ideal EMR Functionalities in ranked descending order of importance.

1. **Ability to quickly document patient visit in desired format** including symptoms, diagnosis, treatments, medications and follow up plans
2. **Ability to quickly retrieve all relevant data for patient's condition during visit, with minimal clicks** to complete common tasks and an easy user interface
3. **Drug interaction checks, based on dosing and guidelines, integrated into prescribing**
4. **Seamless preventive care and complex care management**, using reminders, predictive analysis and clinical decision support
5. **AI-powered clinical efficiency** (e.g. scribe/documentation, inbox management, smart templates, automated coding, automatic billing)
6. **Integrated patient portal** with appointment booking, secure messaging, pre-visit intake and other forms
7. **Workflow automation** (e.g. auto routing, pre-drafted responses, auto-assigning coverage)
8. **Population health insights** (e.g. chronic disease management, screening reminders, sending required patient communication for overdue intervention)
9. **Customizable dashboards for different roles** (e.g. NPs/MDs, MOAs, dieticians, specialists, other team based care)
10. **Ability to track and audit the time spend on certain tasks** towards practice and functionality improvements (e.g. how long did I use the EMR after hours? How long does it take me to schedule someone in?)

Following this ranking, additional analyses found no statistically significant differences in rankings based on career stage or other respondent characteristics.

When the ranked lists were reviewed with the ACE Panel, members discussed possible differences in EMR functionality priorities could be due to types of physician specialties. Given the mandate to improve EMR functionality to help physicians work faster and better, we conducted a deeper dive of ideal functionalities using focus groups with targeted recruitment by specialty.

In the focus groups, participants were given time to engage with the list of **ideal** functionalities to categorize each item as ***Most important***, ***It depends***, or ***Least important***.

Figure 3. Focus material: Visual of ideal EMR functionalities

Despite differences in specialty and group composition, there were common findings across groups.

Two functionalities were consistently rated as the ***Most important*** across all groups:

- **The ability to quickly document patient visit in desired format** including symptoms, diagnosis, treatments, medications and follow up plans
- **The ability to quickly retrieve all relevant data for patient's condition during visit, with minimal clicks** to complete common tasks and an easy user interface

Similarly, two functionalities were either placed in the ***Least important*** or in the ***It depends*** category:

- **Population health insights** (e.g. chronic disease management, screening reminders, sending required patient communication for overdue intervention)

- **Ability to track and audit the time spent on certain tasks**[10] towards practice and functionality improvements (e.g. how long did I use the EMR after hours? How long does it take me to schedule someone in?)

For the remaining functionalities, views varied across groups and specialties. While it is difficult to capture all the nuances of these discussions, Figure 3 summarizes how different groups categorized the remaining six ideal functionalities:

Figure 4. Examples of cross-group differences in prioritization of ideal EMR functionalities.

Workflow automation (e.g. auto routing, pre-drafted responses, auto-assigning coverage)
- Most important for FPs on TELUS PSS and OSCAR Pro + all specialist groups; OSCAR group characterized item similar to AI
- It depends for FPs on Accuro

Integrated patient portal with appointment booking, secure messaging, pre-visit intake, and other forms
- Most important to one Surg Spec group
- Least important to FPs on Accuro
- It depends for all other groups, citing differences across clinics and barriers that don't work with patients' own technology

Seamless preventive care and complex care management , using reminders, predictive analytics, and clinical decision support
- Most important to FPs on OSCAR Pro and Accuro
- It depends for FPs on TELUS PSS
- Least important to all specialists citing "more in the realm of primary care" with the caveat "all specialist care is complex care"

AI-powered clinical efficiency (e.g. scribe/documentation, inbox management, smart templates, automated coding, automatic billing)
- Most important to FPs on OSCAR Pro + all specialist groups but one
- It depends for FPs on TELUS PSS and Accuro– some reluctant, some enthusiastic; also cited clunky software not ready for AI, challenges for busy PCs to adopt new tools

Drug interaction checks, based on dosing and guidelines, integrated into prescribing process
- Most important to FPs on TELUS PSS + one Med Spec group
- It depends (on the clinic) for FPs on OSCAR Pro and Accuro
- Least important to Surg Spec

Customizable dashboards for different roles (e.g. NPs/MDs, MOAs, dieticians, specialists, other team-based care)
- It depends for FPs on TELUS PSS and OSCAR Pro + Surg Spec – re type of clinic, roles within clinic (i.e. whether each role needs own view)
- Least important for FPs on Accuro + Med Spec

[10] As was noted in the "superuser" review group at the end of the study, physician awareness of the new FHO+ model - in which compensation will be more dependent on ability to track and audit – may still have been too low for them to associate this functionality as important for daily practice.

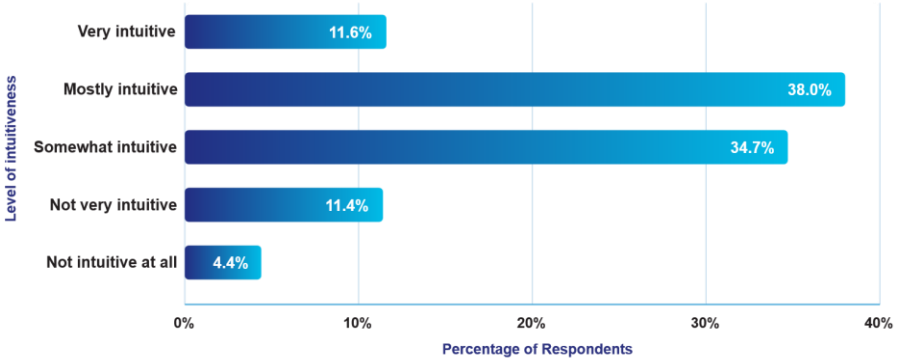
Intuitiveness

The concept of intuitiveness was included in the survey since it is commonly reported as a key contributor of EMR usability[11] [12] as it is with any software product. For this reason, the survey, included the question "How intuitive is your EMR system's interface?"
Respondents answered using a five-point scale:

- ***Very intuitive***
- ***Mostly intuitive***
- ***Somewhat intuitive***
- ***Not very intuitive***
- ***Not intuitive at all***.

Only 49.6% of physicians in the survey reported that their EMR was ***Mostly*** or ***Very Intuitive***. 34.7% reported their EMRs were ***Somewhat Intuitive***, while 16% selected either ***Not very intuitive*** or ***Not intuitive at all***.

Figure 5. How intuitive is your EMR's interface?



Further analysis showed a **bi-directional positive relationship between EMR intuitiveness and overall EMR satisfaction.** (Physicians who rated their EMRs as more intuitive s were more likely to report higher satisfaction and those who rated their EMRs as less intuitive were more likely to report lower satisfaction.
This suggests that because most respondents described their EMR as at least somewhat intuitive. Given the relationship with satisfaction, the majority were also likely satisfied with their EMRs.

[11] Lloyd S, Long K, Probst Y, et al. Medical and nursing clinician perspectives on the usability of the hospital electronic medical record: A qualitative analysis. *Health Information Management Journal*. 2023;53(3):189-197. doi:10.1177/18333583231154624
[12] Olakotan O, Samuriwo R, Ismaila H, Atiku S. Usability Challenges in Electronic Health Records: Impact on Documentation Burden and Clinical Workflow: A Scoping Review. *J Eval Clin Pract*. 2025;31(4):e70189. doi:10.1111/jep.70189

However, additional analysis yielded two findings:

1. Differences in reported intuitiveness across EMRs
2. User experience issues

To explain the former, in our Power BI report, we included filters to select the three most common EMRs both in terms of number of respondents and market share (i.e. TELUS – PS Suite, QHR - Accuro, and WELLSTAR - OSCAR Pro).

To explain user experience we analyzed the open-text responses to "What don't you like about your EMR?" **The most common theme was *Intuitiveness and user experience issues***, with 138 references coded under that theme.
Respondents cited issues with:

- Tasks that require too many steps
- Cumbersomeness of tasks that should be quick and simple
- Excessive clicking, scrolling or tabbing
- Difficulty finding key data or tools

Given that the open text questions were optional, we were struck by the number of physicians who provided detailed, and sometimes colourful, descriptions of their frustrations with their EMR's intuitiveness (examples at right). These responses also reflected a spectrum of physician perceptions and experience of their EMR's intuitiveness, across different EMRs.

Extracts from survey responses to "What don't you like about your EMR?" (coded under Intuitiveness)

"It feels like multiple groups of monkeys made each part without consulting the other groups and another group of hyenas glued it together along with macaroni and glitter."

"Stinky looking non-functional Family History section on CPO. Recurrent unable to check meds pop-up messages, requiring unnecessary clicks. Goofy allergy section discouraging entry."

Given these nuances, the decision was made to include **Intuitiveness** was selected as a key theme to explore via focus groups (i.e., as an issue that speaks directly to the usability of EMRs for physicians).

As described in Methods, focus group participants were asked to reflect on the survey findings regarding intuitiveness, and describe their experiences in this light. Participants were encouraged to volunteer both negative and positive experiences. Common themes raised tended to align with open-text survey responses, in particular:

- Too many clicks – including to skip "required" fields that aren't actually required
- Manual data entry for information that could be pre-populated
- Difficulty finding information due to poor navigation and bookmarking
- Searches are not customizable
- Interface is not customizable

Specialists using EMRs designed for family physicians described frustration with being unable to customize their interface to eliminate primary care elements irrelevant to their practice. This was described as a daily frustration users "**just have to get used to".**

One specialist highlighted an issue in many/most EMRs that is relevant across primary care and specialist practices, noting its centrality to patient-centred care: **the inability to change pronouns, gender and names** for patients who have transitioned or changed from a given name to a chosen name. They noted the example of a patient being assigned their deadname in their chart, which causes emotional injury to the patient each time they visit their medical practitioner – even in clinics providing gender-affirming care – because this field cannot be adjusted by the physician. This practitioner noted that correcting this problem requires system level change.

Although not prompted, some physicians described workarounds they employ to compensate for poor usability. Some examples included:

- When a drag-and-drop feature is absent, the physician uses copy/paste from PDFs
- Using free text notes "paper chart style" when templates are non intuitive
- Creating and sharing custom e-forms and other tools that are better than what the vendor creates, and sharing them among the physician community
- Setting up folders for faxes to specialists because the system doesn't retain faxes, so a referral can be easily forwarded after one specialist rejects it
- Printing lab requisitions because it is faster to fill them out by hand than completing digital forms

In more than one group, we heard some variation on the opinion that if an EMR requires a lot of work to set up or understand, then it is not intuitive. This was also emphasized in discussions around the ability of new users to easily learn an EMR. While there were inconsistent perspectives on the teachability of specific EMRs across users, there was an overall agreement that teachability is an important aspect not only for physicians leading a clinic and wishing to quickly get new staff up to speed, but also for locum physicians who work in a variety of clinics. One physician noted that the EMR used by a practice would influence their decision on whether to accept a locum position.

Similarly, for less intuitive EMRs, when there is a poor response from vendors for escalated issues, physicians who are more technologically inclined often assume responsibility for customizing the EMR interface for all team members. In one group, there was discussion of creating access to specialized or quasi-programmers to provide technical support as a way to avoid this extra burden on the physicians who step up to take on this customization task at the expense of their own work time. Access to extra support of this nature, it was suggested, could be a source of hope for physicians who often feel discouraged about their EMRs that persistent problems could be solved. In another group, superficial interface changes that are cognitively disruptive to physicians without meaningful improvements to EMR usability were described as **"putting lipstick on a pig".**

Finally, we asked focus group participants to suggest examples of intuitive interfaces from other areas of life that they wished their EMR could emulate. Frequently cited examples included consumer-platforms like Amazon, Apple, Microsoft, and Google came up in more than one group. Others noted generic services like online banking, grocery store platforms, and private practice health appointment booking systems (e.g. physiotherapy, veterinary). More unique references included Old Navy (for the purchase history / trend monitoring), Air Canada ("frustrating but still better than my EMR"), and the customizability of video game interfaces.

In a few groups, physicians expressed excitement at the promise of voice-command options similar to Siri or Google. One participant referred to this as the **"Star Trek Clinic"** model in which clinicians could verbally request to look up charts, results, search for specialists and send referrals etc. from anywhere in the clinic and picked up by the system efficiently.

Extra Hours Worked

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Among the key questions identified by the ACE Panel for inclusion in the survey was the number of hours physicians routinely work on their EMR outside of patient time.

The number of hours physicians spend working on their EMRs outside of scheduled patient time is a critical measure of administrative burden. These "after-hours" tasks — often completed in evenings and weekends — represent unpaid clinical documentation and system navigation work that extends the workday well beyond direct patient care. Research consistently shows that additional administrative hours are strongly associated with physician burnout[13], characterized by exhaustion, disengagement[14], and reduced professional fulfillment[15].

National data indicate that nearly all physicians report that administrative work disrupts their work–life balance, and the majority agree that clinical documentation contributes to burnout. The consequences are significant: more than half of physicians' report plans to reduce their working hours, and one-quarter are considering leaving practice or retiring earlier than expected[16]. Conversely lower administrative burden is a major incentive to help recruit doctors. In the context of ongoing physician shortages and millions of physician-hours lost annually to red tape, reducing after-hours EMR work is not simply a matter of convenience — it is essential to physician retention, workforce sustainability, and maintaining patient access to care.

In this survey we asked, "How much time do you spend on your EMR outside of patient-facing hours on a typical workday (including time at home)?" with four response options*: Less than 60*

[13] Jones M, Jason T, Liu D, Graham J, Comeau J, Chandrasena C, McDonald N. A study of technology-related burnout among physicians in two Canadian provinces. Unpublished findings, 2025.

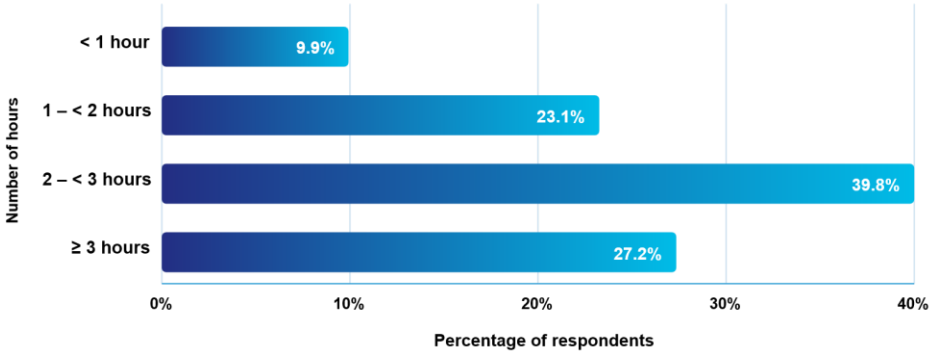
[14] Chen Y-H, Jong G-P, Yang C-W, Lee C-H. Prolonged Overtime Predicts Worsening Burnout Among Healthcare Workers: A 4-Year Longitudinal Study in Taiwan. Healthcare. 2025; 13(15):1859. https://doi.org/10.3390/healthcare13151859

15 Canadian Medical Association (CMA) and Canadian Federation of Independent Business (CFIB).Losing doctors to desk work: Canadian physicians lose 20 million hours each year to red tape. Ottawa: The Association; 2026 Jan. Available: https://digitallibrary.cma.ca/link/digitallibrary1478 (accessed 2026-02-06)

16 Canadian Medical Association (CMA) and Canadian Federation of Independent Business (CFIB).Losing doctors to desk work: Canadian physicians lose 20 million hours each year to red tape. Ottawa: The Association; 2026 Jan. Available: https://digitallibrary.cma.ca/link/digitallibrary1478 (accessed 2026-02-06)

minutes, 1-2 hours, 2-3 hours, and *3+ hours*. Those who selected *3+ hours* were asked to estimate the number of hours per day (Figure 4).

Figure 6. How much time do you spend on your EMR outside of patient-facing hours on a typical workday (including time at home)?



Two-thirds of respondents (67%) reported spending at least two extra hours per day on their EMR. Of those who reported more than three hours and wrote in a numeric response, their average extra hours spent were four per day. **A significant difference was observed between early and late career clinicians on time spent on EMR outside practice** (i.e., in comparison to late-career clinicians, early-career clinicians tended to spend more time on their EMR outside of their practice). There was some variation among EMRs; for example, QHR - Accuro use was associated with significantly fewer extra hours spent.

When this visualization was shared in focus groups, most participants reported that they worked between one and three extra hours per day. The specialist groups tended to note they would not necessarily spend as much time as a family physician outside of patient hours.

They listed several activities that generally comprised this time, such as:

- Manual retyping for forms when EMR does not auto-populate or in EMRs where the copy/paste function does not consistently work
- Writing notes for patients (uncompensated hours for specialists working in the community)
- Billing (including correcting errors)
- Documentation for medico-legal requirements
- Chasing incomplete referral information (for specialists)
- Following up bloodwork
- Triaging the waitlist
- Communications with staff for follow-ups or questions

- Reviewing results and labs
- Reports
- Custom forms
- Responding to patient messages
- Sending referrals and consults (for family physicians)
- Prescription refills (one suggested these can take an hour per day; another said they have begun requiring a billable visit for refills, even if by phone)

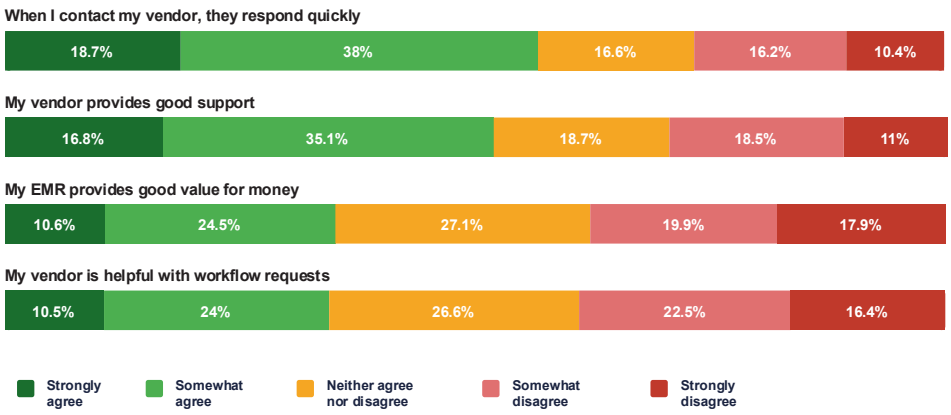
In some groups, it was suggested that the expenditure of extra hours could be reduced by effective customization early on (e.g. creation of templates). However, not all physicians believed that they could manage this focused work, and some believed that their EMRs did not offer the customizability to make this possible. Some noted that it would be helpful to have support in customizing the EMR effectively, although they would want this to be available to physicians free of charge.

When asked in the focus groups to reflect on the ideal functionalities to consider for reducing extra hours spent, most participants pointed to AI-powered clinical efficiency and workflow automation. This could assist in inbox management, faxing, prescriptions, letters etc. Some who had already used AI (e.g. a scribe) reported benefits in terms of efficiency. Participants also noted that AI scribes still require further development to optimize their benefits, related to: user confidence in data privacy and security; AI hallucination requiring oversight/review; and integration with EMRs that have not been upgraded to accommodate AI. Similar to the above point, many physicians indicated they would want the cost of these tools to be subsidized.

Vendors and EMRs

In the survey, we asked four questions about respondents' experiences with their EMR vendors. Breakdown of responses to these questions appears in Figure 7.

Figure 7. Please indicate your level of agreement with each of the following statements.



Over half of respondents *Strongly* or *Somewhat agreed* that their vendor responds quickly (57%) and provides good support (52%). Vendors fared less well in terms of their helpfulness with workflow requests (35%) and that their product provides good value for money (36%).

Respondents also elaborated on the theme of *value for money* in the open text responses to the question "What don't you like about your EMR?" with 56 references coded under the theme *Cost*. These included concerns about the cost of both the system itself and add-ons, particularly given the quality of the experience for the amount paid.

Apart from the three EMR-specific primary care physician groups, we did not devote dedicated focus group time to vendors. We did, however, include a prompt about vendors under the "intuitiveness" section asking participants what they would say to their vendors if they were in the room (regardless of whether they had already said this directly to their vendors, which many said they had). Even without prompts, some physicians began speaking of their experience with their vendors earlier in the session. Some notable examples included:

- "I think I would tell them that your product is not worth the money I'm being asked to pay for it. If I were to pay what it is worth, I would say 50% or less."
- Upgrades often make things worse or at least are not helpful – "I have not noticed a single change in anything in the last 15 years with this EMR."
- "For what I'm paying, it should just work without workarounds."
- "I would love them to actually listen to what we want, and not just assume they know what we want."
- If I could have them sitting beside me, I'd like them to know that they should be penalized for every time that I have to click 6 times to do a simple task."

In the survey, we also asked "How often do you encounter technical issues that affect your practice's efficiency? (e.g. system updates, downtime, slow response time). Respondents were offered five response options: *Never, Rarely, Sometimes, Often,* or *Always*. **About three-quarters of respondents reported experiencing technical issues at least *Sometimes*, with almost one-third reporting these occur *Often* or *Always*.** Some significant points arising from the analysis included:

- Compared to other EMRs, QHR - Accuro is associated with significantly less frequent tech issues
- A significant difference was observed between early and late career clinicians on frequency of tech issues (i.e. In comparison to late-career clinicians, early-career clinicians tended to experience more frequent tech issues)

Open text coding of responses to "What don't you like about your EMR?" also yielded themes touching on this issue, including *Speed* (i.e. slow response speed and freezes – 49 references); *Vendor tech support issues* (i.e. slow response or failure to resolve known issues – 29 references); *Service outage and impacts* (20 references); and *Glitchiness* (17 references).

While disruptive tech issues were not explored as a separate category in the focus groups, a few participants spontaneously shared stories. For example, one participant described an update that caused the EMR to crash and then operate slowly for an entire month while the vendor attempted to fix the problem.

More EMR-specific experiences were elicited from the three focus groups involving primary care physicians on each of TELUS - PS Suite, QHR - Accuro, and WELLSTAR - OSCAR Pro. Although the specialist groups were not convened according to EMR used, several participants in these groups used one of these three EMRs and volunteered their perspective. Tables 1 and 2 below summarize perspectives on these EMRs expressed by physicians participating in different focus groups.

Table 1. EMR-specific comments from Primary Care Physician groups.

	TELUS – PS Suite	QHR - Accuro	WELLSTAR - OSCAR Pro
Intuitiveness	Not as simple to teach to new residents as it could be Poor custom form creation is "hugely inefficient" Would be nice to have access to UIs designed by clinician community. However, TELUS online forum is "awful to navigate"	Compares poorly to TELUS - PS Suite and WELLSTAR - OSCAR Pro (one participation, a locum, noted avoiding taking roles with clinics on QHR - Accuro) Must resort to free text workarounds for nonintuitive design issues (compromising data quality for retrieval) Non-intuitive medications template asks questions that don't align with how physicians prescribe Address book for specialists not searchable by specialty or location – requires knowing specialist name	Difficult to navigate through menus and sub-menus for simple things; once found, difficult to create a shortcut Main interface not customizable to user priorities; "there are hundreds of things to click on, but I only use 10 of them in 90% of cases Tradeoff between intuitiveness and cost; they've saved them "thousands of dollars" in licensing fees other EMRs would have charged (challenging to implement but "I'm willing to tolerate that pain") Easy to use for basic things like notes and prescriptions, but not for advanced functionalities Editing custom forms not intuitive Need to be a "techie doc" to fix everything that doesn't work well
Upgrades	Lack of competition means TELUS is not motivated to improve their "ancient" technology Lack of integration of AI tools	Recent upgrade changed colour schemes (which were challenging to adapt to) but made no substantive improvements "Lipstick on a pig" – if the base functionality is outdated and inadequate, cosmetic changes will not fix the problem	Given a lot of docs have programmed workarounds for WELLSTAR - OSCAR Pro, the vendor should consider these when planning improvements Interfaces are 25 years old; much of this should be replaced by AI in future (another doc here referred to vision of the "Star Trek Clinic")

Costs	Clinician-created shared custom e-forms are "so much better than what TELUS makes, which is not great considering how much we pay them."	Introduces new functionalities but charges for all of them Cost goes up over time but with no improvement in functionality	
Support	Poor support - "I gave up speaking to them because they don't care enough to fix anything, in my experience"	Poor support	Submitting tickets and waiting for a response, then feeling that the vendor doesn't truly listen to what you're hoping to achieve; does not provide a clear path to improving the functionality Even things that should require a simple fix take a long time for the vendor to correct
Specific examples	Referrals – if declined, all attachments have to be reassembled to be redirected (not saved to the referral) Drug interaction checks "too aggressive" and difficult to customize (functionality "dictated by a lawyer for TELUS") Prescription error alerts do not identify which medication has the error, forcing review of all (re patients on multiple meds) Prescribing window sometimes defaults to wrong pharmacy Within-chart search functionality is good but global population searches can be "finicky"	Inability to keep all documents for a referral attached so it can be re-sent Scheduler does not allow the user to change appointment lengths Trending graphs complex to create No follow-up section in inbox Messaging via Ocean or Medeo (integrated) is useful – but "like everything in Accuro, there are a few too many steps" Example of major disruption to clinic when integrated e-consult functionality was lost in QHR - Accuro – rates of e-consults dropped drastically after that	Workarounds are often required for functions that should be fairly simple, e.g. attaching a pediatric growth chart to a referral without having to convert it into a PDF PrescribeIT works pretty well but requires too many clicks, and doesn't allow scrolling through all long-term meds Required 45 minute session to integrate Ocean with WELLSTAR – OSCAR Pro; for another issue, received a 12 page guide from vendor on how to link the LOINC codes

Table 2. EMR-specific comments from Specialist focus groups.

	TELUS – PS Suite	QHR - Accuro	WELLSTAR - OSCAR Pro
Intuitiveness	Selected it for similarity to Windows, which indicated it would be teachable; however is not suited to specialist care Billing is non-intuitive	Easy to teach to new team members… …but too easy to enter data under the wrong patient when multiple windows open Mostly intuitive, but could be streamlined; found the recent interface update[17] with slight changes to icon size and colour difficult to adjust to A locum who had used TELUS – PS Suite and WELLSTAR - OSCAR Pro noted QHR - Accuro is hardest to learn of the three Data retrieval frustrations – "wild goose chase" – too many clicks and barriers to easily construct a trend chart of a patient's labs	Compared to QHR - Accuro and TELUS – PS Suite, easy to pick up as a new user, but steeper learning curve for advanced functions Tabbed visual interface is inferior to panelled Too complex and layered to be intuitive When multiple windows are opened they don't shut after task is complete; requires "maddening" alt-tab back & forth - embarrassing in front of a patient
Upgrades		No improvements over the last 15-20 years except for the useful ability to sweep labs into notes	
Cost	"if I were to pay what [their product] is worth, it would be 50% or less what I pay now"	"Accuro nickels & dimes you, and never at a price that's reasonable" Must pay for storage space for photos –essential for dermatology	

[17] This interface update and its negative effects were referred to in two separate focus groups as well as in the open text comments of the survey.

Support		Inconsistent ability to copy and paste; when escalated, was told "we don't have this feature"	Help desk is "not bad but not fast"
Specific examples		Difficult to integrate Ocean with QHR - Accuro Must scroll through alpha list of forms rather than typing to search – "most silly thing ever"	Graphical UI to download and highlight PDF forms is great One participant keeps ConnectOntario open all the time as it allows quicker data review pre-encounter than WELLSTAR - OSCAR Pro does

Discussion

The study findings outline broad areas of concern for physicians with their EMRs, which could be briefly characterized as:

- **Let me enter data easily**
- **Let me retrieve and export data quickly**
- **Let me work seamlessly across systems (i.e. interoperability)**
- **Let me boost my efficiency by automating routine workflows and (in many cases) using AI solutions**
- **Make my EMR flexible and customizable**

While these themes were common across physicians in this study, there are distinct differences across physicians in terms of their priorities – making the last point, "Make my EMR flexible and customizable", perhaps the most important one.

We return to the quote from the beginning of the report: "Ask a hundred different doctors the same question, you'll get a hundred different answers…" We heard from physicians that:

- Apart from the top two priorities (briefly, reentering and retrieving data), **different EMRs and roles create variation in priorities**
- **Some features are consistently valued, and others are context-dependent** (i.e. primary care vs. specialist, specialist type, size and focus of practice, staff complement and roles)
- **EMR-specific differences matter**: what's critical in WELLSTAR - OSCAR Pro may be optional in QHR - Accuro or TELUS - PS Suite

This complexity explains why it's difficult to define a single "ideal state" for vendors. One size doesn't fit all; EMR design must accommodate diverse needs, workflows, and context if EMRs

are to work better for physicians. In focus groups, a few physicians noted that EMRs seemed to be designed by the vendor's lawyer, an engineer, or in general by "**someone who had clearly never done patient care**". Working with physicians to understand what they mean by flexibility and what they value in upgrades (i.e. not headache-inducing colour scheme changes) would not only help vendors shift physicians' experience of their products but also contribute to the well-being and efficiency of this essential professional community.

Finally, we would draw attention to the trade-offs physicians typically negotiate in relation to their EMRs:

- **Flexibility vs. work/life balance:** Physicians appreciated the flexibility that their EMRs offer, with the ability to log in from home to review time-sensitive results, etc. Many also noted the benefit of smartphone access (although in one focus group we heard a participant say their EMR does not render well on their phone, preventing effective remote work). At the same time, many physicians we heard from – and have heard from in previous surveys conducted by our team – referred to this as a double-edged sword. Physicians in this study talked about their EMR being their "best friend… well maybe not best"; being married to their EMR; and even being chained to it.
- **User-friendliness vs. customizability:** In focus groups, participants described taking under consideration, when selecting an EMR, its ability to be easily learned as well as its ability to be customized for their use preferences. There is a suggestion of trade-off where more tech-savvy docs who could, on their own, easily navigate and adapt a customizable EMR must also consider whether new staff will be able to easily learn a system, and the extent to which the physician wishes to assume the role of the principal "problem solver" role in relation to the clinic's EMR. Originally, our study focused on customizability related to the interface, but physicians expanded this focus by bringing in other features they wished were customizable (e.g. searches). As vendors are able to limit customizability to retain physician reliance on their support, we might say that what physicians are really looking for is "the ability to self-manage EMR customization without vendor intervention."
- **Cost vs. functionality:** Physicians recognized that their EMRS are an essential tool that merits a budget. However, with the costs of running a practice, they may be faced with a choice to adopt a less expensive EMR that is neither as intuitive nor provides all the functionality they need. Physicians also expressed concern about add-on costs that don't always deliver value or, they feel, should be included in the basic cost of the product.

Limitations

The survey sample of 545 eligible respondents (i.e., EMR users) is neither generalizable to nor representative of the physician population in Ontario. However, it is sufficient to provide robust, statistically derived insights.

Focus groups are not generalizable and can only be seen as representative in the sense that an effort was made to represent different viewpoints with an interest in the topic.

Commented [CC2]: perhaps add a limitation of not asking front staff and patients:

can pull this in with other stats and survey
- next steps is to look at MOa
- have a parallel report for MOAs
- for patients: some pieces on SDOH

Patient safety came up a few times so can speak to this as "not the scope" but can highlight that it is something for future

While the perspective of patients was not within scope for this study future investigations could explore patient experience with particular focus on the social determinants of health and patient-centred care, topics which were raised and explored by focus group participants. In addition, patient safety was also identified due to EMR functionality at the visit level, and lack of interoperability at the system level. Both were out of scope for this project but could be explored in future.

We recognize that even with our efforts to develop a robust methodology and accurately distill findings from the survey sample and focus groups, there are perspectives that have been missed. We have attempted to reflect the key concerns shared by physicians who so generously gave us their time and perspectives in the hope that doing so would support actions that could make things better for them and their colleagues.

Medical Office Staff

One limitation is the exclusion of medical office administrators and staff. Office staff who support medical practices are key users of EMRs and can share insights on usability. Expanding on why this matters is that their support cuts down on the administrative burden faced by physicians. These are also staff who are employed by doctors, and improving the functionality and ease of using EMRs cuts down on their time (and associated costs) which further supports physicians and patient care.
EMRs can help identify efficiencies and enable medical office staff to take on a more active role in practice operations, supporting better workload distribution. However, realizing these benefits can be more challenging in smaller practices, where physicians often must absorb the full costs. Staffing limitations—particularly in rural settings where recruiting qualified personnel is difficult—create additional barriers to effectively leveraging EMRs in this way.

Connections with Hospital Information Systems (HIS)

One point of note: As noted at the outset of the report, the scope of this study was confined to community-based EMRs (i.e. hospital-only physicians were excluded). However, during data collection we heard some comments from community-based physicians who also used HIS about their challenges with those systems which were similar to challenges with out-of-hospital EMRs. Additional vetting of high-level findings with the ACE Panel and other physicians reinforced the idea that the findings of this study could lead to guidance for digital health tools and information systems beyond what was defined in the original scope. We have reflected this need to explore the implications of this work to HIS and other digital health tools in the Next Steps section of this report.

Costs

This work was scoped to focus on EMR functionality and not on any specific aspects of costs. Exploration of various EMRs and costs would have been well beyond the scope of this priority. It is well-established that EMRs have significant costs in terms of ongoing time and investment costs that can be prohibitive, particularly for community-based and small practices. While improved usability and functionality may require upfront investment, these enhancements may

also yield downstream value through reduced administrative burden, improved continuity of care, enhanced data-informed decision-making, and potential improvements in patient outcomes. The Recommendations outlined in the subsequent section represent another step towards improving the experience of EMR use. These were the result of additional activities we engaged in to review the study findings and develop, validate and rank key action items.

Accessibility

Although this was not explicitly mentioned in the study, EMRs can improve accessibility for users with disabilities by enabling features such as screen reader compatibility, adjustable text sizes, and alternative communication methods (e.g., secure messaging for patients who are deaf or hard of hearing). They can also support more coordinated care by documenting accessibility needs and accommodations within the patient record. However, accessibility is not always consistently built into EMR systems, and poorly designed interfaces can create barriers for both patients and providers with disabilities.

Improved integration with third-party applications may further enhance accessibility and care delivery by supporting more flexible workflows and better treatment coordination. This could include the use of more accessible applications or tools that support inclusive practices, such as language translation.

Ensuring that EMRs meet accessibility standards and are designed with inclusive, user-centered approaches is essential to avoid widening existing disparities in care and be more inclusive.

Recommendations

Following the collection of findings from the survey and focus groups, additional review sessions were conducted to support the development of recommendations.

1) **"Superuser" group** (expert EMR users with deep health system knowledge) group drawn from OMA, Section of General and Family Practice (SGFP) and OntarioMD Peer Leaders (in two sessions Oct 7 and 9, 2025).
2) **Community-based EMR working group**, (former ACE Panel members, who had participated in study co-design (Oct 27, 2025). Dr. Gareth Seaward (Chair), Dr. Rayudu Koka (Vice-chair), Dr. Julie Kovacs, and Dr. Dannica Switzer.
3) General Assembly special concurrent session (Nov 22, 2025). There were 43 physician-leaders registered for this session.

Recommendations were initially generated by distilling collected feedback from Groups 1 and 2. Then, a prioritization approach was developed to engage physicians attending the General Assembly session. Four broad themes were identified, each comprising 4-5 recommendations:

- Health System
- EMR Standards/Core Requirements
- EMR Vendors
- AI Enablement

General Assembly Session

A recap slide deck outlining the PLG ask and survey results were presented prior to the table discussions. Led by OntarioMD's Chief Medical Officer, Dr. Chandi Chandrasena, the session reviewed the work completed to date, key survey findings, and the draft recommendations. Participants were then assigned to table groups with each group tasked with validating, refining, and expanding a specific set of assigned recommendations.

Each table at the General Assembly was facilitated by a physician from the Special Working Group and provided with a rubric to assess the importance and feasibility of their assigned recommendations. Group participants were then asked to collectively rank the recommendations within their group.

An OMA scribe was assigned to each table to capture the discussion. These notes, along with input from the physician facilitators, were incorporated into the final recommendations. The following table captures the top three approaches under each theme.

Theme 1: Recommendations for the Health System

1	**Advance interoperability -** Take a faster pace with initiatives like single sign-on to enable seamless data access at point of care, reducing burdens on clinicians and creating the digital environment for the move to comprehensive care (see also federal initiatives such as CIHI data standards; erstwhile Bill C-72).
2	**Work nationally -** Participate in existing national efforts, such as Pan-Canadian data standards and Bill S-5 (formerly Bill C-72), Renew72, and PTMA table discussions to support the data flow physicians need by preventing data blocking (e.g. vendor charges for data portability).
3	**Understand the impact of EMR frustrations on physicians' capacity for patient-centered care -** Addressing persistent EMR usability challenges for physicians will directly benefit patient access and attachment, quality of care, and readiness of physicians for integrated care pathways.

Two additional themes presented to this group but not ranked in the top three were:

- **Automate public health priorities -** Remove the burden (from family physicians) to initiate and close the loop on routine preventive care (e.g. mammography) where action is not required for a normal test result. Make it possible for normal results and routine common actions (e.g. immunizations) to be automatically updated in a chart without the need for physician action.
- **Use available policy and regulatory levers to improve physician experience -** Provide guidance to remedy inconsistent report labelling from sending facilities (e.g. hospitals). Use financial incentives and regulatory enforcement (e.g. penalties) to push vendors towards innovation and functional improvements. Create innovation challenges for tech solutions that will help doctors and their patients.

Additional notes from this session:

- The framework to develop these recommendations should be physician centric and led by physician leadership at all levels.
- The number one priority issue requiring correction in the health care system is the inability to easily share patient data. The landscape needs to be changed to one central data repository that can be accessed by all physicians for all patients, regardless of locale (e.g. home care).
- Feasibility is greater now with the opportunity to access funds via PCAT for attachment. Reframe these recommendations to take advantage of this.
- The EMR should only be a conduit to gather the data, not the data repository itself.

Theme 2: Themes for EMR Standards

NB. The terms "standards" and "certification" were used as they are understood by physicians, and do not accurately align with how they are understood in technology fields. We used the physician-friendly terminology, but in the Executive Summary and elsewhere we refer to "standards" as **EMR Core Requirements***.*

1	**Set a higher bar for standards -** Making certification a greater challenge for vendors, while bolstering the trust physicians have in certified EMRs to guarantee they will get what they need from their EMR solution, could reduce the market to a few options that provide all basic functionalities to the standard.
2	**Modernize standards so that basic functionality needs are consistently met across certified EMRs -** Through health system direction, broad consultation across diverse physicians, and alignment with Pan-Canadian standards, secure basic functionality as the foundation for certification. This includes customizability (including specialists), as well as interoperability (e.g. seamless data exchange with provincial assets like OLIS, HRM and eConsult), and AI readiness. TIED WITH **Create standards that support physicians to easily delegate while maintaining privacy and security -** In the reality of clinical practice, physicians will either assume extra hours of work or create workarounds for EMR restrictions so that they can delegate admin tasks to staff. Clarifying roles and permissions will create seamless delegation pathways and enable easier transitions for temporary access (e.g. locums, residents).
3	**Create standards that prevent add-on costs to physicians -** Make data portability and basic training access standard across EMRs so that vendors cannot charge for these basic services. Removing the ability to charge for data migration will also encourage innovation in the sector, as EMRs will need to become more competitive to retain clients.

An additional theme presented to the group but not ranked in the top three was:

- **Use standards to promote patient-centered care -** Support EMR standards that require complete fields for social determinants of health (SDOH). [Although this was seen as a feasible recommendation with potential practice-wide impact, the group felt that some patients may not wish to provide this information for fear of compromising their care. One session participant submitted a handwritten comment that this recommendation will be key for future issues in AI use: "re AI keynote, can't validate or rank regarding racial bias without having that data there in the first place!"]

Additional notes from this session:

- **Setting a higher bar** will face political impact, affecting feasibility.
- **Creating standards that prevent add-on costs** is important, but it's an open market and vendors don't have an incentive.
- **Modernizing standards to meet basic functionality needs** is important but not as feasibility, as it would be very difficult to create standards that meet everyone's needs.

Theme 3: Themes for EMR Vendors

1	**Make correct data entry easier -** Support physicians to enter correct data in a correct way as smoothly as possible, including the use of tools like automatic coding such that data quality can be assured without additional work on the physician's part. (i.e. Correct data entry enables correct data *extraction/transfer*.)
2	**Create better customizability -** Interface needs differ across physician and practice types (e.g. specialists who use EMRs where primary care features like the CPP are immoveable). Make it easier to customize their screens without compromising functionality or requiring workarounds.
3	**Modernize EMR systems -** Prepare technology to meet interoperability initiatives (including those already underway in Ontario) to enable data access as soon as these initiatives are available. Make EMRs AI-ready, and update so that AI tools can be integrated.

Two additional themes presented to this group but not ranked in the top three were:

- **Better training and support without hidden fees -** As all EMRs have some challenges with intuitiveness, make it easier to access support and training, included in the cost of the EMR, so that physicians can quickly understand how to use their EMRs as they need.
- **Enable standardized automatic coding -** Enable LOINC coding for report categorization, SNOMED for results, HTML acceptability, etc.

Additional notes from this session:

- **Creating better customizability** would enable better data flow into the system. Software is driven by people, so we should be able to get it to do what we want ("Software is like clay, we can make it what we want so we need to dictate or create what we need if the vendors won't do it. Now is the time!")
- **Modernizing EMR systems** requires first that the provincial backbone (provincial data repository) is comprehensive and accessible. There are current access issues, and improving stability is essential.

Theme 4: Themes for AI Enablement

1	**Integrate AI tools within the EMR -** Vendors, standards, certification, and the health system need to work together to ensure that new AI tools can be integrated within EMR systems.
2	**Understand the AI tools that will help physicians most -** This includes not only scribes but also inbox management, referral management, clinical decision support[18], toolbars, auto-updating, and many others. Engage physicians in a vision of the future clinic (e.g. voice-commanded systems) so they have a co-design role in tool development.
3	**Create tools that help physicians access pertinent data faster -** Develop solutions that enhance the signal and reduce the noise in the overwhelming amount of information physicians encounter every day.

Two additional themes presented to this group but not ranked in the top three were:

- **Make correct data entry easier -** Support physicians to enter correct data in a correct way as smoothly as possible, including the use of tools like automatic coding such that data quality can be assured without additional work on the physician's part.
- **Establish a robust privacy and security framework for AI tools –** Ensure that privacy and security governance for these new tools will increase physician trust (confidence that their risk is low) in their use and enable innovation to meet physician needs. [It was noted in the sessions that it's important, but physicians have little ability to influence changes in this area (PHIPA) and patients are not that concerned unless something goes wrong.]

Additional notes from this session:

- **Integrating AI tools within the EMR** could be incorporated in the certification process.
- **Understanding AI tools that will help physicians the most** requires validation to ensure they do what they're supposed to do. This will require working with vendors and supporting physicians to have a voice in creating and validating AI tools.

[18] Clinical decision support or CDS refers to systems designed to enhance medical decisions with targeted clinical knowledge, patient data, and other information sources (e.g. guidelines, quality standards, etc).

Next Steps: Translating Recommendations into Action

The prioritized themes summarized above indicate several actions that the OMA and OntarioMD can take to advance EMR functionality for Ontario physicians in alignment with corporate priorities.

OMA

- **Leverage these findings to support advancing acceleration digital innovation in healthcare:** Ontario already has a digital health strategy**.** A coordinated approach is essential to improve access to patient records, enable centralized referrals, modernize EMRs and integrate AI to improve care delivery and system efficiency.
    - Advocate for physician governance and leadership in implementing solutions, and this should be informed both primary care and other specialists to ensure this is clinically grounded and practical
    - Support physicians adopting the best EMRs for their practice to improve patient outcomes
    - Reduce barriers to care by advocating for improved internet connectivity and supporting infrastructure (e.g., power generators in areas with unreliable electricity) across the province, enabling effective EMR use and equitable access to care for all patients
- **Advocate for government-supported funding to improve and modernize EMRs:**
    - Current EMRs often lack interoperability, create administrative inefficiencies, and require costly upgrades and maintenance that are largely paid for by individual physician practices.
    - Priority investments should include: EMR modernization and interoperability improvements, integration with provincial digital health infrastructure, cybersecurity and data protection upgrades, workflow optimization and usability enhancements, and ongoing technical support and maintenance.
    - While it may not be realistic to implement fully funded EMR implementation and ongoing support, other models could be supported by Ontario government and health sector partners e.g. targeted grant programs, matching funds, or phased cost-sharing. This strategic investment will enhance patient care, reduce administrative burden, and strengthen system-wide integration.
    - Physicians also bear substantial hidden costs related to EMRs and digital innovation, including cybersecurity insurance, privacy and compliance responsibilities, and the significant time investment required to navigate complex legal and vendor contracts.
- **Strengthen access to care.**
    - Leverage EMRs to improve referrals and enhance access to specialists by centralizing referrals and implementing coordinated care.

- **Develop a Provincial AI strategy with system partners.**
    - Identify tools that best support physicians and their practices.
- **Support physician wellness.**
    - We know that having digital tools that are effective and integrated into clinic workflow supports physician wellness. Improving EMR usability could:
        - Reduce administrative tasks and the "second shift" of after-hours charting contributing to physician burnout.
        - Decrease burnout.
        - Enhance recruitment and retention.
- **Align advocacy efforts for EMR Systems with OMA Digital Health Principles.**
    - Advocate for the integration and functionalities to enable digital health solutions that are:
        - Seamlessly integrated
        - Co-developed with physicians
        - Interoperable
        - Focused on usability and patient centered care
    - Engage the Ministry of Health and Ontario Health on EMR-related challenges in the trilateral Digital Health Advisory Table.
- **Coordinate advocacy efforts nationally.**
    - Digital health challenges extend beyond Ontario. The OMA should collaborate with provincial-territorial medical associations (PTMAs) and the Canadian Medical Association (CMA) to coordinate advocacy efforts across Canada, to:
        - Decrease physician administration burden
        - Improve portability across jurisdictions
        - Strengthen patient care and safety
    - Continue to support pan-Canadian advocacy efforts such as Bill S-5 (formerly Bill C-72), the *Connected Care for Canadians Act* and sustain membership in Renew72 coalition to become a fully digital health sector.

OntarioMD

- **Inform internal priorities:** Use the study insights to guide initiatives such as the Managed Digital Services (MDS) program, strengthen vendor engagement strategies, and inform discussions on core EMR requirements and modernizing the EMR Certification Program.

- **Support strategic decision making:** Apply the study findings when participating in advisory tables, working groups, and committees to ensure Ontario physicians' perspectives and priorities are consistently represented.

- **Drive system level advocacy:** Leverage the evidence to advocate for meaningful change at both provincial and national levels, including collaboration with organizations such as the CMA and others, to influence policies, requirements, and funding related to EMRs and digital health.

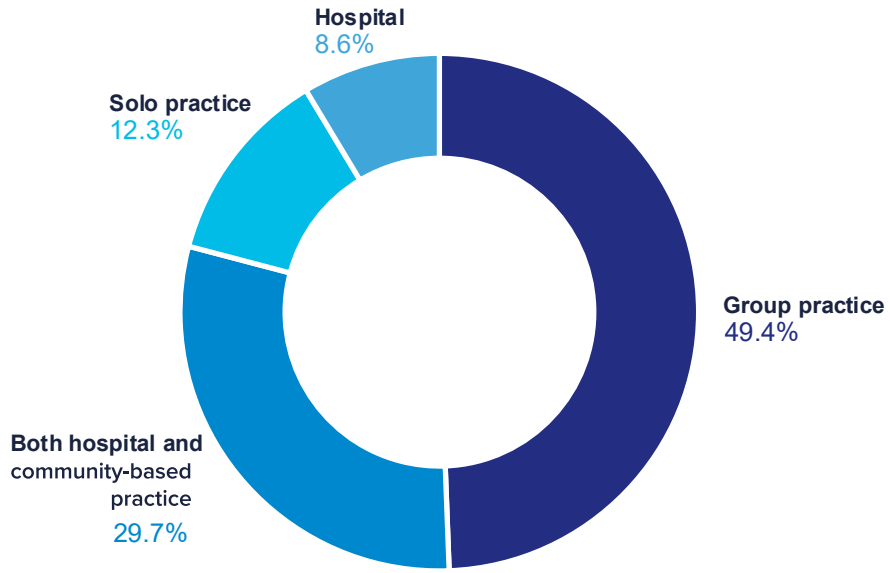
- **Translate recommendations for digital tools into action:** Identify concrete steps and projects (i.e. with a focus on AI) where OntarioMD can implement, test, or pilot recommendations, ensuring that the findings lead to tangible improvements for clinicians and the broader health system.

- **Extend best principles across digital health:** Synthesize the themes from this work into a set of guiding principles that apply not only to EMRs but to other point-of-services (e.g. HIS, as noted in the Limitations section), medical health tools, and technologies, and use this broader lens to inform future strategy, partnerships, and system planning beyond EMRs. This could also inform identifying metrics to identify progress being made across the system.

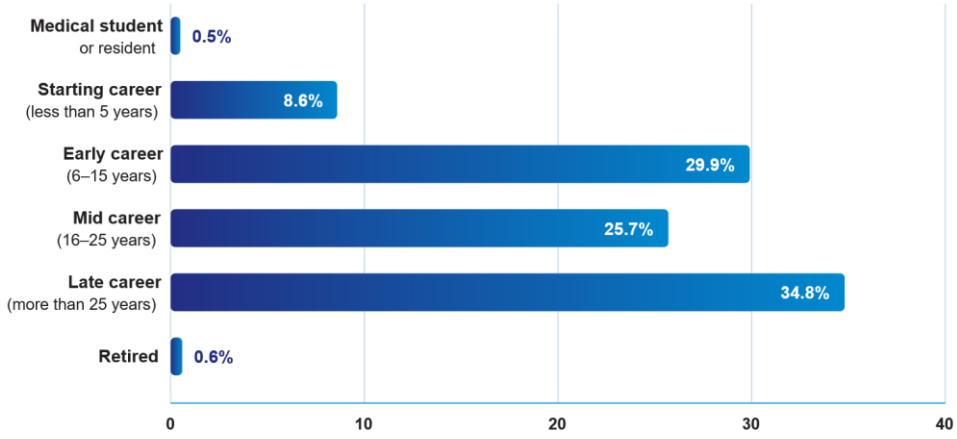
- **Enable seamless, reliable, and cost-effective data migration between EMR systems**: OntarioMD should advance standardized, vendor-agnostic data migration options to reduce barriers to change and support high-quality patient care; current processes are resource-intensive, prone to inaccuracies or data loss, and often require significant clinic downtime, creating risks to patient safety and continuity of care.

Appendix 1. Breakdown of respondents by key characteristics

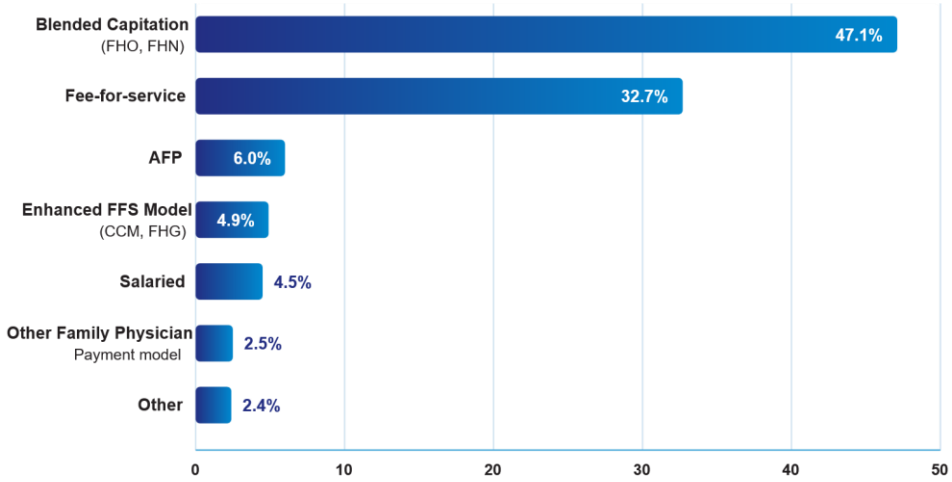
Respondents by practice type



Respondents by career stage



Respondents by compensation model



Additional notes on these respondents:

- Unlike group and solo practices, the majority of which use one EMR, most hospital-based physicians use either one or two EMRs.
- Hospital-based physicians use the following HIS solutions: Meditech (39%), EPIC (33%), Oracle Cerner (17.5%), or Other (10.5%).
- Unlike group and solo practices who must rely on themselves (24%, 48%), or admin staff (67%, 37%) for tech support, hospital-based physicians have dedicated on-site tech support at their disposal (60%).

Appendix 2. Detailed research reports available for review

A separate report was generated for each piece of this study. The current final report is a synthesis designed to accurately represent key findings (as well as general context for the work and methods). The following reports may be reviewed in a guided session with the study team upon request:

- Quantitative analysis of survey (Power BI interactive report)
- Qualitative coding report of responses to survey open text questions (Word document)
- Focus group report (Word document)
- Analysis by EMR Vendor (Power BI interactive report)