HEALTH INFORMATICS:

The Enabling Infrastructure for Effective COVID-19 Crisis Response

October 1, 2020 | Virtual Event

EXECUTIVE SUMMARY

The Scottsdale Institute convened 28 chief medical informatics officers for a CMIO Summit on October 1, 2020. These leaders gathered to discuss how health informatics enabled hospitals to rapidly and effectively respond to the COVID-19 pandemic starting in the first quarter of 2020. Informatics delivered new solutions at scale in new ways, playing a central role in enabling new workflows and new work locations, collaborating to serve patients and clinicians in new use cases, and helping to implement the standard of care for the new disease as knowledge evolved.
### SUMMIT PARTICIPANTS

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### CONVENER

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**Moderator**: Jeffrey Rose, MD

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Informatics at the Core of the Pandemic Response

Never has the flow of information and staying current with practice expectations been so important as in the hospital response to the onslaught of COVID-19 cases beginning in the first quarter of 2020. Everyone at every hospital suddenly had to work in a new way, with clinicians caring for patients remotely, facility-based clinicians following new safety protocols and everyone adapting to new standards of care for treating a novel disease. Mobilizing and adapting quickly was only possible because of the digital infrastructure in place across the country, and skilled leadership in maximizing these channels and building solutions for new needs and use cases. A mature informatics function and skilled leadership proved indispensable to responding to the COVID crisis. Chief Medical Informatics Officers (CMIOs) across the United States hold a central position in propelling healthcare forward to address a new widespread disease, care for ongoing patient needs and help the hospital workforce do their work in a new way.

The CMIO role elevated in the crisis response. “During COVID, we were able to get informatics in a central seat in our command center which they continue to occupy,” said Ranjit Aiyagari, MD, CMIO & professor, Michigan Medicine. The urgent and even existential demands of the pandemic illuminated the strategic value of informatics. “It did allow health informatics in our organization to be highlighted and be brought to the table,” said Bina Desai, MD, CMIO, Loyola Medicine. “We were a part of incident command; we were part of all of these rapid movements and changes within the organization.”

Lessons Learned from Crisis Management

Tom Moran, MD, VP & Chief Medical Information Executive, Northwestern Medicine, hosted a discussion on what Northwestern Medicine learned from their response to the COVID-19 crisis. He and others in the group attributed their success of execution during the crisis to the unprecedented clarity of focus across the organization. “Prior to the crisis we had many initiatives, each with its individual focus, but all of a sudden the crisis made us get real clarity on what we are trying to solve for. We pivoted as a system to go from many key initiatives to one, and the one was: We’re going to solve for COVID-19, for the health system.” With this focus, the health system was able to develop intentional work groups, information hubs and playbooks to support the various clinical workstreams. As changes rolled out, Moran and his team guided Northwestern Medicine
to incorporate the new practices for the long term, whether as a more efficient or effective process or as a crisis-response playbook should it be needed in the future. “The crisis of COVID made us look at the ways that we already have built the system and optimize them. We also stopped labeling items as ‘COVID’ because we saw the benefit of adopting the new way of doing certain things.”

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Some of the practices started during the crisis that will continue into the future include: streamlined training, Disaster Operations Mode in system tools, advanced automation with predictive dashboards for resource needs, telehealth and virtual care, and remote monitoring—whether the patient is at home or in the facility, to reduce exposure risk for nurses.

**SPEED TO IMPLEMENTATION**

Programming timelines dropped from weeks or months to days or even hours. David Ting, MD, CMIO, Mass General Physicians Organization, noted, “We saw a rapid change in turnaround times, from what used to take months to develop, now takes 10 days or sometimes hours to develop.” Alan Weiss, MD, CMIO & VP, BayCare Health System, said, “Part of the agility was that we streamlined some of the decision-making governance aspects.” He cautioned against an expectation that all projects could be completed at the same pace: “It is not sustainable in the long run because our teams are burnt out. There is a lot of pleasure in knowing what you did had a huge impact, but the teams now have been working 12-to-14-hour days, for most of the past six months.”

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PERFECTIONISM AND THE CULTURE OF GRACE

Agility was also possible because perfection was not the goal. “Our people realized that it’s okay to be good instead of being perfect,” said Moran, and that system changes were more readily accepted. The group agreed that idealized perfectionism often extends project timelines, and that a balance must be struck.

They also acknowledged the abundance of grace that their colleagues bestowed during the crisis. “With COVID, there was abundant grace...we just had to be good, it does not have to be perfect,” said Brett Oliver, MD, CMIO, Baptist Health. The changes made were adopted and met with gratitude.

“A component of that grace was also that there was more self-ownership by our clinicians to be consuming the communication that was coming out from the organization, with respect to the changes,” said Shannon Dean, MD, CMIO & Associate Professor of Pediatrics, UW Health. She explained that, like physicians generally, many CMIOs expect to be spoon-fed communication. “I think a lot of our physicians now recognize the need to be more active in their own absorption of the communication that is coming, and take it upon themselves to learn the information and understand the change.” Others observed this culture change as well. “We definitely had a tremendous increase in physician engagement and reading emails, looking for changes, responding promptly as we were developing order sets and clinical decision support in ways that we had not seen prior,” said Julie Hollberg, MD, CMIO, Emory Healthcare. This engagement has started to decline, and the group seeks to promote the shared responsibility of communication in the culture.

The power of unified organizational focus has been proven and is a worthy goal for a health system’s leadership to renew and sustain post-crisis. “It shouldn’t take a pandemic to cause that to happen, but it did,” said Will Holland, MD, VP Care Management & CMIO, Banner Health. “I think if there’s a takeaway for me it’s how do I help simplify what is strategically important for the organization down to the things that uniquely make us different, and then align my informatics teams, my quality teams, my safety teams, around driving that particular objective.”
Top 10 Lessons Learned from COVID-19

With the second confirmed case of COVID in the United States on January 23 and Chicagoland being an early hotbed, AMITA Health saw the whirlwind of the pandemic earlier than many. Bonny Chen, MD, VP & CHIO, AMITA Health identified the top 10 lessons learned in the journey so far.

1. IT can move fast. IT has traditionally been known to move at a slower pace due to its traditional “build requirements” and governance. “It was really refreshing to see we could make changes so quickly in such a relatively short period of time.”

2. Collaboration is key. With the volume of changes and rapid pace of changing needs, Chen started scheduling meetings between IT and informatics leadership multiple times a week and has continued this practice.

3. Be ready to pivot. “The name of the virus changed, the travel screening seemed like it was changing daily, the orders and types of labs that you could place for COVID were changing constantly, and the best-practice evidence was constantly changing.” Her team needed to be ready to keep moving and not be trapped by previous modifications.

4. Three EHRs are two too many. Jointly owned by Ascension and AdventHealth, AMITA Health’s structure and heritage gave them three EHRs to manage across various sites that in some instances are locally controlled. “It was complicated to coordinate changes needed for AMITA with those needed across AdventHealth, Cerner more broadly at dozens of hospitals, and with the local Ascension Epic and MEDITECH instances,” Chen said.

5. Get creative. Chen’s 45-person health informatics team had to get creative about training and support quickly when they began working remotely. They experimented with a variety of applications and approaches to support physicians and nurses and activities such as rounding. “We were able to train our new batch of residents that came in, even those who lived outside of the country.”

6. Perfection is the enemy of good. Chen observed, similar to Moran, that “when you have to move as quickly as you can, you just don’t have time to be perfect.” The urgency to roll out solutions and make programs available, and the need to pivot constantly required a discipline to get the work done emphasizing timeliness over perfection.

7. Communicate often and well. Weekly touch-base meetings with the team became crucial as people began working from different locations. “When you pull back your teams and you don’t see people, people start to fill in the blanks,” Chen explained. “Their minds can go wild if their sole source of information is media coverage. We made sure they heard things directly from us, and that everything else was a rumor until it was confirmed.”

8. Borrow, leverage and learn. With Ascension and AdventHealth as parent organizations, a variety of EHRs in use and colleagues across the country rapidly innovating to meet the challenges of the pandemic, building upon others’ work is a good way to make more rapid progress locally and to advance the science of COVID-19 care nationally. “In the end, the patient is the winner when you do this,” said Chen.

9. Find your own Zen. COVID has demanded a response beyond what could have been imagined, with everyone running at full capacity and working long hours. Chen emphasized the importance of taking time for oneself to restore and recharge. “COVID really pushed you and everybody else to the limits,” said Chen. “Whether it was to pick up baking or gardening, taking walks outside or spending time with your kids, you had to find something to maintain your sanity.”

10. Help where you can. The pandemic’s demands also showed how willing people were to chip in to cover responsibilities for those who were out or under quarantine, or for new needs that arose. Chen collaborated with a colleague in the Czech Republic who had a 3D-printer template for face shields, and she helped coordinate with Northern Illinois libraries and school districts to make more than 1,000 face shields for frontline workers. “It was just really heartwarming to see how everybody really wanted to help their colleagues and help the community,” she said. “The community was also really interested in making sure that they could support the healthcare workers in any way they could. So that was something that was really nice to see as well.”
Transforming the Way We Work

Weiss led a discussion of perspectives on how work has changed with remote teams, reflecting on major decisions made in the COVID response and the need to navigate cost pressures.

CULTURE OF REMOTE WORK

Weiss found success in setting clear expectations for availability and responsiveness when his team transitioned to remote work, and his team is even more productive than before. “The turnaround time has improved, so we are getting more work done as a result of setting these expectations and letting people work from home.” Other organizations such as Texas Health Resources were accustomed to working remotely prior to the pandemic. “The one challenge that this increased movement toward virtual interactions introduced is that it has made it more difficult for our informatics staff to spend time in the clinical setting,” said Ferdinand (Ferdie) Velasco, MD, CHIO, Texas Health Resources. “Our system is truly limiting the availability of staff who are not providing direct patient care in the clinical setting. We still have a lot of virtual interactions with the clinical staff we support, but obviously it is not the same as meeting them on the floors and seeing them use the system while taking care of patients.”

DECISION-MAKING UNDER PRESSURE

While many health systems succeeded across the board in their COVID-driven rapid response initiatives, not all decisions ended up delivering intended value. Weiss and the group acknowledged some COVID-response initiatives consumed significant time and resources but yielded little or no benefit. For example, creating a dashboard to monitor internet search terms of symptoms in hopes of predicting a local outbreak, refurbishing a vacant hotel for COVID patient convalescence and reaching operational adequacy after the surge subsided, or attempting to stand up a skilled nursing facility and dealing with the sea change of regulatory and documentation requirements associated with that venue. Participants considered how they might respond in the future.

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future to similar initiatives that affect the informatics workflow and documentation but judged as unable to deliver a net benefit that justified the effort, even though other leaders in their organizations might favor them. He also observed that production levels in crisis mode cannot be sustained long term. “Pushing back is something we have to start doing because the resources we have are just so limited,” said Weiss.

**COST PRESSURES**

Given the economic pressures triggered by COVID such as staff furloughs and cutbacks, no department has been immune to financial scrutiny. “I think one of the struggles we are having is that, although the role of health informatics is more valued in our organization, from a perspective of being involved earlier in many conversations trying to drive changes in the organization, we are finding that we are left with fewer resources and more work,” said Bina Desai. Helping the organization understand the value of the informatics teams is essential so that the true return on investment can be considered by the resource decision makers. “I was able to negotiate having the informatics team physicians and staff to help with the reporting and the training,” said Babatope Fatuyi, MD, CMIO – UT Houston, University of Texas System. “And, of course, help with other aspects of research because we are part of about six schools out here.”

Financial considerations are at the forefront of most conversations at health systems across the country, which are facing difficult resource decisions. “Keep that in mind when decisions in our departments are made that might not be quite to our liking, that the folks making them are usually working with our best intentions and the organization’s best intentions in mind,” said Michael Shabot, MD, former EVP & Chief Clinical Officer, Memorial Hermann Health System. “Some of our activities—and even FTEs—may fall by the wayside, but the decisions still have to be made.”

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Prior to the pandemic, one of the major issues in healthcare was clinician burnout. Topher Sharp, MD, Clinical Professor of Medicine, Stanford Medicine, led a discussion on how to help nurture caregiver wellness under prolonged duress, the prevailing context for clinicians months into the pandemic. He described the Stanford strategy of support and wellness, digital adaptation and innovation in adverse times.

SUPPORT AND WELLNESS

The COVID crisis has altered the dynamic between CMIOs and their clinician users, who prior to the crisis expressed significant frustration with the EHR and other workflow technologies, then during the crisis expressed appreciation and gratitude for the technology because it enabled them to continue seeing patients. As Jeffrey Sunshine, MD, PhD, CMIO, University Hospitals, described: “We are not the enemies anymore—we are the facilitators. That’s a dramatic change!”

Sharp emphasized the continued need to “check the temperature” of the organization. With hallway conversations more scarce, the Stanford team very quickly offered a series of listening sessions so that clinicians could share what is working and what is a struggle. In these sessions, they were able to identify pervasive pain points that had relatively easy solutions, such as optimizing the home-office setup with better equipment. They started issuing all-in-one integrated monitors instead of laptops to improve clinicians’ ergonomics and camera angle with an elevated display. They shared other best practices for remote work, such as having a private space and a desk.

In their workflow adaptations, they sought to preserve as much clinician freedom as possible. “Preserving control and flexibility is a critical element of wellness,” said Sharp. “When you take that away, it absolutely impairs the environment and culture.” With the opportunity to offer remote work, they gave clinicians the option to work from home while scheduling wherever they wanted to work at other times. They also provided flexibility to choose their home-workspace.
setup. Instead of centralizing the purchasing of peripheral equipment, they allowed clinicians a dollar cap and a list of pre-approved hardware selections they could purchase directly and have shipped promptly to their home.

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**DIGITAL ADAPTATION**

Sharp and team recognized the need to help physicians interact digitally instead of in person. “The virtualization of healthcare delivery is so critical, but so is the virtualization of collaboration and the workplaces we’re experiencing today.” They helped others learn new etiquette such as how to use chat, invite others to participate, whether and when to turn cameras on and why the visual connection is valuable. Doing so promoted engagement and wellness and helped the organization bridge the divide between those who were working at home and those still working onsite at facilities.

**INNOVATION IN ADVERSE TIMES**

As COVID struck, many organizations experienced a breakdown in communications and needed to navigate new ways to communicate. “COVID broke our internal communications mechanisms because the emails just started flying,” said Sharp. “The departmental or enterprise communications started walking on top of each other. It was very difficult for our organization to even know what the next change was and changes were happening constantly.” They put more rigor into the communications and stood up new channels to ensure information was cascading effectively.

Clinical innovations were also necessary, as physicians recognized they needed to design a new way to examine a patient over video. They worked together to design physician-directed patient self-exams, created a set of standards for evaluating patients, then aligned them with standard documentation tools and training videos.

The crisis also created an opportunity for physicians to develop a new advocacy voice. Many physicians began raising concerns about health equity and the need for many patients to access the digital resources required for telehealth.
The CMIOs discussed other observations about digital adaptation such as an apparent reduction in the number of follow-up tests, labs or referrals in telehealth visits. “There are some big questions around whether quality of care actually is improved,” said Sharp. “I don’t know that more test ordering—simply because the patient happened to be there in person—is better. I know it can be better for revenue, but I don’t know if it’s actually better for our patients.”

James Douglas, DO, Regional MIO, Mid Maine Region, Northern Light Health, commented on the improved patient satisfaction scores that many organizations saw with telehealth visits. “A lot of people were afraid. They didn’t want to go into an office. They didn’t want to leave their homes. And just the ability for a provider to reach out and talk to them, to call them on the phone, to get them on Zoom, they were thrilled and thought, ‘You still care about me.’ That was huge. I think that part of those satisfaction scores reflect that this was part of maintaining our doctor patient-relationship.”

Forging New Relationships

The COVID pandemic has exponentially accelerated the drive for innovation and transformation of healthcare. “What COVID has done is really helped us understand a fundamental question: How do we leverage our current solutions and our systems? And more importantly, how do we change?” said Nick Desai, MD, CMIO, Houston Methodist, who led a discussion about partnerships for innovation. At his Center for Innovation, he offers a simulation lab for partners to help design the synchronous experience of healthcare for the patient. Examples of his design and innovation collaborations include WELL for frictionless texting, CARE AI for temperature scanning of employees, Vidyo for the video platform of the virtual ICU, and Amazon and Parveida for conversation-driven visit documentation. “Every one of these companies needs organizations like ours to work with their proof of concept and push out new models. It was bringing together these people who likely would not talk to each other, figuring out how to synchronize information, and that collaboration came as a result of COVID,” said Nick Desai. “So as we think of bridging the new frontier, we think about leveraging the crisis to figure out how to do something different.”

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The need for rapid and transformative innovation must be coupled with the discipline of sunsetting initiatives that do not deliver. “Everybody says, and it is almost cliché to say ‘fail fast,’ but it is important to know when the concept has failed,” said Craig Norquist, MD, CMIO, HonorHealth. Holland reinforced the importance of identifying the key decision-maker and defining the criteria for measuring a project’s success, both of which were challenged in the crisis environment. “Some of this discipline went out the window when COVID came about, because of the speed with which things were happening. It was, frankly, at times easier to figure out who the decision-maker was than to figure out the rubric by which we were going to make a decision. We are re-instilling the approach of clarifying who has decision rights around whether something continues or stops, and the related metrics for making that decision.”

The group recognized that the informatics response to the pandemic crisis was successful due to new ways of working and communicating, through acceptance of different standards of success under pressure, and because of new partnerships and responsibilities. Tolerance, perseverance, empathy, abandonment of bureaucracy, acceptance of disruptive processes, adaptation to change and openness to new ideas under pressure all typified success with the integration of technology in care delivery. “The central role of clinical informatics in rising to the COVID challenge was unquestionable,” said moderator Jeffrey Rose, MD, from Hearst Health. “Without the computerized health record systems and supportive technology informaticists have spent years arduously developing, it would have been truly impossible to meet the unprecedented public health challenge COVID-19 presented.”
Embracing the Future of Healthcare

Care has changed forever because of COVID. Telehealth and virtual care will continue to grow in use and become increasingly sophisticated. The crisis has been a unique moment in healthcare’s recent history to align focus and force transformation.

Said Brian Young, MD, Enterprise Physician Informaticist, CommonSpirit Health: “COVID—at least in the short term—is an almost magical, one-size-fits-all use case to rule all use cases. The pandemic really shook and rattled the sleepy, hibernating beast of how healthcare has traditionally been done as fee-for-service, or what I’d call ‘friction-as-a-service’... The shock to the system really made me wake up and bust through some obstructive barrier doors in my brain, and patterns of thinking, about how we conduct healthcare and, essentially, wellness.”

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