A Meeting of the Minds: Integrating the Best of Medical Informatics

SCOTTSDALE INSTITUTE 2021 CLINICAL INFORMATICS SUMMIT

November 15-16, 2021
Executive Summary

About 175 years ago, physician Ignaz Semmelweis began to consider a question that likely was considered ridiculously forward for its time: *What can we do to decrease maternal and infant mortality?* His probing yielded a profoundly simple answer: *Wash up first.* While few paid attention to his admonitions to clean their hands and tools before working with patients, after his death his wisdom gained greater acceptance, as Louis Pasteur confirmed the theory of germs and Joseph Lister incorporated more hygienic practices to great success.

As always, today’s questions yield tomorrow’s answers—some simple and some profoundly life- and system-changing. To kick off Scottsdale Institute’s (SI’s) 2021 Clinical Informatics Summit, moderator Dr. Nicholas Desai, CMIO, Houston Methodist, lobbed a few “easy, breezy” questions to the professionals gathered:

- How will healthcare be delivered in 2025?
- Where are we today and what’s changed about what we are doing?
- What does innovation look like?
- Are SI Members inventing internally? Disrupting externally?
- Will non-traditional partners become friends or foes?
- Are our EMR partners playing well or not?
- What will the ecosystem look like? What’s accelerated… and what’s decelerated?

If only the answers were as clear as *wash up first*; these are the questions keeping SI Members awake at night and, in our “peri-pandemic” world, there are many COVID-related challenges that linger. Toward this end, the Summit invited sharing, learning, comparing and reimagining around:

- Health in a digital world,
- The future of informatics and key organizational roles,
- The enhanced consumer experience,
- Strengthening clinical decision-making 2.0, and
- The public health imperative.

Without a doubt, digital is the future of healthcare, and Summit discussion hosts are proposing the tough questions and concerns we all share about how to get there from here—intuitively, efficiently, effectively—to permanently and positively change the health systems of tomorrow.
SUMMIT PARTICIPANTS

Lea Ann Arnold, DNP, MS, RN, Director of Nursing Informatics, Northwestern Medicine
Jason Atkins, MBI, BSN, RN-BC, Nursing Quality Officer, Emory Healthcare
Gretchen Brown, MSN, RN, NEA-BC, Associate Chief Nursing Informatics Officer, Stanford Medicine
Andrew Burchett, DO, CMIO, Avera Health
Bonny Chen, MD, MBA, FACEP, CPHMIS, VP & CHIO, AMITA Health, Regional CMIO, AdventHealth
Nick Desai, DPM, MBA, CMO/CQO, Houston Methodist Sugar Land & System CMIO, Houston Methodist
James Douglas, DO, Regional MIO, Southern and Mid-Maine Region, Northern Light Health
Joseph Evans, MD, CMIO/VP Clinical Informatics, Sentara
Jennifer Fogel, RN-BC, BSN, MSN, VP, Regional Nursing Informatics Officer, Northern Light Health
Seraphine Kapsandoy, PhD, RN, Chief Clinical Information Officer & AVP, Intermountain Healthcare
Tamera Larsen-Engelkes, MSN, RN, NE-BC, Clinical Information Officer, Avera Health
Gabrielle Pina, DO, FAAP, Dir. Quality Improvement & Advocacy for the Primary Care Track of Loma Linda Pediatrics, Co-Lead of DIME (Diversify, Include, Mentor, Educate), Loma Linda University Health
Eric Poon, MD, CHIO, Duke University Health System (Guest)
Michael Ross, MD, FAAP, FACMI, Regional MIO, Northern Light Health
Ann Shepard, RN-BC, MSN, SVP & CNIO, CommonSpirit Health
Hardeep Singh, MD, MPH, Chief, Health Policy, Quality & Informatics, Center for Innovations in Quality, Effectiveness and Safety, Michael E. DeBakey VA Medical Center and Baylor College of Medicine

Donna Wellbaum, RN-BC, MSN, Nurse Informaticist, UCLA Health
David Wetherhold, MD, CMIO – Ambulatory Systems, Scripps Health
Nancy Yates, MS, RN, RN-BC, CNIO, Centura Health

CONVENER

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Luis Saldana, MD, MBA, FACEP, VP, Clinical Strategy, Zynx Health; Jeffrey Rose, MD, SVP Clinical Strategy, Hearst Health

Summit Member Moderator:
Nicholas Desai, DPM, MBA, CMO/CQO, Houston Methodist Sugar Land & System CMIO, Houston Methodist

Writer: Karen Sjoblom
Introduction

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Health in a Digital World

Discussion host David Wetherhold, MD, Scripps CMIO-Ambulatory Systems, began by asking attendees to consider the current (albeit sad) scenario about where and how physicians are allowed to practice telehealth care. Only half-joking about being pulled over after driving across state lines (‘I’m sorry—your driver’s license is only good in California’), his point was poignant: He has patients traveling across state lines—patients he’s known for some 20 years—but if he treats them while they are outside of California, he becomes a criminal. ‘How are we supposed to say, ‘Find someone local, someone who doesn’t know anything about your history’? We’re basically forcing the patient to lie to get their care. One was telling me, ‘I’m at home in California’ and I could see snow coming down in the background!’

This launched a deeper-dive conversation about how member health systems were scaling this shift to virtual care, including training of virtualist clinicians, supporting patients technically and structuring the virtual care team and their infrastructure support.

When we went live with our telehealth offerings, we had a model that walk-in clinics offered both on-demand video and asynchronous visits. People almost always picked the person in front of them. But we’re trying to move to a virtual system with ‘virtualists’—both for telehealth and asynchronous e-visits—where that’s all they do. Our patients also love e-visits (not video, but e-communications); those are chargeable events that go very quickly and easily for simple problems. It’s convenient for both sides.

-David Wetherhold, MD, Scripps
Desai then queried Members about understanding their patients’ preferences and the drivers of influence for seeking in-person vs. virtual care (access, economics, reputation, payors), and whether the three Cs (cost, convenience, care) are still important to consumers. Per a recent Huron Healthcare Economics Study Comparison, much change has transpired (graphic, below).

### Lets drill into what they* said...

**Have behaviors & attitudes changed? Are we different?**

<table>
<thead>
<tr>
<th>What changed?</th>
<th>What stayed the same?</th>
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<tbody>
<tr>
<td>50% of US respondents consume healthcare differently (as reflected with cancelling, postponing or leveraging alternative means of care)</td>
<td>Consumers desire healthcare to resemble “retail or hospitality” experience</td>
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<td>Telehealth has gone mainstream • 60% participated in a TH visit in 2020 • 72% were satisfied with a digital visit</td>
<td>Preference for single point of contact for health information needs</td>
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<td>Providers can drive loyalty • 60% would switch providers for more trust and respect, as these are more valued than any other factor (e.g., location, cost, etc.)</td>
<td>R&amp;R matters: referrals &amp; recommendations noted to be #1 reason for provider selection • 75% of consumers are satisfied with care they receive but 50% of those are willing to switch for experience</td>
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<td>There’s a growing acceptance of virtual care as a primary care option in lieu of or supplemental to in-person care</td>
<td>Cost matters: 72% of respondents noted knowing the cost of a healthcare visit or treatment is important to their healthcare decision</td>
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<td>Patients have shifted to become more digitally inclined</td>
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*Huron healthcare economics study comparison 2019 and 2021

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### SECOND OPINIONS

Our e-program was the biggest in the world but not profitable. Every provider has to be licensed in every state and every facility. They’re in 40 states, with over 200 docs! I can’t be credentialed in every facility, so we need to get past the administration of all of it.

—Andrew Burchett, DO, CMIO, Avera Health

We know we’re looking at a nationwide crisis for our nursing staffing. I’m intrigued to talk more around what virtual nursing looks like in the acute care environment. Part of it is the logistics of setting up systems so nurses could be virtualized... caring for 18 patients virtually while leaving the hands-on care to bedside nurses. Also, we need to be forward-thinking: If I’m a nurse who lives in Missouri but is remoting into Minnesota, what does that licensure look like?

—Tamera Larsen-Engelkes, MSN, RN, NE-BC, Clinical Information Officer, Avera Health

We haven’t discussed how to do new care models. We’re trying to do “Anticipatory Care” right now, but how do we not dump all of this on our clinical nurses? There’s not only a nursing shortage, but techs and others, too. not to mention we still have to have nurses available to do hi-touch, hands-on work.

—Jason Atkins, MBI, BSN, RN-BC, Nursing Quality Officer, Emory Healthcare

We’re on the same journey—digital front door and growth strategy—but are we preparing our clinicians to operate like this? How do we capture quality as we go into the virtual/digital world? We are building our platform to be EHR agnostic. We need to design holistically to include both the clinician and patient experience. We were so focused on the patient consumer side that we missed some critical pieces on the clinical EHR side resulting in unintentional consequences and extra work. In addition to patient experience, we also have to think about the experience of our providers and clinicians in that digital space.

—Seraphine Kapsandoy, PhD, RN, Chief Clinical Information Officer & AVP, Intermountain Healthcare
“Overall, consumers are demanding new ways to access help, seek proactive approaches to their care and evolve their preferences from year to year,” Desai commented. ‘Providers can drive loyalty differently; if you give your patients the right ‘formula’ or ‘recipe,’ they might change their loyalties. They’re willing to switch doctors…and their trust goes to that new person, too.”

Further, Desai outlined five main types of healthcare consumers:

- **Me-focused**, who choose healthcare based on trust, respect, personal attention and convenience;
- **Results-focused**, who look to achieve positive results without regard to cost;
- **Affordable/Results-driven**, who are like the above but more sensitive to cost;
- **Digitally inclined**, who seek digital tools and have a strong affinity toward a personalized, end-to-end experience; and
- **Time- and money-oriented**, who are mostly concerned about cost and who also hate to wait.

“The largest growth segment since 2019 is for the digitally inclined, so the key takeaway is this. We need to shift our thinking. It’s not just about financial or clinical information. To develop a consumer mindset, we must not only understand demographics and disease-specific segmentation, but also values, attitudes and preferences,” Desai noted. ’There’s been a shift to a consumer mentality, besides disease conditions, etc., so we have to be intentional. They’re saying, ‘I can have access to my doctor however I want, whenever I want.’ That changes what we think about brick-and-mortar locales.”

**Future of Informatics: How Will Organizational Roles Evolve?**

“This is like going back to fourth grade and answering what we wanted to be when we grew up,” said Duke Health’s **Eric Poon, MD, MPH, FACMI, CHIO**. “Those leading change have to have courage in their decision-making while also managing risks and benefits. How have you all done things a little atypically the past few years? There are new roles emerging, and partnerships and collaborations, but how can we also ensure accountability for our outcomes?”

Poon asked participants some key questions around changing organizational roles and how participants’ skillsets will play a key part.

- How dependent are you on your skillset to do things differently, and are you a good marketer of the same?
- What are some new ways to partner with others both inside and outside of your organization?
- What new experiences are you seeking out, and what do you want to do when you grow up?

In this open discussion, Members’ responses revealed the wisdom they’ve gathered—and are willing to share—from years of experiences, changes, failures, initiatives and risks taken.
ON SKILLSETS

It is critical for executive leaders to understand that clinical informatics is a key partner in the delivery of high quality, safe patient care and should be included as a core team member of quality initiatives. This acknowledgement ensures that the technology solution needed to implement or support change is possible, prevents unnecessary delays, and minimizes the potential for IS or informatics to be seen as barriers. While some leaders recognize the value, there is still opportunity for change.

–Jennifer Fogel, RN-BC, BSN, MSN, VP, Regional Nursing Informatics Officer, Northern Light Health

We have to position ourselves as strategic partners, to be at the table. At Intermountain, the consumer experiences team doesn’t report up through the informatics team, so it becomes imperative that we form strong strategic partnerships and collaboration between our teams. We make deliberate efforts to offer them our expertise. Often we have to come in late in the process versus sooner. We’re not just about the EMR; we expose the skillsets at the table, bring them together, define the value of projects and show ROIs.

–Seraphine Kapsandoy, PhD, RN, Chief Clinical Information Officer & AVP, Intermountain Healthcare

So much of informatics is leadership and change management, and you have to experience it. If you’re just coming out of a fellowship, you won’t necessarily have gained this experience yet. I have had an opportunity to serve in several different roles before I became a CMIO. I’ve been able to have more influence because my senior leadership realizes I bring value. When leadership brings you to the table, that’s where you have an opportunity to influence change…but it might not happen until people realize the value you bring.

–Bonny Chen, MD, MBA, FACEP, CPHIMS, VP & CHIO, AMITA Health; Regional CMIO, AdventHealth

One of my key skills is to manage up. If not, there will be roadblocks, steps missed, etc. As a merged company, we’re two years in and probably have another good five before things are smooth. I knew our strategy person from before; our new person does things completely differently. Same thing with IT leaders: Our current CIO is very good, but there are about a dozen offshoots within the IT world that are being led by technicians who don’t ask our clinicians first for a sniff test.

–Ann Shepard, RN-BC, MSN, SVP & CNIO, CommonSpirit Health

ON PARTNERSHIPS

A newer partnership that has become very important is with Compliance and Legal. Before, if I didn’t have to interact with them I felt I was doing great but, over time, I’ve come to see that having their support is very good. They’re our partners.

–David Wetherhold, MD, CMIO – Ambulatory Systems, Scripps Health

Our relationships are critical: Sometimes we step into things that maybe aren’t in our paths but we do it to build those connections. We’ve made it a practice when the Joint Commission shows, we’re there. During COVID, we looked at our ventilators via cameras…and that came from lots of work with our vendors. At Northwestern Medicine, they’re wanting to have an informaticist on every Joint Commission review team this year because they’re starting to see the advantage of these relationships.

–Lea Ann Arnold, DNP, MS, RN, Director of Nursing Informatics, Northwestern Medicine

Jennifer Fogel, RN-BC, BSN, MSN, VP, Regional Nursing Informatics Officer, Northern Light Health
If you look at our org chart, there are dotted lines everywhere. For example, the CNIO jointly reports to me and our system CNO. The system CNO has my back and she knows I have hers. Also, over the last few years we’ve introduced an informatics/IT “buddy” for every leader in the organization—key leaders always can reach out to someone from our IT/informatics team for anything. –Eric Poon, MD, CHIO, Duke University Health System

Some of what was revealed through COVID was that our environment was too complex. We’re good at implementing but now we have to connect these strategies, and our roles and relationships will help do this. The latter, between vendors and the EHR, has been an important focus for us. –Gretchen Brown, MSN, RN, NEA-BC, Associate CNIO, Stanford Medicine

Our biggest accelerant was having a major challenge; at THR we had the first Ebola patient in the country. When you experience something like that and have to lead through it, you understand how to communicate effectively within the organization and outwardly across to others (e.g., CDC). It’s a big skill to develop important relationships. –Luis Saldana, MD, MBA, FACEP, VP, Clinical Strategy, Zynx Health

ON NEW EXPERIENCES

Digital, patient-facing endeavors have really opened up opportunities for Clinical Informatics. We’ve got tremendous opportunity to lead and support from an executive level, as well as implement this functionality in the more traditional CMIO/CNIO sense. The old paths have really opened up to new experiences via new functionality. –Michael Ross, MD, FAAP, FACMI, Regional MIO, Northern Light Health

We want to own our innovations, but what about handing them off to someone who can take them to scale well? It’s like, “I’ve birthed you—now go.” Others can break things down and play with them and find a way to make them very successful. –Nicholas Desai, DPM, MBA, CMO/CQO, Houston Methodist Sugar Land & System CMIO, Houston Methodist

We are successful at implementing complex initiatives, but are reaching a point where we are stretching our resources to continue maintaining the demand for new implementations or optimizations while also having the required resources to provide effective support to maintain our systems. –Donna Wellbaum, RN-BC, MSN, Nurse Informaticist, UCLA Health

COVID has been a painful time. We’ve gone to war. We had to turn things around in three months, and we came together but it took long hours. Now, coming to the other side, part of the benefit we’re seeing is that we’ve come back from this war with similar scars, as colleagues. And this is opening up our communications: If we could do it for COVID, we can do it for other things. –James Douglas, DO, Regional MIO, Southern and Mid-Maine Region, Northern Light Health

Seraphine Kapsandoy, PhD, RN, Chief Clinical Information Officer & AVP, Intermountain Healthcare

Tamera Larsen-Engelkes, MSN, RN, NE-BC, Clinical Information Officer, Avera Health

Gabrielle Pina, DO, FAAP, Dir., Quality Improvement & Advocacy for the Primary Care Track of Loma Linda Pediatrics, Co-Lead of DIME (Diversify, Include, Mentor, Educate), Loma Linda University Health
Enhanced Consumer Experience

“2020 and 2021 have been two of the longest years. I have to admit, at first, I didn’t think COVID was going to be a big deal but then in January 2020, AMITA admitted the second COVID case in the U.S., followed by the first case of human-to-human transmission,” recalled Bonny Chen, MD, MBA, FACEP, CPHIMS, VP & CHIO, AMITA Health, and Regional CMIO, AdventHealth. “Life didn’t only change for us but also for our patients in how, whether and when to seek care. Then in May 2020, the ONC released the CURES Act final rule. Just as in our ‘new normals’ with FaceTime, masking, e-learning and Zoom, we saw the same thing in healthcare with video visits, remote monitoring, patient portals and online scheduling. All of these now are becoming even more the norm.”

Chen explained that AMITA is a joint operation between Ascension and AdventHealth with 19 hospitals in the greater Chicagoland area. With plans to dissolve back into two separate entities in the next few months, the health systems have multiple EHRs, which present challenges of their own. But an opportunity exists to deliver on the AdventHealth brand promise and unlock new business growth by delivering a whole-person care experience that helps consumers achieve their life potential.

Because AdventHealth didn’t have the advantage of a single business/clinical system, they needed to create an experience that minimized complexity and maximized the patient experience. In 2018, the user experience journey began with a single consumer identity and API layers to expose needed functions. Moving toward omnichannel advocacy, with operational and technological alignment, they offered core capabilities like messaging a care team, scheduling appointments, accessing personal or family data, paying bills and having video visits. This omnichannel ecosystem has the consumer at its center, plus their care advocate, surrounded by options: Home visits and monitoring, Experience Center, web, live chat, AdventHealth locations, Hope (the chatbot), and a mobile app.

“We wanted to make it easy for the consumer, with two models: Assigned and unassigned. You don’t have to be an AdventHealth patient, for example, to utilize the chatbot,” Chen explained. “But if you’re in the assigned model and have an AdventHealth account, you then can have an assigned Care Advocate who can help you with medication refills, questions about COVID and more.”

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<th>CARE ADVOCACY, ASSIGNED MODEL</th>
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<td>BENEFITS &amp; FEATURES</td>
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<tr>
<td>• Is introduced to Assigned Care Advocate to build trusted relationship with Consumer</td>
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<tr>
<td>• Supports any healthcare need including scheduling, refills, navigating healthcare system</td>
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<tr>
<td>• Has nurse on staff to support clinical questions</td>
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<tr>
<td>• Identifies health goals</td>
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<tr>
<td>• Accesses daily journals</td>
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<td>• Connects health tracking devices</td>
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<table>
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<th>CARE ADVOCACY, UNASSIGNED MODEL</th>
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<tr>
<td>BENEFITS &amp; FEATURES</td>
</tr>
<tr>
<td>• Has access to first available Care Advocate</td>
</tr>
<tr>
<td>• Establishes foundation of help and support for those new to AdventHealth network</td>
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<tr>
<td>• Offers single interaction only (no messaging history)</td>
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<td>• Assists with more generic logistics and routing across system</td>
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As of February 2021, AdventHealth reported 36,034 patients enrolled in Assigned Care Advocacy, with 444 providers and 39 assigned Care Advocates tackling 205,000 messages and averaging 8.47 minutes for Care Advocate response time. Concurrently, Unassigned Care Advocacy experienced 14,312 chats (with 14,193 resolved), a 99.8 percent connection rate and an 11.58-minute average chat duration.

"Portal messaging experienced a 33 percent drop for those working with care advocates, along with 2.8 times increased telehealth visits and a 31 percent drop in no-show rates (see above)," Chen recapped. "We’re finding there are many benefits that come from having such a ‘trusted friend’ on a consumer’s health journey."

"We found that only one percent of our patients were able to do online scheduling. This is a huge barrier, mostly due to providers not wanting to open their schedules and have patients schedule themselves. So we’re starting from square one, with all the duplication of answering the same questions and requiring resources to take all those phone calls."

—Nancy Yates, MS, RN, RN-BC, CNIO, Centura Health

"Our digital front door brings everything to one place. Symptom checker, find a doc—you’ll get one unique experience that’s digital. Nurse recruiting always starts with a bot. You’ll never know you’re not talking with a human because there is always a synchronous warm transfer to a human. It’s about the experience: Connectivity, information and even entertainment."

—Nicholas Desai, DPM, MBA, CMO/CQO, Houston Methodist Sugar Land & System CMIO, Houston Methodist
Strengthening Clinical Decision-Making 2.0

In the spirit of innovation and information-sharing, SI then asked three Member experts to detail projects they’re undertaking to strengthen and augment decision-making on various facets of care. Sparking ideas and spurring on possibilities, here are their experiences.

AMBULATORY PRIMARY CARE CLINICAL DECISION SUPPORT
Michael Ross, MD, FAAP, FACMI, Regional MIO, Northern Light Health

“Being in Maine makes Northern Light Health (NLH) diverse, as we have a lot of space to cover for a relatively small population. But it also makes us innovative, with the installation of a single EHR platform (Cerner), a single ERP platform (Infor Cloudsuite), a master facility plan and an operational improvement program,” Ross outlined.

Within Cerner, there are many different ways to review patient-pending studies, such as if a colonoscopy is pending/due, overdue or not due. Most of these require a deeper investigation to confirm whether EMR content and pathology results are available to meet the necessary timeframe for completion and other recommendation satisfiers, which could be clinical (visible, done by clinical staff) or clerical or automatic (invisible, done by clerical staff), as shown below.
“The biggest pain point within EMRs is trying to find that information. For example, a patient could refuse the procedure, go somewhere else, not show up or have the results documented in a legacy system,” Ross says. “It can get really complicated very quickly so our Clinical team has to work together: MAs, clerical, physicians, etc. Otherwise, if somebody scans something in the wrong area or hits the wrong button, you have the potential to miss colon cancer.”

Their perseverance has paid off, though, as Ross reports the NLH team has strong governance, educational resources, provider engagement, excellent IS/CI resources, new tech and workflow investment, clinical support staff buy-in, clerical staff accuracy and far more benefits from undertaking this project.

**CLINICAL DECISION SUPPORT: INTERRUPTIVE ALERTS**

Joseph Evans, MD, CMIO/VP Clinical Informatics, Sentara Healthcare

Sentara Healthcare is the second largest private employer in Virginia with 28,000 team members and over 20 years on US News & World Report’s “Best Hospitals” list. But they came to a point where their clinical interruptive alert burden was getting in the way of their positive practices.

“We studied our 2020 data around Best Practice Alerts (BPAs) and found nearly 13 million issued. This translates into an average of about 18,000 hours spent annually to manage them,” detailed Joseph Evans, MD, CMIO/VP Clinical Informatics, Sentara Healthcare. “Distributed over RNs, LPNs, physicians, PAs, NPs, pharmacists and others, it was too much. And this didn’t even include another 13,000+ hours annually on DDI, dose, allergy, duplicate and alternative alerts as well.”

To streamline this process, Sentara instituted the #SaveClicks hashtag to allow users to note alert helpfulness (or lack thereof), noise levels, irrelevant warnings and more with the goal of saving clinicians time, effort and frustration. An automated weekly report provides over 40 pieces of data filed in the background, with both Epic and clinician teams working to save time. By typing “SaveClicks” in the comments, alerts are pulled into automated reports...and the results have been remarkable (see below).

**RESULTS - SAVECLICKS**

**2020 Year in Review:**

- 1,276,808 alerts/year were eliminated across Sentara for all providers
- 1,773+ hrs/year were saved (assuming 5 seconds per alert)
- 9.9 percent reduction in system-wide BPA time (17,968+ hrs spent in 2020)

**SaveClicks SharePoint Site**

- Created to allow providers to proactively give feedback, create transparency around ongoing efforts, and record progress across multiple teams

“Many of our alerts go into production silently, but we need to review them. We use these images as well to help people learn what not to do,” Evans said. “We’re getting ready to automate the comments we’ve received but, by Q3 2021, we’ve found we’ve been able to save almost 1,600 hours on clicks while also doing well on Epic benchmarking around IP and OP Interruptive BPAs with action.”
SAFER GUIDES FOR EHR SAFETY: IMPLICATIONS OF A LANDMARK NEW CENTERS FOR MEDICARE AND MEDICAITD (CMS) POLICY

Hardeep Singh, MD, MPH, Chief, Health Policy, Quality & Informatics, Baylor College of Medicine

As one of the developers of Safety Assurance Factors for EHR Resilience (SAFER) Guides, Hardeep Singh, MD, MPH, Chief, Health Policy, Quality & Informatics, Baylor College of Medicine, helped define three main domains of EHR-related patient safety: Ensuring safe EHRs, using EHRs safely and leveraging EHRs to improve safety. Focused on nine high-risk areas overall, SAFER guides are self-assessment tools for EHR-related patient safety and help better define organizational responsibility, identify areas of risk and what high priority practices should be implemented.

SECOND OPINIONS

We already have to do this for unsafe things at the hospital. Why couldn’t this be part of that? For example, at Ascension we had a patient safety process; this is just another thing we could do to help strengthen our safety systems.

-Jeffrey Rose, MD, SVP Clinical Strategy, Hearst Health

What’s the accountability of the vendor? Vendors could say, “We allow our clients to customize the program, so how could we be held responsible?”

-Michael Ross, MD, FAAP, FACMI, Regional MIO, Northern Light Health

Why isn’t there a crosswalk between these Guides and our EHRs? We already have clinicians at the table helping with workflow design and implementation; why have things not been standardized?

-Lea Ann Arnold, DNP, MS, RN, Director of Nursing Informatics, Northwestern Medicine

5 KEY STEPS to Complete the SAFER Guides Assessment

1. Identify the “SAFER Assessment Team”
   - Multidisciplinary representation
   - Become familiar with all guides

2. Identify SAFER Recommendations
   - Review EHR developer’s SAFER assessment
   - If not available, ask them to make one

3. Use Both Synchronous and Asynchronous Meeting Formats
   - Gather appropriate expertise
   - Review each SAFER recommendation

4. Document Implementation Status of SAFER Recommendations
   - Record implementation status of each recommendation
   - Identify contact most knowledgeable about recommendation
   - Gather evidence on status of each recommendation

5. Prioritize and Address Unmet SAFER Recommendations
   - Focus on recommendations partially or not implemented
   - Empower a team to begin work
"We generally recommend doing the High Priority Practices and Organizational Responsibilities guides first to determine what your organization is doing well and which practices should you implement first for areas needing help. Since 2014, SAFER Guides have been voluntary," Singh noted. "But in mid-August this year CMS made an annual SAFER Guides EHR Self-Assessment a requirement, and organizations now have to attest they've conducted such an assessment annually."

Singh reports that Epic already has a guide to address SAFER Guides, and Cerner is working on one, but since CMS may eventually conduct some type of an audit, organizations need to show evidence that an assessment was actually done. Finally, while suggesting that vendors also should do such assessments, Singh outlined the above five steps to make completion a little less daunting.

"Dr. Ekua Cobbina and I met and asked, 'What are we doing? We're supposed to be pillars in the communities, but it doesn't feel like we're doing anything,' Pina recalled. "Then we were approached by Dr. Richard Chinnock, Children’s Hospital CMO, who said he believed Loma Linda could be doing more. He recognized how our communities were hurting."

Out of pain came promise: DIME (Diversify, Include, Mentor, Educate), which is split into two groups: Patient Health Equity (DEI Taskforce) and DIME proper. "We overlap. We think of ourselves as a Venn diagram: Where the DEI Taskforce focuses on equity, DIME focuses on changing culture," Pina described. "We don’t change just the process but also people's habits. what they're doing. We know that measuring cultural competency, doing Moodles or conducting surveys doesn’t help. We're looking at literally changing the culture."

DIME’s focus areas include the following branches.

- **Diversify**: Increase Underrepresented Minorities’ (URMs’) presence and retention at Loma Linda University Children’s Health (LLUCH)
- **Include**: Establish recurring events that highlight the uniqueness present on LLUCH’s campus to spread awareness, cultivate appreciation and spark conversation
- **Mentor**: Facilitate long-lasting relationships between URM faculty members and residents/medical students while equipping both URM and non-URM faculty members with the skills to cultivate an atmosphere of acceptance
- **Educate**: Create and sustain a curriculum based on small group exploration aimed to foster relations and broaden knowledge regarding personal differences

"Diversity is always going to be the less-beaten path, with no clear points. It’s specific to each community. My community is about 50 percent Hispanic and 20 percent Black, with the remaining 30 percent a mix. But my colleagues are mostly white and Asian, which can lead to a community not feeling like this is their home," Pina explained. "Diversity is both a group effort and community effort, and allies are extremely important. We're keeping our brain trust small but chose people who are passionate about this work plus targeted allies who also feel passionate but may not know how to help or question their confidence."

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**The Public Health Imperative**

As a pediatric hospitalist, **Gabrielle Pina, DO, FAAP, Director, Quality Improvement & Advocacy for the Primary Care Track of Loma Linda Pediatrics and Co-Lead of DIME (Diversify, Include, Mentor, Educate) at Loma Linda University Health, worked in outpatient for years but got bored with doing well-child checks. With a heart for the unspoken (which is why she chose pediatrics), her first love is sick kids. Her faith is her North Star and her muse is Dr. Seuss, as she quotes The Lorax in her email signature: **Unless someone like you cares a whole lot, nothing is going to get better—it's not.**"
Currently, DIME is focused on the following initiatives:

- Institutional and community pipeline program development
- PROUD (Physicians Reading Out Loud About Diversity) channel for children’s hospital inpatients (also disseminated to all clinics under LLUCH’s umbrella)
- Qualitative research project (in conjunction with DEI) to delve into why some URMs leave Loma Linda and why some stay
- Further development of educational curriculum to be utilized at medical school and residency levels
- Robust social media presence to expand to Facebook while continuing a joint presence with the LLUCH residency page

Pina also believes there’s room for expanded outreach and strengthening how Loma Linda represents itself, stating they must be judicious in communicating but they can’t delay in responding to newsworthy events. Also, there are opportunities for virtual groups and more branches on the tree to represent the high numbers of Jewish and Muslim community members. All in all, she’s doing her part to ensure DIME’s roots run deep.

“There shouldn’t be a single person who represents DIME; DIME should represent itself,” Pina noted. “Sometimes it feels like the same six people are identified for the same things repeatedly. We need to start succession planning now to include our medical residents. I believe when you feel as though your organization is invested in your personal growth, and that you belong and are needed there, you’re more likely to stay. And the more you stay, the more good that can happen.”

We’ve always included equity, but then Loma Linda rolled out a seven-year plan to approach DEI issues. Seven years is a long time before seeing real change. At first we thought, This is awesome: Someone sees this! But also, what can we do right now to help patients?

—Gabrielle Pina, DO, FAAP

SECOND OPINIONS

Why aren’t we asking everyone from different departments to have an active DEI role? In Houston we have eight hospitals. The needs are different, but we use one strategy across them all—like they’re all equal. They’re not...so how can we better balance our efforts?

—Nicholas Desai, DPM, MBA, CMO/CQO, Houston Methodist Sugar Land & System CMIO, Houston Methodist

Changing culture takes real funding: It’s got to be baked into the mission, vision and values. At Intermountain, we now have equity as one of our fundamentals; we’ve set up a system equity steering committee to oversee equity initiatives at a system level and I am the inaugural chair. You must have executive and leadership support to move this work forward. At Intermountain we have sponsorship from the executive leadership team.

—Seraphine Kapsandoy, PhD, RN, Chief Clinical Information Officer & AVP, Intermountain Healthcare

“We stood up a DEI team several years ago and set target goals and objectives each year to align with the health system mission and values. Hospitalization is a small component of healthcare; we are on a mission to build healthy communities and form community partnerships to meet patients where they are. We are also focused on clinicians and care team members wellness and health.

—Lea Ann Arnold, DNP, MS, RN, Director of Nursing Informatics, Northwestern Medicine

David Wetherhold, MD, CMIO - Ambulatory Systems, Scripps Health

Nancy Yates, MS, RN, RN-BC, CNIO, Centura Health
Conclusion: Bringing It All Home

Affectionately referred to as the closing therapy session, the final hour of the Summit entailed asking each participant for their top three priorities as they move forward. Digital front door was a common reply, but so was the recognition that clinical staff needed to be protected and unburdened—from ill-planned technology, excessive documentation, unrealistic expectations and outdated practices. Staff efficiency, safer practices, vendor responsibility, intentional decision-making and data governance rounded out the list...but so did sharing experiences, preventing burnout and fostering joy. Opening moderator Nick Desai also closed the time together by sharing what turned out to be a prophetic writing—his own, in a note penned before the Summit began. In it, there’s plenty of wisdom to go around—for today and tomorrow—and to focus on the possibilities that await.

To my future CMIO/CNIO: Stay resilient, be intentional and remain focused yet nimble. Remember that tactical is just as important as strategic. Be a visionary and dream big; get creative, be inspirational and collaborate. Speak up: Don’t just manage but lead up. Dig deep into “consumerism” and remember that innovation is great, but don’t forget its impact to workflows, safety, quality and outcomes. Be mindful, because the people we serve will have different needs. Help drive focus with iterative governance and prioritization. Know that digital is here and EMRs won’t fix everything. Differentiate between widgets and platforms. Remember that alerts should help drive change, not irritate users. Culture matters: Our ecosystem will evolve as will our operational needs but lean on your partners and the data. Don’t forget it’s ok to say no. Communicate often, define experience and work to make efficiency a real word, but have fun and enjoy it.

Here’s to you—go transform healthcare.
#yourbiggestfan, Nicholas Desai

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