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SCOTTSDALE INSTITUTE

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Scottsdale Institute Fall Conference Summary

EXECUTIVE SUMMARY

The Third Annual Scottsdale Institute Fall Conference was held Oct. 16-17, 2003, at The University of Texas M.D. Anderson Cancer Center in Houston. Having our fall conference at a member site like M.D. Anderson has proven to be a popular strategy because 1) it provides a real-world setting for conference presentations and panels, and 2) it gives attendees an inside view of the kind of leading healthcare delivery organizations that make up Scottsdale Institute.

From that perspective, M.D. Anderson came through with flying colors. Attendees and presenters alike came away awe-struck by M.D. Anderson's first-rate facilities, professionalism of its staff and the sheer scale of its operation.

M.D. Anderson executives David Callender, MD, Executive VP and COO, and Leon Leach, Executive VP, welcomed the audience and provided an overview of M.D. Anderson, ranked the number one cancer center in the country by U.S. News and World Report. Its focus is patient-care driven research, also called translational research. M.D. Anderson's mission is to eliminate cancer in Texas, the United States and the world.

M.D. Anderson has 14,000 employees at 38 locations, each year has 518,000 outpatient visits, 19,430 inpatients and performs 360,000 diagnostic-imaging studies. It is also first in the number of grants received from the National Cancer Institute.

Amazingly, M.D. Anderson's growth plans during the next two years are to expand to 8.4 million square feet from its current 5.9 million. That will further challenge its IT environment, which today incorporates 20,000 data and 15,000 voice connections and 20,0000 desktop computers. The cancer center's IT staff number 560 and its annual IT budget amounts to $120 million.

On the first day, M.D. Anderson provided a Technology Fair featuring ClinicStation (clinical viewer), MOSAIC (EMR Nursing Documentation), Close Call Reporting System (an aviation model developed under an AHRQ grant), EMR (iKnowMed Oncology Physician Documentation), FReD (Funded Research Database), PICIS (critical care EMR), myMDAnderson.org (Patient Portal) and CORe (Research Protocol Database).

On the second day, the cancer center hosted Technology Tours covering the IT and Data Center, a Patient Care Unit and Radiation Oncology. All in all, M.D. Anderson was a perfect venue for onsite learning and the expert presentations that follow.

WELCOME NEW MEMBER

Scottsdale Institute is proud to welcome new member Norton Healthcare in Louisville, Kentucky.

Norton Healthcare, a leader in healthcare for more than a century, has more than 60 locations throughout Louisville and the surrounding area. Norton Healthcare is a non-profit network of medical services, including five adult hospitals, Kosair Children's Hospital, Norton Cancer Hospital, Norton Leatherman Spine Center and the region's leading women's programs at Norton and Norton Suburban Hospital. More than 2,000 doctors, 3,000 nurses and over 6,000 other healthcare workers and staff of Norton Healthcare collectively provide about half the medical care in the region.

Welcome Steve Williams, CEO; Kevin Wardell, President and Administrator of Norton Hospital; Marilyn Black, CIO; and the entire Norton Healthcare team.

"On the Road to CPOE: What can you do now?"

Donald Crandall, MD, VP Clinical Informatics, Trinity Health, Farmington Hills, Mich., provided an overview of Project Genesis, its ongoing clinical IS roll-out. Trinity is the nation's fourth-largest Catholic healthcare organization, with 45 hospitals, 44,0000 employees and 7,700 physicians coast to coast.

Dr. Crandall's talk highlighted how it's possible for a large healthcare delivery system to migrate incrementally toward CPOE.

Trinity is investing $200 million in Project Genesis over four years as an integrated, patient-focused system that incorporates revenue cycle and ERP components. Its guiding principles:

1. Patient-centric data across continuum;
2. Decision support at the time of decision-making;
3. Access from anywhere.

Like many leading IDNs, Trinity has been driven both by internal demands for quality and external ones like the expectations arising from the IOM and Leapfrog Group.

Phase 1 of Genesis, which was launched in May 2001, includes ADT, lab, pharmacy, transcription reports and an enterprise master patient index (EMPI). Phase 2 includes CPOE, clinical documentation, pharmacy and medical records.

Pharmacists comply

Phase 1 includes medication management components such as adverse drug event (ADE) alerts. These involve data about prescription drugs feeding into a transactional database that incorporates rules. Pharmacists can either ignore the alerts or make authorized changes. If required, the pharmacist can contact the physician.

"There's been pretty good compliance," said Dr. Crandall. The Trinity Pharmacy Council meets every two months to determine rules for the system. For the fiscal year, the organization experienced a whopping 147,000 alerts, of which 11% or 17,025 were true positives—pharmacists debate what a true positive is—physicians were contacted 11,447 times and 80% of those times they changed the order.

Dr. Crandall said it's difficult to translate how many of those changes reflected real ADEs. He said that after conducting post-implementation site visits, the consensus was very favorable. Pharmacists thought the ADE alerts were quite helpful. Firstly, the alerts created a process for stimulating implementation of other clinical pharmacy programs and secondly, they helped standardize the medication management process in the hospital.

For hospitals that already had clinical pharmacy systems, the alerts added a valuable screening process that helped streamline the workflow. "They were able to significantly improve identification and response time for specific issues," said Dr. Crandall.

Phase 1 identified issues like the real need for automatic documentation and improved specificity for clinical terms. The clinical IT team also grappled with what rules should be presented to physicians.

In Phase II, Trinity will have a more sophisticated pharmacy system that will provide much more discrete information.

Linking clinicals and financials

In terms of ADE analysis, Trinity had an extensive decision-support database, but not one for clinical events. "So, now," said Dr. Crandall, "we're going to have to extract data from the clinical system and combine it with financial information. We

can then see if Trinity ADE firings [alerts] are related to outcomes in hospitalized patients."

In a preliminary look at Phase I data, about 16% of prescriptions resulted in alerts. For that group of patients, LOS could be up to 25% higher; readmission rates 9% higher and total complications 12% higher than other patients. Trinity currently has 15 sites live on PEERS (Potential Error Reporting System) and receives 1,800 reports per month. Almost 30% are medication related; less than half that number are from falls and under 10% are customer-service related (patient or family complaints). All of the medication events are reviewed by a pharmacist; a fifth of those involved some harm to a patient; 14% were opiates, 13% anti-coagulants. Nearly half occurred when the drug was administered intravenously.

"We think the alerts have identified the population at significant risk, but we need a Phase II study to confirm that," said Dr. Crandall, adding that those patients may require case management to control the severity of their illnesses.

Trinity is continuing to refine its clinical processes using Zynx Evidence-based tools developed at Cedars Sinai. Crandall said the organization's Readiness Process workflow redesign initiative requires evidence-based rules and alerts, order sets, reports, documentation and interdisciplinary plans of care.

Links to the literature

"How do you standardize approaches to order sets?" he asked. At Trinity, a clinical rules oversight group develops principles for design and development of care sets. Using Zynx, the organization is rolling out knowledge provided in the form of clinical rules and order sets for integration into the CPOE system. The order sets were first used in paper form. Once CPOE goes live, links will be created to evidence-based medical literature.

"Our physicians love it," said Crandall of the Zynx system, which allows customization for individual hospitals.

Crandall said that Trinity has dropped the term "decision support"—because of its political baggage—in favor of "knowledge management," which headlines its strategy to integrate clinical, financial and patient administrative data and provide access in one location. The ultimate goal is to be able to push reports out to all users on user-specific "dashboards."

One goal of Project Genesis is to create an executive information system that will support benchmarking, said Crandall. In terms of lessons learned, he reiterated many of the same lessons executives have enumerated for years but which bear repeating:

1. Ensure strong CEO and senior management support;
2. Develop an integrated approach across planning, process review, training and communication;
3. Seek committed support and leadership from formal and informal medical leadership;
4. Encourage local ownership (via communication strategies like posters, etc.);
5. Commit to teamwork across the organization (blur the lines);
6. Start early with readiness; maintain a sense of urgency;
7. Offer a personalized and customized approach to physician engagement;
8. Emphasize the role of the manager in leading the department through the transition;
9. Train users in real-life patient scenarios (The sooner you get super-users in place, the better.);

Upcoming Events

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December 10, "SI – HIMSS Solutions Toolkit Webinar." Sach Diwan, Director of Internet Product Development, HIMSS, presents and demonstrates a new tool that provides efficient access to the healthcare industry's top data sources (Gartner, KLAS, Dorenfest, AHA, Solucient, HealthLeaders and HIMSS) on IT operations and the IT marketplace. Learn how you can take advantage of this data at a fraction of the cost of subscribing to even a few of the sources; SI members are being offered an additional special offer.

December 12, "CPOE: Update on Implications from the Latest IOM Report on Patient Safety and review of A Report on Community Hospital Results." David Classen, MD, First Consulting Group, and IOM Data Standards Committee Member, reviews the 11/03 IOM Report on Data Standards and a research report on CPOE progress in community hospitals.

December 16, "SI – HIMSS Solutions Toolkit Webinar." Sach Diwan, Director of Internet Product Development, HIMSS, presents and demonstrates a new tool that provides efficient access to the healthcare industry's top

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10. Communicate, communicate, communicate;
11. Provide dedicated resources;
12. Be responsive to change requests while evaluating requests carefully before taking action.

Panelists respond

Don. Rucker, MD, VP and CMO, Siemens Medical Solutions, Malvern, Pa., said, "As a community we're missing the boat on patient safety," and that we need to view CPOE as more transformational, not so narrowly focused on drug/drug errors. "This is an operational issue: faster antibiotics, faster x-rays, they all aim to treat the patient in a more timely manner," which is both effective and efficient. CPOE can be used as an interdepartmental communication device.

David Classen, MD, VP, First Consulting Group, Long Beach, Calif.

David. Classen, MD, VP, First Consulting Group, Long Beach, Calif., agreed that CPOE goes far beyond medication safety, that it is a major change initiative. It's possible to implement CPOE without benefit if it is used by house staff only. "Don has outlined the new [more relevant] model, not the academic historical model," he added.

Responding to an audience question regarding transparency, Dr. Crandall said that Trinity makes performance information available to anyone in Trinity on the Trinity Website. Only approved users can drill down into specific patient information. Dr. Classen said that JCAHO and CMS will likely publish such performance information regardless.

Ed Septimus, MD, Medical Director, Memorial Hermann Health System, Houston

Ed Septimus, MD, Medical Director, Memorial Hermann Health System, Houston, said the focus of the IOM Report (To Err is Human) has been on medication errors; in fact, the #2 adverse event in hospitalized patients were infections and a recent article in JAMA indicated that in terms of morbidity, mortality and cost that surgical infections and line infections had the greatest impact. Therefore, he said, we should broaden our focus and consider preventing infections as a safety issue just like medication errors. Dr Classen affirmed that IOM 11/10 report will address other areas beyond medication safety.

Michael Shabot, MD, Chief of Staff, Cedars Sinai Health System, Los Angeles, said that cycle time—how long it actually takes to enter an order—is the single core metric for CPOE. Doctors expect others to complete the process. If it takes an extra 30 seconds, the cycle time is unacceptable. The concept of eliminating the downstream process (in which errors were picked up by someone else) is absent to many of them.

Implementation varies among specialties

The audience discussed the need to connect this discussion to one on ROI and benefits measurement. Today's environment requires a much more rapid rollout, there isn't the time to build CPOE incrementally and as customized as the early homegrown systems in academic medical centers. Dr. Crandall said that implementation differences not only exist for CPOE between academic and community hospitals but between specialists such as internists and surgeons, who require different ease-of-use order sets.

Upcoming Events continued

data sources (Gartner, KLAS, Dorenfest, AHA, Solucient, HealthLeaders and HIMSS) on IT operations and the IT marketplace. Learn how you can take advantage of this data at a fraction of the cost of subscribing to even a few of the sources; SI members are being offered an additional special offer.

January 9, "Tang and Classen: IOM Recommends Data Standards." Paul Tang, MD, chair of the IOM committee and David Classen, MD, a member of the committee, provide a briefing on the latest findings and recommendations of the IOM committee, including the Letter Report on Key Capabilities of Electronic Health Record Systems. This recent report focuses on the need for data standards, a national health information infrastructure that supports secure exchange of patient data, and on preventing medical errors. It calls for Congress to authorize and fund the Department of Health and Human Services to take a leadership role by accelerating the development and adoption of data standards and systems that support patient safety.

January 13, "Six Sigma Results at Heartland Health." Mike Dittemore, Black Belt Team Leader, Performance Improvement, Heartland Health, St. Joseph, MO, provides an in depth look at applying Six Sigma techniques to revenue cycle and medication

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Dr. Classen said that simple explanations are often more important than actual references from medical literature. Dr. Shabot said that Cedars uses CliniGuide which employs little "factoids" that are easier to use than ponderous medical references. Keep it simple and quick. "MDs want to be able to make the right choice," said Dr. Crandall. Trinity physicians can now easily save order sets in their "Favorites" folder.

Dr. Shabot said that workflow issues top the list of lessons learned at Cedars. "Magic nursing glue" holds the hospital together and it's quite difficult to replicate this, especially as 45% of patients are moved each day, and this hasn't been mapped well.

Dr. Crandall noted another invaluable lesson from the Trinity experience: Local clinical leadership made the difference between 98% adoption in one hospital and 35% in another.

Breakout Session: "Using Human Factors Criteria to Select and Deploy IT"

Todd R. Johnson, Associate Professor, School of Health Information Sciences, University of Texas Health Science Center, Houston

Todd R. Johnson, PhD, Associate Professor, The University of Texas Health Science Center at Houston, School of Health Information Sciences, emphasized the importance of the human interface in technology but noted that most interfaces were developed by programmers, not users. Usability is key and at least 10% of development cost should be dedicated to human factors engineering. Human factors is an iterative process; we need to get feedback to the vendors. In IT especially, modifications and local use patterns are rarely anticipated by vendors.

The best study method, Prof. Johnson said, is to observe software use in the clinical setting. Buyers should ask vendors for human factors plans, flexibility and use scenarios. Vendors need to hear that "I'm not buying your product because…," in order to get them to make changes. "I'm not very good at using computers" is not an acceptable excuse for poor use of technology. "Fix the IT before you fix the users," said Prof. Johnson.

Kate Peterson, principal at Minneapolis-based Human Centered Strategies, followed Johnson's talk by, first, reinforcing that usability – the *result* of human factors engineering – is not about what the user "likes" or "wants." Instead, usability relates to what goal or objective the user needs to reach, and the human tasks required to achieve that goal. So, in addressing the key factors of being effective, efficient and safe, one is really asking "how usable is the system in the context in which it will be used?" Peterson also asked the audience to challenge the prevailing reliance in IT development on the "super user." This expectation for "super users" is a convenient way for software developers to dismiss complaints about usability, but increases the overall cost of systems to customers in terms of ongoing training and support.

Kathy Rapala, JD, RN, Director of Risk Management and Patient Safety, Clarian Health Partners, Indianapolis

Kathy Rapala, RN, JD, Director of Risk Management and Patient Safety at Clarian Health Partners in Indianapolis said of her organization's human factors

Upcoming Events continued

administration processes, and the dramatic results Heartland has seen in just 2 years. He also reviews Design for Six Sigma, used in conjunction with significant IT implementation, and shares their approach to measures, accountability, and a variety of training tools. The Revenue Cycle team was one of only 3 teams in Missouri to win the Missouri Team Quality Award (MTQA) and be considered a "role model" competing against over 35 others including Boeing, Honeywell, SSM Healthcare (Baldrige Award winner), and Missouri Department of Revenue.

January 15, "Project Office: Tools for Managing Change." Eric Yablonka, CIO, and Nora Ellis, Project Office, University of Chicago Hospitals and Health System, present the governance, management and results of the Project Office implemented at UCH. Nora will describe the origins of the PMO concept, define its current state in healthcare, and review the recommended steps you should take to create a PMO. She will also cover its organization and role within UCH, its primary functions and benefits, and project portfolio and management.

January 19, "Six Sigma Results in Laboratory Services at Memorial Hermann Healthcare System." Melody Peeples, MEd, MT (ASCP), Process Excellence Coordinator, Laboratory Services,

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Upcoming Events continued

Memorial Hermann Healthcare System, Houston, will review practical applications by presenting the Six Sigma project that was conducted for her initial Black Belt certification, and outline other laboratory improvement initiatives with results to date. She will provide specific examples of how the methodology and tools have been applied in the Lab. This teleconference is ideal for those who are relatively new to Six Sigma, or those who are new to its application in the Lab.

January 22, "Leading IT Management Practices and Benchmarks." Carvel Whiting, CIO, Intermountain Healthcare, Salt Lake City, UT, and Andy Smith, Vice President, First Consulting Group, Chicago, review a management dashboard created with data collected during IT assessments and comparing IT functions according to their performance in Strategic Alignment, Value Realization, and Operations Management. Carvel will provide an overview of how CIO's can use this tool for executive education about IT management and leadership. Leading practices will be highlighted along with tactics for achieving them and a commentary on industry trends.

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strategy, "We wanted people to think differently, to have local nurse experts identify gaps, human factors and work complexity." They work with the users to answer several key questions: What will be different? Beyond the planned change, how will this change about the work? Why won't this work?

Joel Shoolin, DO, Medical Director for Quality and Care Management, Advocate Health Care, Oakbrook, Ill.

Dr. Joel Shoolin, DO, Medical Director for Quality and Care Management at Oakbrook, Ill.-based Advocate Health Care, noted that what's usable for one is not usable for another. The challenge is how to effectively address that issue. Ms. Peterson said the wrong strategy is to take users out of their work context and isolate them in a conference room to study human factors. "Get closer to the work," she said, and identify discrete user groups, study the work of a sample of users from each group. If direct observation of the clinical setting is not possible, then observe the work in a high-fidelity simulated use environment. "Focus on the goal that the real user is trying to achieve. Once you have collected data on how a sample of your users work with the system, you can choose or design the system that best supports the common strategies and tasks performed by all users," said Ms. Peterson.

Ms. Rapala also noted that there are different decisions and choices depending on whether you're on a nursing floor or the ICU. You need to consider different environments. Prof. Johnson concluded by suggesting that we need to understand what drives preferences and why.

Breakout Session: "Security in an Increasingly Hostile World"

Todd Peterson, system support CIO at Sutter Health in Sacramento, asked, "How do you deal with security in a distributed-IT world?" Sutter is a case in point: it has 26 hospitals, each with separate IT directors and staffs, and ranging from 30 beds each to 1,100 beds. It also has five medical foundations, 40,000 employees, 300-plus servers and 16,000 desktop computers.

A big challenge is to understand IT-network attachments, including IT and biomedical devices (including those not owned by IT). In many cases, he said, "we couldn't gain access to the devices." As a result, it's important to develop administrative rights assignments. It's also important to "push" technology acceptability, which is a very different task than staying up to date, Mr. Peterson said. Making software acceptable for users is different than having the vendor's latest version. Another critical issue deals with FDA regulation of devices. Many vendors claim they cannot update their devices to maintain FDA compliance.

A second big challenge for Sutter, he said, is support of isolated networks. Implicit in that effort is to nail down vendor contact lists, communication ownership (identify the user community) and maintenance responsibilities (don't leave it in the hands of vendors). Contract language with vendors should also spell out update requirements. Vendor and contract management is critical. Make sure device safety checks are part of a vendor policy.

Sutter experienced a case in which patient monitors "crashed" or went down because they were connected to a server that was linked to the network that got hit by a virus. "You have to look at secondary attachments," said Mr. Peterson.

In 2002, Sutter conducted a "Hacker's eye-view" or system vulnerability assessment of its facilities and found that Sutter was its own worst enemy when it came to security. Many SI members participated in Sutter's offer to test their assessment and got the analysis in return for participating. In his presentation, Mr. Peterson once again invited other organizations to have Sutter run an evaluation of their IT security.

"ROI, Benefits Metrics and Setting Realistic Expectations"

Richard Tayrien, MD, VP, Clinical Information Systems, Catholic Healthcare West, Phoenix, opened by comparing how we've advanced in aviation to the space station in the 100 years since the Wright Brothers, but we still have the same paper medical records. In Oct. 2002, CHW convened a quality summit resulting in an epiphany that the organization needed to move faster on developing an electronic health record (EHR). Pilot development was begun this year and the EHR will be fully deployed in 2005.

Lessons learned so far, Dr. Tayrien said: First, know the primary audiences, addressing their needs and priorities; Second, define the functional scope and manage to outcomes expectations; Third, focus on attributes of clinical systems that are unique in their ability to capture benefits; Fourth, integrate your clinical decision support rules engine into your care management and clinical process.

Kim Pederson, Corporate VP, Automated Medical Records and Revenue Cycle Systems at Allina Hospitals and Clinics in Minneapolis, said that the organization is undergoing an Epic implementation built around guiding principles that include the development of a rich set of benefits. "We're setting up the project completely around benefits, redesigning from the outset to gain ROI," she said.

Pederson cited her CEOs' statement that "The project will be a failure if it's not on time, on budget, with all the benefits realized."

Allina's ROI strategy includes a small, "parsimonious" set of true outcome metrics to determine project benefits. Those are supplemented by process metrics where there's a direct link with the EMR. Pedersen said they sold the $150-million project to the board and senior management with data on how the system would eliminate duplicate testing, adverse events and other costs.

As the system is phased into each facility, a balanced score card is used to evaluate each implementation, with a list of clinical benefits to date. "This is absolutely essential," said Pederson, adding that a key to ensuring the benefits are realized and documented is to devote significant staff resources to that task.

Life-cycle costs missed

Alan Abramson, Senior VP of IT and CIO at Health Partners in Bloomington, Minn., made two points about calculating ROI for IT. First, he said that you must determine if a dollar spent in IT is worth a dollar spent elsewhere in the organization. He also said that a problem with the traditional ROI model is that calculates the initial IT investment, but often fails to consider additional costs of maintenance over the life of the system. In an information environment, he said, it's easier to get capital to acquire the system than it is to get operating capital to run it.

"The IT project will be a failure if it's not on time, on budget, with all the benefits realized," said one CEO.

George Bo-Linn, MD, VP and CMO at Catholic Healthcare West in San Francisco, said ROI is difficult because there are so many audiences. In the end, "ROI is a function of the energy and enthusiasm of the sponsor," he said. Anyone can do the spreadsheet, but it's the metrics that go into it that's critical.

"ROI is a function of the energy and enthusiasm of the sponsor."

George Bo-Linn, MD, VP and CMO, Catholic Healthcare West

Jay Herron, CFO at CHRISTUS Health in Dallas, which is centralizing IT management, has just launched a research project on ROI and said, "You can't just look at financial models." CHRISTUS is using the balanced score card on the top level. The challenge: the organization is running 2% over revenue in IT expenses.

David Bradshaw, VP and CIO, Memorial Hermann Health System in Houston, spent $18 million to become HIPAA compliant starting in 2000 with the business system, and in 2001 with the clinical system. The CFO presented it to the board as infrastructure, something that was just the cost of doing business. Benefits are measured in the line operation.

"We're very much into the idea of physician-relationship management," said Bradshaw, because it helps clinicians learn how to optimize systems. He also said that, since they didn't make up-front "promises" about benefits, they didn't calculate any ROI, but did look at processes and process improvement.

Magnet Hospital standards work, as a study showed that facilities that emphasized coordination among care providers had a 58% lower mortality rate.

Dr. Bo-Linn said "It's often necessary to do the ROI to assure colleagues that you're not crazy." It's necessary to bring the board along as they make the investment decision; to bring physicians along, as they must use the system. However, if banking were to lose as many transactions as we have drug-drug interactions, using IT such as an EMR would be a regulatory requirement.

Dr. Classen said ultimately the ROI of IT will become moot because it will become a regulatory requirement to have IT in order to do clinical care. Public communication of hospital performance may surpass regulatory pressure as a driver for IT because it will be an imperative. The audience discussed the likelihood of such regulatory requirements and agreed.

Breakout Session: Enhanced Clinical Relationships in Magnet-Designated Hospitals

Linda D. Urden, DNSc, RN, Chairperson, ANCC Magnet Recognition Program, Washington, DC, said of nursing, "We are the 'super glue'" that holds together a hospital. She described what characterizes the country's 88 credentialed Magnet Hospitals. [All presenters were Magnet Designees.]

"Interdisciplinary Relationships" is one of the characteristics or "Forces of Magnetism" that describe the structural, measurable and qualitative features expected in a Magnet hospital. These standards work, as a 1986 study showed, for example, that facilities that emphasized coordination among care providers had a 58% lower average mortality rate.

Rosemary Luquire, PhD, RN, Senior VP of Patient Care and Chief Quality Officer, St. Luke's Health System in Houston, said that places like St. Luke's and the Texas Heart Center—which have a high case-mix index and independent physicians—have staff nurses with a long history of professional practice, collaborative teams, a focus on improving practice patterns, collecting data and analyzing populations and patient risk.

"What builds collaboration?" she asked. "Attitude and competency creates credibility, then collaboration can be achieved. If we hire people with the right attitude, we can create the competencies."

Methodist The Methodist Hospital

Pamela Triolo, PhD, RN, senior VP and CNO, The Methodist Hospital, Houston

Pamela Triolo, PhD, RN, Senior VP and CNO at The Methodist Hospital in Houston, described the work of the Greater Houston Partnership Health Services Steering Committee, a Houston collaborative to address the nursing shortage. The collaborative has launched a campaign to encourage nursing as a career and improve the education environment. The Houston Partnership also aims to determine why nurses are leaving the profession, what we need in a healthy workplace and how those two factors relate to the physician/nurse relationship. It has established a legislative task force to lobby for solutions to the nursing shortage.

This partnership between hospitals, schools of nursing, business and legislative leaders has helped increase nursing enrollment by 20% by using hospital staff as faculty, allowing nursing students to be taught by caregivers in a clinical setting. As much as $27 million has been raised for the program, which emphasizes diversity and is even targeting junior high students.

Recalling what Mom said

Susan Distefano, MSN, RN, senior VP and CNO at Texas Children's Hospital in Houston, said collegiality is an antecedent for improved outcomes. The nursing task force, "Creating a Healthy Work Environment," focused on agreed-upon outcomes. Professionalism, teamwork and shared decision making are critical to the new emphasis on teamwork. Professional societies are now defining acceptable behavior in the workplace, due to erosion of behavior patterns.

Texas Children's formed a council for professional partnerships, concentrating on all the basics: "What your mother told you should do, but you forgot because it's a high stress environment," said Ms. Distefano. She noted that "charged communications" have two elements: emotion and concern about clinical results. It's necessary to separate the two by dealing with emotion via coaching and training; and finding another "home" for the clinical concern. "We must clear the brush before we can deal with redesigning the process as we implement clinical systems," said Distefano.

You should use non-traditional ways to educate, such as the Charlie Victor Romeo replays of aviation disasters, an off-Broadway production. HHS has provided a three-year grant to develop this idea. The #1 reason nurses leave the profession is no longer physician relations, which shows that that area is improving. The #1 reason now is RN supervision.

Dr. Triolo noted that some research indicates that IT actually increases the time a nurse spends documenting. Rosemary Luquire, PhD, RN, VP of Patient Care and Chief Quality Officer, St. Luke's Health System, Houston, agreed: St. Luke's implemented barcoding and experienced a spike in nurse documentation time but that has now returned to previous levels.

On another note, Dr. Triolo concluded by observing that the value of physician/nurse relationships is proportional to the time physicians spend reading nursing notes. A new patient care model at Methodist promises that new IT will support real interdisciplinary practice and a comprehensive record. She said, "We are shifting the culture first, then building the technology to support it."

The # 1 reason nurses leave the profession is no longer physician relations—which shows that that area is improving—but is now RN supervision.

Breakout Session: myMDAnderson.org: A Case Study

Alan Powell, director of Internet services at M.D. Anderson, opened by telling us that the patient Web portal "myMDAnderson.org" was created because patients had expressed frustration in communicating with the organization. The Website aims to improve the patient experience and address issues around the patient/physician relationship.

M.D. Anderson believes that their Web portal is an opportunity to:

1. Enhance the patient experience by providing a virtual 24x7 patient care environment and improve access to care center staff;
2. Create an interactive resource for patients to learn about MD Anderson, their diagnosis and treatment;
3. Improve workflow;
4. Better manage delivery of service;

Focus groups in 2001 found that patients were very interested in the Web portal concept. They wanted help with appointment scheduling, to communicate with the care team and support units, view their bills and ask questions, have easier ways of completing forms, get information on resources, services, drugs, etc., and help reduce their anxieties.

M.D. Anderson patients were interested in a Web portal to help them with appointment scheduling, communicating with the care team and support units, viewing their bills, asking questions, completing forms more easily, getting information on resources, drugs and services, and to help reduce anxieties.

The Web portal incorporates secure messaging for patients, more secure than email because messages go to a database which is monitored by staff.

Reflecting the survey results mentioned above, myMDAnderson.org offers the following key features for patients:

- FAQs;
- Appointments;
- Personalized patient education content;
- Demographic updates that can be viewed online;
- Prescription refills;
- Personal Rx history.

As of late September, a total of 6,370 patients registered with 2,783 active on the Web portal, about 44% of all patients. About 10,000 messages had been sent by patients, an average of 3.6 per user. "There haven't been any delays that clogged email like some thought," said Powell. More than 11,000 documents were distributed for patient education. In September alone 6,501 patient visited the site, 13.4% of those on the weekend. Daytime use is nearly 60%.

Plans include activating the Website for all care centers, allowing patients to pay their bills via credit card, one:one messaging for psychiatric patients, multilingual message handling via the cancer center's international center, staff access through M.D. Anderson Clinic Station for authorized users, patient history assessment and e-learning.

Leapfrog Group Survey Results Review

David Classen, MD, VP at FCG, will publish the results at a later date.

The full panel is listed on page 11.

Conclusion

The Scottsdale Institute 2003 Fall Conference at M.D. Anderson provided an invaluable opportunity for information sharing, executive networking and an up-close-and-personal view of a world-leading cancer center. On behalf of all attendees and members of the Scottsdale Institute, our thanks go out to M.D. Anderson as the host and to all the presenters and participants for a wonderful conference.

Fall Conference Faculty

"On the Road to CPOE: What can you do now?"

Donald Crandall, MD, VP Clinical Informatics, Trinity Health, Farmington Hills, Mich.

The panel:

- Michael Shabot, MD, Medical Director, Enterprise Information Systems, and Chief of Staff, Cedars Sinai Health System, Los Angeles
- David Classen, MD, VP at First Consulting Group, Long Beach, Calif.
- Don Rucker, MD, VP and Chief Medical Officer, Siemens Medical Solutions USA, Malvern, Pa.

Breakout Session: "Using Human Factors Criteria to Select and Deploy IT"

Todd R. Johnson, PhD, Associate Professor, The University of Texas Health Science Center at Houston, School of Health Information Sciences, Houston.

The panel:

- Jiajie Zhang, PhD, Associate Professor and Associate Dean for Research, The University of Texas Health Science Center, Houston
- Constance M. Johnson, RN, MS, The University of Texas Health Science Center, Houston
- Kathy Rapala, RN, JD, Director of Risk Management and Patient Safety, Clarian Health Partners, Indianapolis
- Kate Peterson, Principal, Human Centered Strategies, Minneapolis.

Breakout Session: "Security in an Increasingly Hostile World"

Todd Peterson, System Support CIO, Sutter Health, Sacramento.

"ROI, Benefits Metrics and Setting Realistic Expectations"

Richard Tayrien, MD, VP, Clinical Information Systems, Catholic Healthcare West, Phoenix.

The panel:

- Kim Pederson, Corporate VP, Automated Medical Records and Revenue Cycle Systems, Allina Hospitals and Clinics, Minneapolis
- George Bo-Linn, MD, VP & CMO, Catholic Healthcare West, San Francisco
- Alan Abramson, Senior VP of IT and CIO, HealthPartners, Bloomington, Minn.
- David Bradshaw, VP & CIO, Memorial Hermann Health System, Houston.

Breakout Session: Enhanced Clinical Relationships in Magnet-Designated Hospitals

Linda D. Urden, DNSc, RN, Chairperson, ANCC Magnet Recognition Program, Washington, D.C.

The panel:

- Susan Distefano, MSN, RN, Senior VP and CNO, Texas Children's Hospital, Houston
- Rosemary Luquire, PhD, RN, Senior VP, Patient Care, and Chief Quality Officer, St. Luke's Health System, Houston
- Pamela Triolo, PhD, RN, Senior VP and CNO, The Methodist Hospital, Houston.

Breakout Session: myMDAnderson.org: A Case Study

Alan Powell, Director of Internet Services at M.D. Anderson.

"Leapfrog Group Survey Results Review"

David Classen, MD, VP at First Consulting Group, Long Beach, Calif.

The panel:

- John D. Fields, VP Quality Services, Central Maine Healthcare, Lewiston, Maine
- David Lutterbach, Director of Employee Benefits, Siemens Corporation, Iselin, N.J.

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Featured Speakers include:

Alan Abramson, CIO, HealthPartners, Bloomington, Minn.

Jim Anderson, CEO, Cincinnati Children's Hospital Medical Center, Cincinnati

Jeff Blair, VP, Medical Records Institute and VP, National Committee for Vital and Health Statistics, Washington, D.C.

David Classen, MD, VP, First Consulting Group, Long Beach, Calif.

Molly Joel Coye, MD, Founder and CEO, The Health Technology Center, San Francisco

John Glaser, PhD, CIO, Partners Health System, Boston

Alan Goldbloom, CEO, Children's Hospitals and Clinics, Minneapolis

Van Johnson, CEO, Sutter Health, Sacramento, Calif.

Steve Lieber, President and CEO, HIMSS, Chicago

Sherry Martin, VP Quality Management, U.T.M.D. Anderson Cancer Clinic, Houston

Gary A. Mecklenburg, President and CEO, Northwestern Memorial HealthCare, Chicago

Brock Nelson, President, Regions Hospital, HealthPartners, Bloomington, Minn.

Stan Nelson, Chairman, Scottsdale Institute, Minneapolis/Scottsdale, AZ

John Nussbaum, Executive Director, Shared Services and Corporate Responsibility Officer, Ascension Health, St. Louis

Chris Seitz, Chief Nursing Officer, United Hospital, Allina Health System, Minneapolis

Joel Shoolin, DO, VP, Clinical Informatics, Advocate Health Care, Oakbrook, Ill.

Gayle Vernon Simkin, CIO, Catholic Healthcare West, Phoenix

Jim Skogsbergh, CEO, Advocate Health Care, Oakbrook, Ill.

Paul Tang, MD, Chief Medical Information Officer, Palo Alto Medical Foundation/Sutter Health, Palo Alto, Calif.

Rick Umbdenstock, CEO, Providence Health Services, Spokane, Wash.

Pete Velez, Senior VP, Queens Health Network and Executive Director Elmhurst Hospital Center, Elmhurst, N.Y.

Don Wegmiller, Chairman, Clark Consulting-Healthcare Group, and VP, Scottsdale Institute, Minneapolis

William Yashoff, MD, Special Advisor, National Health Information Infrastructure, Dept. of Health and Human Services, Washington, D.C.