CNIO Roundtable Discussion

March 4, 2020; 1:00-2:00PM Eastern

Meeting Information

Phone: 1-205-206-9624
Access Code: 764-116-358
Teams Meeting Link: Join Teams Meeting
Minutes and Recordings Site: https://www.makesolutionsinc.com/roundtable/cnio-minutes

Attendees / Site

X	Holly Ellison, CNIO; Concord Hospital, NH	X	Chris Skinner, Informatics Officer; Covenant Health, TN
	Jenna Lloyd, CNIO; Centra Health, VA		Tiffany Cross, Informatics Officer Anc; Covenant Health, TN
	Julie Mann, CNIO; Jackson Health System, FL	X	Brant Sloan, Nursing Informatics Coordinator; UTMC, TN
X	Cheryl Pack, App Dir; CAMC, WV		Rae Costanilla, Clinical App Mgr; Northside Hospital, GA
	Tina Stamper, SME ICU, CAMC, WV		Heidi Edwards, CNIO; CAMC, WV
	Diane Sweesy, Clinical Mgr;		Elise Hermes, CNIO; Nicklaus Health, FL
	Brian Kottenstette, MAKE Solutions Inc.		Lori Myers, Dir. Clinical Quality; Covenant Health, TN
X	Patti Marshall, MAKE Solutions Inc.		Dr. Sam Bhatia, MAKE Solutions Inc.
X	John Schott, MAKE Solutions Inc.		

Agenda

- **Introduction to the forum and objectives:**
  - Meeting is being recorded
  - The CNIO forum is for CNIOs and nursing leadership to get together and celebrate organizational wins and get assistance from your peers with organizational challenges.
  - It will be similar to the CMIO Roundtable which has been going on for over a year. CMIO Roundtable is getting into a groove where participating organizations present their successes to each other. We believe we'll get there with the CNIO Roundtable as well. Your participation and thoughts are what will keep this group healthy and thriving and add value to your organization
  - This is not a sales presentation.
  - As a rule, vendors will not participate unless there is a reason to invite them as a benefit to the members of the Roundtable. As an example, on the CMIO Roundtable, they had a session that focused solely on enhancements they'd like to see with Medication Reconciliation. That enhancement list was written up and presented to Cerner, and a future meeting is going to involve Cerner hearing from the Roundtable on how to improve it. This is the power of having multiple organizations band together for a common goal.

- **Attendee introductions and details on organization:**
  - CAMC - Cheryl Pack, Applications Director for Information Services, RN by background.
    - Charleston Area Medical Center has no Nursing Informatics department so she does a lot of work in the informatics space
    - CAMC is in Charleston, WV and is 950 bed hospital split over 4 hospital sites with 85 locations including ambulatory clinics and Physician practices across Southern WV
    - On Cerner since 2016 - big bang move from Soarian/Invision to Cerner
  - Concord - Holly Ellison, CNIO and Diane Sweesy Nursing Informatics and Application Analyst Manager.
    - Concord has a combined Informatics and Analyst team that support all of the inpatient, hospital-based and ambulatory clinic and applications
    - 26 owned practices and support non-owned practices as well
    - Concord additionally has a Provider Informatics team
    - Both report up through the CMIO Dr Clark, they have a group of 5 Physicians that do part-time informatics work along with their clinical practice

    - Clinical system education team also connected to them does new hires training and tier one support so that analysts can focus on tier two and 3 level
    - Big bang go-live 2017 with add-ons afterwards (Alaris pump integration, Bridge Medical, Cap Mgmt) going live with new workflows like PSO, replacing Horizon Clinicals, GE Periop, Anes and ED were on paper and Clinics were using Centricity
    - Live on 2015 then upgraded to 2015.28 shortly after go-live, 2018 on March 30th, curious to hear from others about their 2018 upgrades
    - Challenging 2 years with Cerner, struggling to move to optimization because of performance issues, crashes, screen freezes, Cerner session clean-up tool deployed to end users because of this
    - Would have hoped to have done more optimization by this point
    - Hoping moving to a larger memory footprint with 2018 will resolve their issues, but would like to hear what others are experiencing because they want to set realistic expectations with organization
- Covenant - Chris Skinner, Informatics Officer
    - Broad role combining Informatics and IT Analysts Support Team, oversight of overall database support for Physicians, Nursing, and providing support for CMIO, Dr. Halford who is on the CMIO forum and virtual health in regards to Acute Care for things like V-ICU, Virtual Stroke, Nephrology type Behavioral type Consults
    - Not-for-profit with corporate offices in Knoxville, TN, 10 acute care facilities and 100 ambulatory practices and 200 affiliated practices
    - McKesson for most Acute Care facilities
    - 2018 moved to Cerner with big bang from a technology standpoint, but stages the facilities and by region moved the ambulatory practices off NextGen to Cerner
    - Moving to optimization
    - Haven't had many performance issues because they had a heavy focus on this since it was a big problem with McKesson. They worked closely with the remote hosting team from Cerner
    - Just went live with 2018 code
    - Trying to move into the backlog of change requests and reports
- UTMC - Brant Sloan, Nursing Informatics coordinator - department of 1
    - Been on Cerner since 1999, went to Nursing documentation in 2006/2007, CPOE 2011/2012 2x.
    - They have 700 beds on campus, lost count of Ambulatory clinics on board with PowerChart Ambulatory, more going live every week
    - He works closely with CMIO, Dr. Clay Callison to make sure that changes made work for both Nursing and Physicians
    - Branching out more to Case Management, PT/OT, to make sure that there is one source of truth for everything that is being entered into the system
    - Did a Nursing Workflow optimization in 2017 to move from PowerForms to IView and nursing workflow.
    - They use Cerner Advance to track performance and time in the chart
    - Work to try to improve the efficiency so that they use the system to the best that they can
    - BMDI in ICUs and Step down
    - Pilot for Smart Pump programming/infusion management for a year, but put it on pause because of technical difficulties and data loss of Patient data. Have been doing some upgrades and testing and will try to re-pilot for 1 month and if successful, roll-out. ICU Medical Plum 360 pumps are being used
    - Want to move to Smart phone for Nursing for mobile alerting and communication, but are in the infancy stages
    - Waiting on resources for Cap Mgmt

- **Criteria for adding to the nurse workload**
- Holly - Concord
    - Long-standing Nursing Informatics Council from McKesson days when redoing Nursing Documentation on Inpatient side
    - Since going to Cerner have expanded to all Clinical areas, but mainly Nursing focused
    - Have guiding principles that they follow at the start of any major project

    - They have a form that must be filled out for any documentation change requests that goes through a change process: Education and Communication processes that are well defined
    - Competing priorities within the organization and new regulatory or CMS standards that are impacting workflow
    - Events that happen that cause someone to put in a request for required fields, pop-up and reminders - moving away from the guiding principles that we worked with that group for quite a while to develop
    - We are in the mode of trying to put a band aid on it so we try to coach them through those requests
    - Interested in what other organizations are doing. Do you have criteria around whether or not an element becomes required, or if it is a forced function vs. not
    - We don't seem to ever remove anything, we just keep adding to nursing documentation - inundating them with "just one more thing"
    - Interested in hearing from others about their Clinical Change process and how they manage that
    - How do they weed out what truly needs to be required and how do they keep nursing documentation reasonable
    - Looking at impact to workload and workflow before approving
    - Educating committees and leadership on potential impacts and making it part of governance structure
    - Running into competing priorities and getting so many requests
- Chris - Covenant
    - 2 Guiding principles ported forward from Horizon Expert Documentation (HED)
    - Run through whether: Patient Safety, Regulatory, Evidence-based, Workflow Enhancement before adding new charting elements
    - They also have a grid that they follow with regards to Change Methods starting at the bottom and working up from least effective to most effective
        - Education
        - Policy
        - Checklist
        - Automation (example flipping the Order Communication to protocol, regardless of what the Nurse picks when they know that it is a protocol)
        - Forced function (a hard stop, or only option a or b)
    - Chris to send slides to attach to minutes with regards to Change Methods
    - Some optimization underway, trying to cut back the chart
        - Trying to cut back on Model content that wasn't necessary and is in the way especially when you try to automate or force a function
        - It is frustrating that they just went live with 2018 and already have a lot of clean up that needs to be done
- Brant - UTMC
    - Meeting monthly with a representative from each area (Expert User group). Run all changes through this group following the same principles. It they can't agree if something should be mandatory or not, (if it is regulatory, Joint Commission or CMS requirement it is easy), but if not goes up to Nursing Exec Council and they decide if it is mandatory, or a task. They try to not make things mandatory within a band so that if you open it up it is mandatory. It is nice if you can make it mandatory in the Doc Set, but not in the Band
    - Still too many things in the way if you are only using it once a month
        - need to have things as custom to be added as opposed to face-up on every patient
        - They are constantly working on this
- Holly
    - Regulatory, Compliance and Financial impact requests are easy
    - We struggle with Patient Safety because it can be so broad
        - 1 event, 1 patient vs. several events and several patients
        - 1 person reporting may feel passion vs. those being impacted by the workflow change
- Cheryl - CAMC

        - Interdisciplinary Workgroup meets every Thursday. Try to resolve things within the specific realm and they do have a Nursing sub-group. Most Nursing items are resolved at the sub-group. If it can't be resolved and for all items that cross disciplines it goes to that Interdisciplinary Workgroup for resolution
        - Same groups stay for most of the day to do their testing for things trying to pass to PROD
        - Trying to empower that group to make more decisions instead of being escalated above the group to other parts of the governance structure

- **Requirement from regulatory body for every diagnosis to have a Plan of Care (IPOC)**
    - Holly
        - Have always struggled with Plans of Care and have struggled with this more since going to Cerner. Had sort of a home-grown system with their previous system that was very effective, easier to read, more of a summary, it was not structured
        - Cerner is working towards a 1 plan model, and here team has been engaged in calls with Cerner on this, but it won't be available for a while so they are using the current IPOC model
        - Most recent DNV survey it was identified nursing don't have an IPOC for every diagnosis (Examples: Long-term anticoagulation to have At-Risk IPOC; previous fall should have Fall Risk IPOC
            - Nursing says it looks confusing
            - Nursing doesn't think it is valuable because other providers don't review the information
        - How do other sites handle this? Have you taken a different strategy from a build perspective
        - Looking to enhance rules for suggested IPOCs
        - Looking for guidance on successes others have had
        - Current process needs monitoring or nursing moves away from it
        - Hard to get Nursing adoption - feels like it is redundant and extra clicks
    - Brant
        - Not using IPOCs still using PowerForm with a grid and all of the old NIC and NOC terminology
        - It is filled out once per shift and the speak to shift goals within the PowerForm
        - We are still way behind when it comes to that
    - Cheryl
        - DNV visit in February and sited because IPOCs are not interdisciplinary, it is nurse-driven
            - Interdisciplinary workgroup set up a smaller group focusing on Social Services and Clinical PharmDs, getting them more fluent in using the IPOC
            - They just submitting their action plan last week
            - She is interested to review other pieces of the action plan
    - Holly
        - Are they going to go into the IPOC and add or are you going to pull in their pieces to display in the IPOC?
    - Cheryl
        - We are going to ask them to add into the IPOC
    - Patti
        - Holly you indicated you are DNV as well?
    - Holly
        - Yes, they didn't key into the fact that they were not interdisciplinary it was more that there were some that weren't consistently updated
        - It seems that when we stop monitoring it they stop doing it. They are looking for a reminder because they have so many other places to go within the record. It continues to be a challenge. The IPOC seems to be redundant to them, or extra clicks
        - Providers also feel it is a gap - they can see it but are looking for it to be in a format that is a summary
        - Use visual management board for rounds that we are asking nursing to update and this is a lot of redundant information and they are struggling with the workload and the lack of value that they see in it
    - Chris
        - In same boat need to keep doing additional retraining and when they do, they are always asking why they are doing it because physicians aren't looking at it, so they wonder what the value is to the Patient
        - Physicians aren't looking at it because it is cumbersome

- Patti
    - Topic likely needs revisiting especially if other sites join the group. Especially if someone joins that has success with IPOCs - this doesn't look like it is a win for any in this group yet

- **Initiating PowerPlan orders in the ED - How to ensure nurse compliance**
    - Holly
        - ED on paper prior to Cerner with a paper. Nursing and Physician orders were on that form and if the Admitting Physician came down to add orders to be acted upon in the ED they had to be added to that form and because the IP Physicians were on CPOE in Horizon Clinicals, they also needed to enter them there, so it became very confusing
        - Wanted to move to the process of having the Admitting Physician initiate their orders right away, but kept process the same when they moved to Cerner since the ED was undergoing so much change
        - Hospital side wants to move to Initiating orders right away
        - What do other sites do, do they initiate the orders right away when the Patient is going to be IP or OBS so there is no delay in care, or keep in a planned state and do they work off the tracking board?
        - How does the ED Nurse work off both those orders and the tracking board?
    - Brant
        - 2011 went to CPOE with a model that said it's OK to wait 4 to 6 hours before initiating the order in the ED. Then in 2012 did a CPOE redesign and now they are down to zero hours. The Providers initiate on sign the same as they do for Patients going to floor. The ED RNs go between dealing with just a few orders in FirstNet to an admitting Patient with all of these orders. We don't have ED LanuchPoint. They have seen CareCompass and want to see how they can incorporate that. The orders post to their Orders column and Activities post to the Activities column on FirstNet.
        - Struggling to manage all of the orders - hard to be a ED and IP RN at the same time
    - Patti
        - Do they initiate all orders for all IPs with the PSO, or only the PSO and the Nurse of the floor initiate the rest?
    - Brant
        - Pushed most of the initiation back on the Providers to make that Clinical decision
        - Unless they build the Pathway with a sub-Phase to say RN to initiate or the previous Phase has a communication ordering say "Upon arrival to floor initiate Phase" but these need to be really clear because if it is a multi-phase plan and they initiate all phases at the same time, that isn't safe either
        - Hospitalist that put in the Admission Plan sign and initiate the orders and they are supposed to act on all of those orders and give those meds in the ED. It isn't easy because it is a lot more work than an ED Patient, but it is what they had to do so that there wasn't a gap and a delay in care
    - Patti
        - Brant, you indicated that you went live with CPOE twice
    - Brant
        - We went live in 2011 and stays live but did redesign and went live in 2012 and called it CPOE 2.0
        - We went from having a gap of 4-6 hours to zero because they initiate on sign
        - With the first CPOE go-live they were just trying to meet that measure and get that reimbursement, they didn't build order or the PowerPlans correctly. That is what they did for a whole year. Then they optimized CPOE immediately. From there we have made multiple changes
        - Struggle with Nurse Collect and Lab Collect because lab core doesn't go to the ED. ED draws all of their own labs. They have a rule that any ED provider that orders a lab defaults to Nurse Collect. The orders entered by the Hospitalist default to Lab Collect so that also causes a problem.
    - Cheryl
        - Transition from 45 minute buffer for any Patient to be considered a border and did away with it because it created its own set of issues
        - Just did a PSO upgrade for the whole house. Providers can't reset a PSO only Case Management can reset a PSO. A Patient can't be admitted (it is a hard stop) if they don’t have a PSO. If it needs to change

the only people that can make the change are Case Management. So they have to talk to each other. This has been huge. Completed January 25th We really know we need to get back out to the ED
    - Took a 4 hour downtime to make sure all Patients had an accurate PSO. They had a small contingent of people go out and place the PSOs 640 Patients in house at the time they did it. You have to activate the orders immediately.
    - They knew they would need to go back to the ED and look at the process with the change in the PSO
- Chris
    - Similar issue with order in Horizon that would go downstream to the correct location because the Patient was still in the ED
    - With Cerner they Initiate orders in ED right away. They do have a decent process there
    - Argued that it is a staffing issue: if someone is being boarded in the ED they need to be treated like an IP, increase staffing in situations when Patients are being boarded. They have tried to eliminate the need to have ED RNs take care of Inpatients in the ED
    - Where our process broke down was with the Tracking board keeping up with those Patients because they didn't account for the boarded Patient to be moved multiple times. When the Nurse came in to look after the Patients that were in opposite corners of the ED in virtual beds, they tried to move them closer which broke the connection. They didn't account for the Patients to be moved once or twice. Part of the problem was that they have STAR registration and have issues with the data going back and forth.
- Patti
    - Are any other sites using the new PSO process and managing it completely within Cerner?
- Holly
    - Went live with the Jody Taylor model right out of the gate and only Case Managers modifying the PSO
- Cheryl
    - It has been working really well after the first 48 hours
    - Did a huge communication out - Physician leaders took the brunt for the change
- Patti
    - I know that some of the sites that aren't using Cerner Revenue Cycle change in on the Registration side and don't update Cerner, and I know that isn't the right answer either
    - Are any other sites doing what Chris indicated that Covenant is doing and bringing it IP Nurses to care for the border Patients in the ED?
- Cheryl
    - They have talked about it at CAMC, but not done so yet
    - It would be very hard to do in their biggest ED
- Chris
    - That was one of the unintended consequences that they hadn't planned for. They are doing it in 3 really large EDs. That is why they try to move the patients closer together, which is causing the problems because STAR is in the middle of it
- Cheryl
    - Going to go back and ask more questions. She had assumed that they weren't moving the patient around, but that might be incorrect.
- Chris
    - Our process works really well, we just didn't account for the multiple within the ED

Proposed agenda items for future meetings

- Downtime planning and preparations
- Using SMEs and Chain Nurses for education
- Management of clinical decision report and reminders
- Experience with 2018 Upgrade

Follow-Ups

Who	What	When
Chris Skinner	Send slides on Change Methods to include with minutes	With minutes
Brian Kottenstette	Send out the Site Information sheet with the minutes for sites to update	With minutes

Meeting Cadence

- All meetings start at 1:00pm Eastern on the Wednesday of the first full week of the month.
  - March 4th **Nursing Open Discussion** – 60 minutes
  - April 8th **Physician Open Discussion** – 60 minutes – Cerner Medication Reconciliation
  - May 5-8 Southeast RUG Get-Together
  - May 6th **Nursing Open Discussion** – 60 minutes
  - June 8-10 North Atlantic RUG Get-Together
  - June 10th **Physician Innovations** – 90 minutes
    Presenters: Sidra, UTMC
  - July 15th **Nursing Open Discussion** – 60 minutes
  - August 5th **Physician Open Discussion** – 60 minutes
  - September 9th **Nursing Open Discussion** – 60 minutes
  - October 7th **Physician Innovations** – 90 minutes
    Presenters: Penn State, Northside
  - October 13th All Roundtable CHC Get-Together
  - November 4th **Nursing Innovations** – 90 minutes
    Presenters: TBD
  - December 9th **Physician Open Discussion** – 60 minutes