# CNIO Roundtable Discussion

**July 8, 2020; 1:00-2:00PM Eastern**

## Meeting Information

Phone: 1-205-206-9624
Access Code: 911-012-045
Teams Meeting Link: Join Teams Meeting
Minutes and Recordings Site: https://www.makesolutionsinc.com/roundtables/cnio-roundtable

## Attendees / Site

| | | | |
|---|---|---|---|
| X | Brant Sloan, Nursing Informatics Coordinator; UTMC, TN | | Cheryl Pack, Application Director; CAMC, WV |
| X | Chris Skinner, Informatics Officer; Covenant Health, TN | | Diane Sweesy, Clinical Manager; Concord Hospital, NH |
| | Elise Hermes, CNIO; Nicklaus Health, FL | | Heidi Edwards, CNIO; CAMC, WV |
| X | Holly Ellison, CNIO; Concord Hospital, NH | | Jenna Lloyd, CNIO; Centra Health, VA |
| | Julie Mann, CNIO; Jackson Health System, FL | X | Lori Myers, Dir. Clinical Quality; Covenant Health, TN |
| | Lyn Baluyot, Chief Transformation Officer, Transform, CA | X | Patti Spina, Healthcare Exec, Bear Institute, Children's National, DC |
| | Rae Costanilla, Clinical App Mgr; Northside Hospital, GA | X | Simmy King, Nursing Director, Children's National, DC |
| X | Tina Stamper, SME ICU, CAMC, WV | | Tiffany Cross, Informatics Officer Anc; Covenant Health, TN |
| X | Brian Kottenstette, MAKE Solutions Inc. | X | Patti Marshall, MAKE Solutions Inc |
| X | John Schott, MAKE Solutions Inc. | X | Sue Steckle |

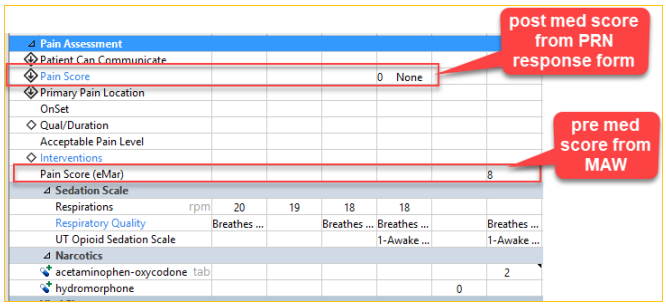
## Agenda

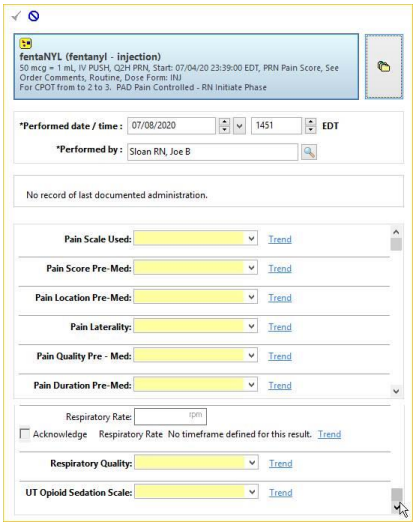
- **Introductions of new members**
  - Children's National - The Bear Institute
    - Simmy King: Nursing Director for Clinical Informatics.
      - Scope includes all of Nursing Informatics, Education and Professional Development and are in a professional simulation program here. In role since 2013
      - Patti Spina: Healthcare Executive for the Bear Institute (partnership between Cerner and Children's National). Pediatric Institute for Innovation in Technology. There are Cerner employees onsite that are dedicated to Children's National
  - Covenant
    - Lori Myers
      - Hybrid role. Work with Quality and Regulatory folks to make sure that chart meets the quality and regulatory requirements of the organization
  - CAMC
    - Tina Stamper
      - Director of Nursing Practice and Innovation and Informatics. Dual role to bridge between profession practice and the EHR and do all of the P&P documentation to make sure that they are in alignment
- **IPOC discussion**
  - From the last call, it sounded like no one was making good use of the IPOCs and that both CAMC and Concord were cited by DVN for use of Plans of Care.
    - CAMC is really struggling with them and would love for this to be on the agenda
    - Holly at Concord recently spoke with Cerner about the One Plan Initiative and may be a development partner. It is not at the stage they would need it at yet to make the leap from IPOCs to the new format
      - They have done lots of cleanup work on their IPOCs to condense them down to more generic IPOCSs for Surgery and ICUs but are still struggling

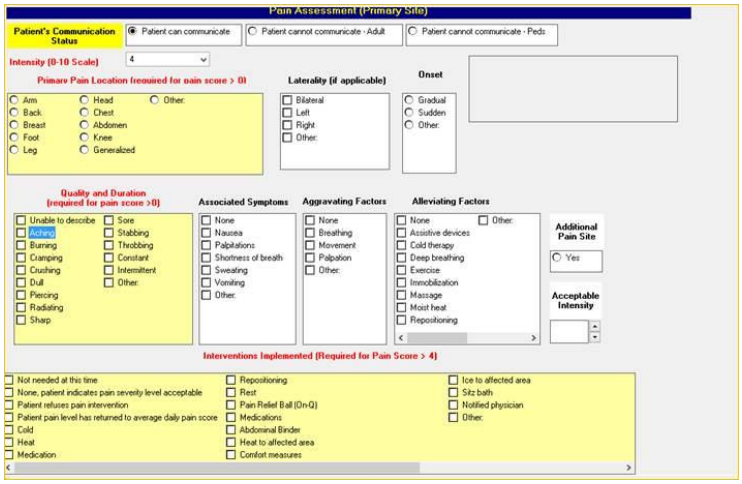
        - Brant – UTMC: Do not use it at all yet. They have a PowerForm that they created in 2007. They do little tweaks to it but it has gotten them through previous site visits. It's not perfect, it isn't integrated to the problems list.
        - Simmy - Children's: Has had IPOC in place for a long time. They haven't done any enhancements because they understood that Cerner was going to sunset it, they had started to demo some new applications or workflows to replace it. It would be good therefore to understand what Cerner strategy is as well because the current one is very Nursing driven non-Interdisciplinary and really hasn't had a lot of improvement in several years
        - Holly: This is what the One Plan Initiative. They are trying to make it Interdisciplinary and carry goals and interventions between the hospital admission and OP follow-up
            - The challenge is how to get the other disciplines engaged and documenting in a format in what they see as duplicate documentation, which is what Nursing is doing every day. Struggling to get buy-in. Because no one owns it, everyone owns it, but nobody does it.
            - I don't think that this is going to go away with One Plan because everyone is going to need to interact with it at an Interdisciplinary level. It has potential and I think they are going in the right way, based on what I have seen. It is going to be a phased in approach and phase 1 isn't going to be eliminating IPOCs completely from what I understand.
            - Live in Dec 2017 and had a home grown process prior to go-live. Moving to a structured IPOC format in Cerner was a big adjustment when on top of that they were trying to learn a new system and all of the other workflows that they had to adjust to.
            - Took time after this DNV finding to re-educate Super Users and leadership at the department level to understand the system functionality and how it can work for them. Not ideal in terms of the format that Cerner uses, there are some key education points that were missed in our implementation because people had so many things to learn. Made some progress and also helped the Super Users identify some potential design opportunities for us to do in the interim before we get to One Plan. Making some small changes were some quick wins for staff.
- Pain Assessments and Reassessments
    - Lori: Currently in the 9 month process of Joint Commission assessing all of their sites and they are hitting us hard on pain assessment and reassessments with interventions
        - Assessments and IView and then and then reassessment on the MAW. Nursing has asked if we can move it out of IView and onto the MAW so that it will be in one place
        - Hope to be able to use their TC51s at some point in the future for this process
        - Interested in knowing what other folks have done that has been successful that the regulatory bodies have approved
    - Brant: Mandatory fields in the MAW. It is also in IView but they don't task the pain assessment because if they get a score that was higher than before it is automatically set to fire a reassessment. The assessment is going to get you to go and get the med and give it
        - Pre-score in the MAW and get a PRN response to get out of the assess/reassess loop
        - Don’t have a task to assess pain
        - If they aren't giving pain meds to a Patient they need to do an assessment q-shift in IView
        - There are 3 or 4 selections in the PRN response that will keep them from getting another reassessment task (Pain acceptable to Patient, Back to Baseline, Chronic Pain Patient and 1 or 2 others). Once this was instituted, it seemed to work well
        - Everything is in the MAW in the PRN response mandatory fields (what scale are you using, is it constant or intermittent, location, something like sedation scoring at the same time, respiratory rate, alertness) in the Pre and if they complete the PRN response, they will have the post
    - Tina
        - Launched a PowerForm. Too many different pain scales from the Patient populations: from NICU babies, to pediatrics, to adults, to intubated patients. When you scan the pain med , it launches the PowerForm and it provides you all of the documentation that you need and then you are

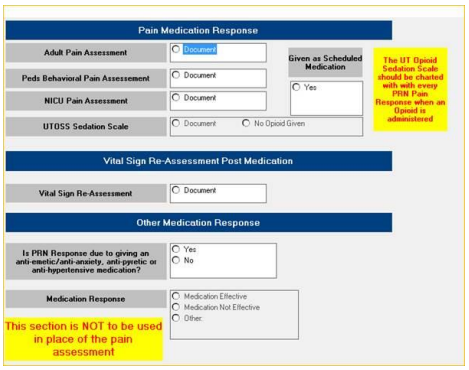
able to go through the MAW and complete the process. Then we have the reassessments like you discussed that launch 30 minutes after the pain medication is given.

- Brant
  - Folded into the MAW. There is a drop down for if it is a scheduled medication and a N/A for if it is NICU because some of the babies are getting scheduled morphine. It is a little more clicks for them, but it worked at our last survey, so we have kept it that way.





- Nursing Communication Tools
  - Brant: In the process of evaluating Voalte. Currently using their call system so there may be some integration there and a partnership that we are trying to learn about
    - Received several demos of CareAware Connect depending on which device you use with it.
    - It is one of the last remaining technological advances we want to provide for the Nurse at the bedside
  - Simmy: Early adopter of CareAware Connect in 2014 when Nurses were primary users. Also rolled out to SW and RT and small provider groups such as Anesthesia and NICU
    - Went through an evaluation process to see if they should stick with CareAware Connect and did a lot of end user engagement and stakeholder buy-in to determine if we were going to go to a different or alternative product or look at whether we were going to continue to look at optimizing Connect. We made the decision to move forward with Connect
    - March 2019 we moved to the 3.0 platform and moved from using iOS devices to using Android TC51 with the built in barcode scanner and as of March 2019 we have not only transitioned all

of our previous user to the 3.0 platform but also deployed shared devices across Hospitalist Service and Residence Service, ICUs, Pharmacy, ED, Perioperative Services
    - Expanded use with COVID to camera capture as well as BYOD Connect Messenger and provisioning Tech users as needed
- Chris: Covenant set up with TC51 in some cases using the TC52. It seems like a pretty stable piece of equipment. We contracted for the hot sway which is more cost effective than life cycle. If one breaks we send it back to Cerner and they send us a new one. We keep a small par level
    - The only real issue we had with stability was Google file dependencies so we worked with Cerner to reroute some of that back through Kansas City instead of Google so in some instances if Google cloud is down, we are still up
    - Homegrown development for mobile as well things like handwashing and visitor screens we are dropping on there because it is a great platform for it.
    - We don't use it for call light integration although we are staging to that. We are dragging our feet a little to see where the technology goes
        - Pilot were the nurses wrote down their individual CareAware numbers on the whiteboard and Patients used those. In some instances, that works OK but obviously call light integration would be a little more seamless
    - Push the use of the desktop version as well. We will evaluate whether a user is more prone to be at a desktop for example inhouse pharmacy really lends itself to the desktop application. The Nurse can be mobile and text the pharmacy down there and get a response back. In some cases we will use a CareAware Connect as a license more than we would connecting it to VIVA or TC51 or TC52
    - The more sites that get on it and push it would be a big help for us. We are pushing any internal development to be for Mobile solution
    - Went up on CareAware a 8 different facilities. They had a plethora of different communication tools. None were Vocera but they had walkie-talkies, cell phones, pagers, many different devices
    - From needs assessment found that they wanted to make calls, texts and then the more applications you put on it that were beneficial, that's what the newer nurses were looking for a handheld device to do more assessment and documentation tools. Meds Admin made them give up their desire for anything handsfree
    - Manage through AirWatch so that they can't download whatever they want we have a pretty solid change control process
    - Providers are using it and we are advancing with BYOD. Anesthesia were early adopters
    - Usually it is the Nurse initiating the communication through CareAware Connect and then the Physician responds
    - Requests to Cerner to have ability to get straight from the look-up to CareAware Connect
        - Want to jump from Nurse X in the care team and from there to their TC51, to be seamless. That is currently the Physician's biggest complain.
- Simmy: Realized during COVID-19 that the desktop messenger was very helpful for any Nurse that was in with a COVID positive patient so that they could message out their observer or to other Nurses if they needed something and didn't want to take off their PPE
    - When we moved to our new building in 2007 with went in with Ascom phones. Nursing was already accustomed to getting phone calls, text messages and physiological alerts, as well as
    - Nurse call alerts on a mobile and transitions with the same features on the Connect device when we moved to CareAware Connect platform
    - Using Clarvia Patient assignment monitor. Have whiteboard that is visible at the front of the unit so Providers can look-up on the whiteboard
    - For Nurses to connect with people in role they created generic roles so you would just look for generic roles so now you don't need to know the name you just sent it by role if they have claimed the role and this facilitates the ability to connect with the right person by role even if you don't know the name

        - Chris: Agree with the role assignment. Going in and accepting that Charge Nurse assignment, that was their first step in turning a facility on. Told them go ahead and look up the Charge Nurse and send them a message, and that got them interested pretty quickly and also got rid of the Charge Nurse phone and pager
- Wireless Vital Signs using VitalsLink
    - Brant: Getting the Nurses a phone and getting the Techs a wireless vital signs device
        - Evaluated them a couple of years ago and were trying to decide if we would go with the Dynamap VC150, which is the wireless version and new ones we have purchased have been the VC150 but until we replace the entire fleet we aren't going to connect any of them
    - Chris: Being successful with CareAware Connect, getting the entire care team involved, so getting phones to the Techs was a pretty big part of that this year
        - Implementing Tech entering vital signs on the mobile device when they are in the room. Interim step while we are working to replace equipment across 8 hospitals
    - Holly: Device integration in the majority of our areas and it works well. Have Philips monitors and work with Biomed and integrated them into Cerner
        - Have the St John's Sepsis Advisor and there is a confirmation process that the Nurse needs to go through to pull the Vital Signs in so that they aren't accepting erroneous values. For areas like the PACU, ICU Post-Cardiac Procedure, it is a necessity; when it is not available, it is not a good day
- 2018 code upgrade experiences
    - Brant going 2018.01.05 to 2018.03 in 2 weeks has anyone else done this?
        - Not a lot for the RN but have done lots of testing with it, but don't really know what the specific benefits are
        - Trying to stay current because we have not always done that and it is terrible trying to get caught back up
        - We are trying to do 1 to 2 upgrades a year to stay up to speed
        - I will be able to report back on how it goes not this weekend but next.
    - Chris : 2018.01.11 had the elimination of downtime with time change
- Blood Bridge Mobile
    - Chris: Is anyone using mobile Blood Bridge. App in the App Store
        - In the App Store there is a mobile version of Blood Bridge so you can utilize the TC51 for scanning of blood and documentation
        - Breast Milk Bridge works very well, it was a little tricky from an implementation standpoint.
        - You can surprisingly scan the wrong one is so many ways. Between the armband, the blood armband and the bag. Have challenges teaching to scan correctly
        - We are trying to get as much on the mobile device as we can. Heard that there was an app and wanted to know if anyone was using it
    - Brant: Blood was an issue last time with TJC because it was on paper - anything on paper is a potential for doing it wrong
- Meds Rec

    Tina: How to other organization reach compliance for Transfer Meds Rec and the complete function for wiping it off the list? We find lots of errors with being able to complete

    Brant: A couple of years ago we were completing the Pill Bottles on the list

        When they brought up ambulatory they had issues because we were wiping their Home Meds off the list. We re-educated to just document compliance unless they tell you that they are no longer taking it or the Doctor took them off of it. Otherwise they didn't have the ability to renew it because it had been taken off the list

    Tina: Only using complete for short term medications like antibiotics or short term steroids that were tapering, that they were taking 3 months ago. They are finding that they can't complete some of those as well

        We found on a couple that somewhere along the line that they didn't put the dose or the route on the Med Hx, and then you can't complete that

## Proposed agenda items for future meetings

- Carve out a future meeting focus on IPOCs to get a list of enhancement requests for IPOCs to improve functionality and potentially send to Cerner
- Downtime planning and preparations
- IPOC and Meds Rec
    - CAMC, Concord (One Plan initiative)
- Using SMEs and Chain Nurses for education
- Management of clinical decision report and reminders

## Follow-Ups

| Who | What | When |
|---|---|---|
| Brian Kottenstette | Send out the Site Information sheet with the minutes for sites to update | With minutes |
| Brian Kottenstette | Will ask out to the larger community about Blood Bridge Mobile to ask if any are using it since a few organizations aren't on today | By next meeting |

## Meeting Cadence

- All meetings start at 1:00pm Eastern on the Wednesday of the first full week of the month.
    - September 9th – **CNIO Roundtable**
    - October 7th – CMIO Roundtable: Open Discussion – 60 minutes
    - October 12-14 – CHC Get-Together *(Tentative)*
    - November 4 – **CNIO Roundtable**
    - December 9th – CMIO Roundtable: Innovations – 90 minutes
        - Presenters: Penn State, Northside