CNIO Roundtable Discussion

November 4, 2020; 7:00-8:00 AM Eastern

Meeting Information

Phone: 1-205-206-9624
Access Code: 139-558-419
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
R	Elise Hermes, CNIO; Nicklaus Health, FL		Heidi Edwards, CNIO; CAMC, WV
	Holly Ellison, CNIO; Concord Hospital, NH	X	Jenna Lloyd, CNIO; Centra Health, VA
X	Julie Mann, CNIO; Jackson Health System, FL	X	Lori Myers, Dir. Clinical Quality; Covenant Health, TN
	Lyn Baluyot, Chief Transformation Officer, Transform, CA		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
	Tiffany Cross, Informatics Officer Anc; Covenant Health, TN	X	Tina Stamper, Dir. Nursing Practice, Innovation, Informatics; CAMC, WV
X	Brian Kottenstette, MAKE Solutions Inc.	X	Patti Marshall, MAKE Solutions Inc
R	Sue Steckle, MAKE Solutions Inc.		

Agenda

- Introductions of new members
- Requested topics
  - Using Advance and LightsOn to pull metrics for project success and to drive process improvement
  - Cerner upgrades and using Cerner Upgrade Center or internal staff
  - IT involvement for hospital downtime operations; communications and recovery
- Open roundtable by hospital
- 2021 schedule and goals

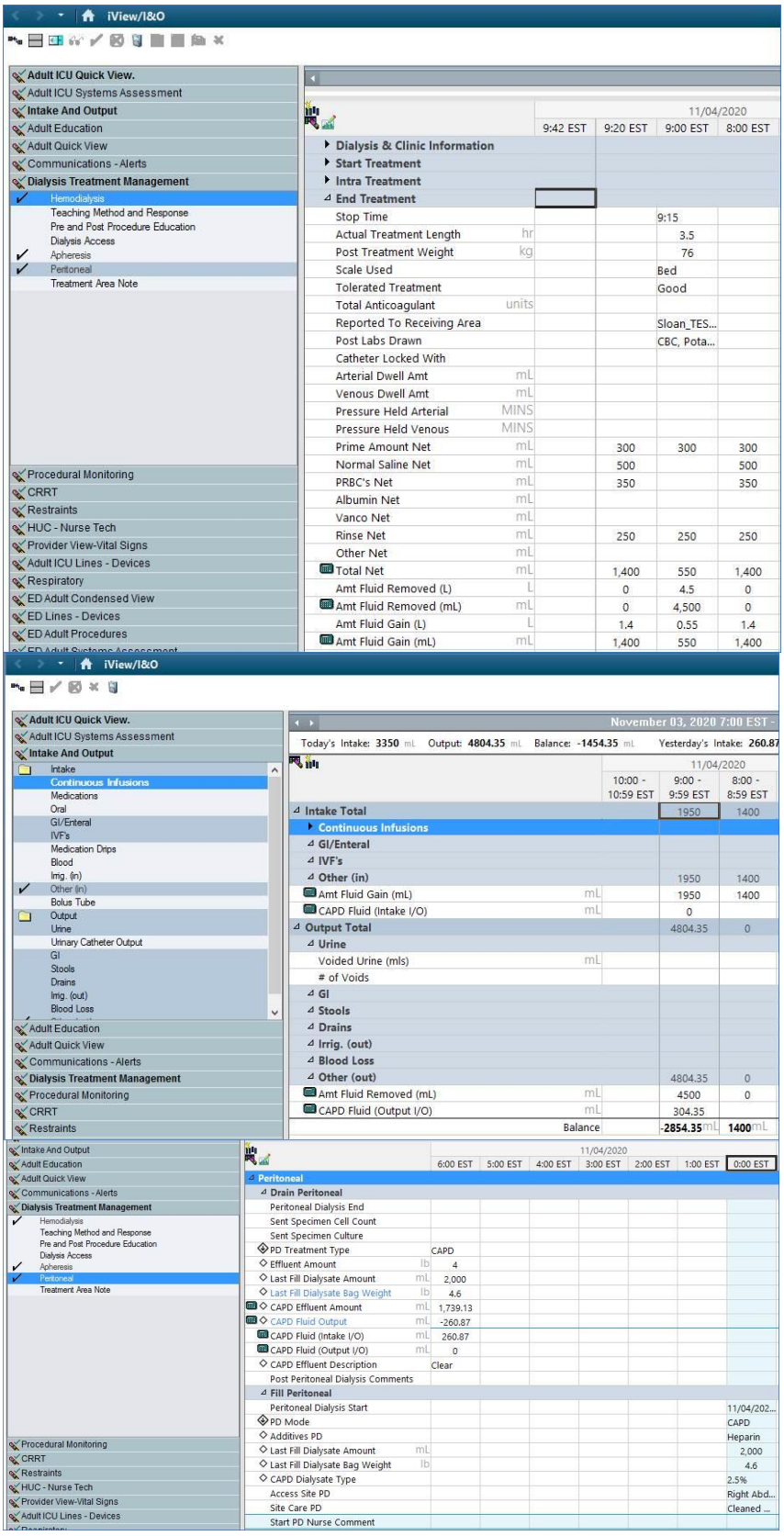
Notes

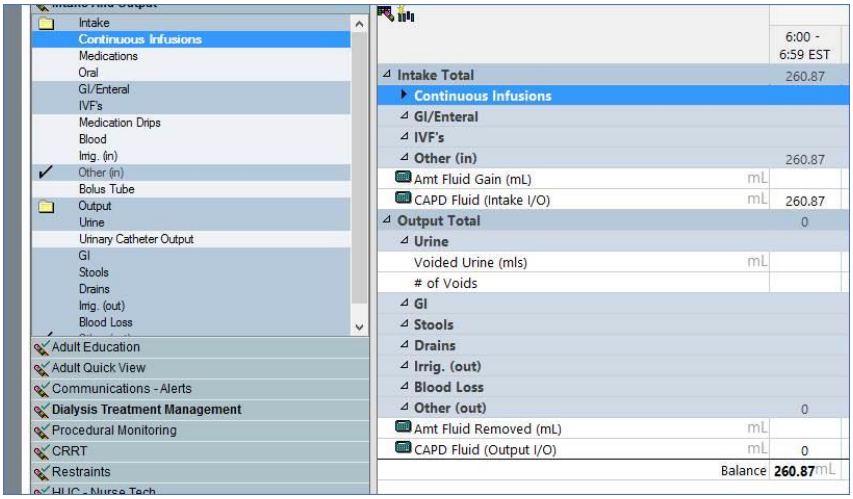
- **Introductions of new members**
  - Introduction from Julie Mann, Clinical Informatics, Jackson Heath System, FL
    - I have been at JHS for over 30 years and am a RN
    - I was the director of Patient Care for a long time and went into IT about 6 years ago and created a role called Clinical Informatics Coordinator. We have a team of 22 of them throughout the health system
    - We are a very large organization with 6 hospitals and multiple ambulatory cares. We primary care giver for all of Dade County. We are the public health system. University of Miami are our primary caregivers for the hospital, and we have other academic affiliations throughout Dade County as well
    - We have been a Cerner shop since 2008. We went to Millennium in 2014 when we did a Big Bang and we uploaded over 90 some odd applications. So we've been on a Cerner journey, trying to make our EHR seamless but you know there are a lot of issues so I'm happy to join your group.
- **Cerner upgrades and using Cerner Upgrade Center or internal staff**
  - Chris Skinner
    - We are a fairly new Cerner customer. We have been at it just a little over 2 years. We've got 10 facilities and roughly 100 practices on Cerner. We are not on Cerner Rev Cycle. Covenant has contracted with the Upgrade Center as we transition most of our analysts from Horizon to Cerner, so they were just learning, and we contracted for the Upgrade Center to do our upgrades. Now that we have a couple under our belt and their contract is coming up for renewal, we wanted to get a fell for if anyone else is doing their upgrades

on their own or are they using different consulting firms to work through that? I know part of it is carrying that many staff long term, in between what you need for an upgrade, so we just wanted to get a feel for what folks were doing and folks that has experience as well. And if you do have the Upgrade Center, what is your satisfaction and how much usage or involvement have they had in your upgrades.

- Jenna
  - We did use Cerner for our upgrade last year, in collaboration with our Clinical Applications team. So we did that upgrade together. It was what I would consider a successful upgrade
  - Needed to really stay engaged with Cerner as they find those critical issues to make sure that they got them corrected before we went up with the new version
  - We did not have any downtime either when we took that upgrade
  - It is my understanding that we will like engage with Cerner again this year for our upgrade
  - As long as it is a good collaboration, ours went really well for our caregivers that we could have impacted significantly. We didn't lose any productivity time, we had no downtime and we closed our Command Center early with that upgrade, but there were lots of different reasons for that to happen.
  - Remote hosted with CernerWorks
- Julie
  - Jackson does the same thing as you just said Jenna and we had a seamless upgrade and we're planning a new one. We are having another one towards the latter part of November
  - The big stress is trying to get a date from Cerner
- Jenna
  - Agreed, we had a date, but when we weren't satisfied with where we were at and we push it back because we were committed to not going live until we were really ready to go live. So again, it's back to that conversation and really engaging with them and ensuring that you have what you need as a client
  - The project management on the Health Care System side is crucial to the success and I think that's what you were eluding to – you really need to get project management around this.
- Chris
  - Yes, that is pretty similar to our experience, the only real issue we had was we did an MPage upgrade at the same time and has some latent slowness with the MPages but we did have a similar experience with the Upgrade Center. I probably wouldn't be asking this question if the price wasn't so high. I guess it's really what is driving us to continue to reevaluate that.
- Jenna
  - It is an expense. I know from a Centra perspective we will do it again. We will likely do it again this year. We are in contracting now but the goal would be to not to have to continue for the long term, but to be able to plan how to have our team take this piece on from an upgrade standpoint. I totally understand where you are coming from
- Brian
  - Did Covenant buy the Upgrade Managed Services where you can use it as much as you want, or are they buying individual upgrades?
- Chris
  - In our original contract, which is what we are still working off of, we bought as much as needed
- Brian
  - Concord isn't on, but they have previously used the Upgrade Center and have been please as well but are questioning the pricing on it. It has been very expensive for them. It has been a positive, but expensive experience so they are trying to determine if they can do it internally or need to continue to use the Upgrade Center

- **<u>Roundtable question about Dialysis Documentation</u>**
  - Tina
    - We are focusing on getting all of our Dialysis (PD, Hemo, CRRT) into clinical documentation. Cerner doesn't have the ability to document negative numbers when too much is being pulled off. What are other organizations doing to handle it? Do the have people go back and forth to document the output. I realize that in the Intake and Output section we don't put a negative number in the Output, but that's not really how we do our manual flowsheets when we are doing calculations for it.

- Brant
  - We ended up using Calculated DTAs in IView to come up with that negative number, but then only sharing the true answer over to the I&O section
- 



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- Tina
  - That would be awesome
  - That was what we thought but our analysts are struggling trying to figure out how to make those calculations happen. Thank you so much
- Lori
  - We ended up doing and Intake and an Output (speaking mainly for CRRT) and if it was a negative it shows as an Intake
  - I will send you those screenshots.
  - Our nurses didn't like the calculations so they are manually doing that.
- Tina
  - That would be great too. Thank you.
- Simmy
  - Will you send to the screenshots to everyone?

- **<u>Roundtable question about Cerner Patient Safety and Command Center dashboards</u>**
  - Jenna
    - We are looking at bringing up Cerner Patient Safety and Command Center dashboards. In the process of currently validating the Patient Safety dashboard. I'm just curious if anyone else in this group has moved forward with them and developed their standard workflow around those dashboards, and any issues that they are seeing, or any recommendations?
    - [No responses from the group]
    - OK, so we may be the first ones on this call. I will bring it back to this group when we go live.
    - We're looking at it from the Patient Safety Dashboards, they align with your falls and then the Command Center Dashboard is obviously for our Transfer Center and really aligning with Capacity and all of those components in the Command Center. So once we go live, the next time I am on the call I am glad to give an update if anybody is interested in learning more about those Patient Safety Dashboards
  - Brian
    - I think it would be great if you could bring it back.
    - Also when we send these notes out, there are a couple of the organizations that haven't been able to attend, so them may have something in places as well, so we can certainly see if any of them are working with it. I have heard of those dashboards, but I haven't heard of anybody that is running them yet though so hopefully you're not too much of the bleeding edge with either of those
  - Jenna
    - It is more making sure that you have your iBus upgraded to the level of code that it needs to be on. We are just in the middle of contracting or the Command Center Dashboard so we don't have all of the different components of that.

        - The Patient Safety Dashboard should only be a 12 week project to get up and running, but it's the validation piece and if you're close to model probably not as long, if you have done some customization it might take you a little longer to get it up
        - We don't use the Morse falls scale, we use JHFRAT so that's cause a little bit of an issue with our data because of the way that we engage with Cerner and they build it, but they built it trying to pull the Morse falls and we don't use that, so it's working through things like that we them that has been a learning journey
- **<u>Using Advance and LightsOn to pull metrics for project success and to drive process improvement</u>**
    - Brian
        - Holly isn't on, but she and I have worked on some of this together. Cerner has LightsOn and Advance tools that are available for each of the hospitals to go and look at metrics and see how nurses are doing with particular items that LightsOn polls. One of the things that she has been working on is seeing if they can pull those metrics out of LightsOn or Advance to look and see how nurses or different departments are doing to see if they can use that to drive any process improvement or go into specific areas and do any additional training. Holly wants to know if anyone else is using Advance or LightsOn from a process improvement perspective?
    - Simmy
        - I've gone into Advance and LightsOn and looked at the data. I reached out to our team to try to interpret the data in a more accurate way because the current presentation of the data for time spent/patient/nurse because it doesn't take into account Patient acuity or other workload related factors.
        - So while we look at it, and we can discreetly see this nurse spent more time with the Patient, until you dig a little deeper, it really is a little bit challenging in trying to determine if the time spent is reflective of workload associated with Patient care, or is that nurse just not being as efficient with her documentation processing.
        - While the data can be useful, it is a little bit challenging right now. The way the data is presented to really get face up data that's usable until you dig a little deeper – that has been my experience.
    - Brant
        - I spend a lot of time with it, not as much time as I think it takes to fully understand this data, but I try to focus on a couple of areas and then look at the nurses in those areas that have the lowest and most time in the chart. Then I can send what we call our "expert" users to spend some time with those nurses to say "how are you doing this, this fast?", or "why is it taking you this long?" then you can even drill down into the pie chart area in Advance to look at, "Ok you're using flowsheets and we've moved all of this over to the Nursing Workflow MPage, so you're spending more time trying to find the information that we have face up", things like that.
        - We are very early in the development and I would like for it to be hard coded and I could push those jobs and we coach those nurses in real time, but I think it takes a Division to do this.
    - Jenna
        - We try to work with it in a similar way. We are not to the point where we send our nurse educators out to work with our clinicians that are taking a bit longer. We do have the time in chart for nursing and for our providers on our scorecard, but we roll it up in the aggregate, but I agree it's difficult to really determine the best way to approach.
        - We have a couple of initiatives that are trying to improve documentation time that we will look in LightsOn to see the impact once we go live with it.
        - For example, moving to the Essential Clinical Data Set for our ICU and Med Surg areas, but it's more in that roll up of the number
        - Sometimes when I go in to review the data it doesn't add up from a number of patients seen perspective, because you'll have the national average of Patients seen like 80,000 and will be sitting at 80 and you know we certainly had more Patient than 80 for that week. So I am trying to get some clarity around what is happening and where Cerner is pulling that data in to try to figure out why we are having discrepancies like that in our data, but just as I think there's still kind of working through the LightsOn, we do use it, but it's at a higher level than it sounds like some organizations are using it.
    - Simmy
        - I was going to add, in aggregate we were able to use the data

        - We did move adopt the Essential Clinical Data Set for the Admissions workflow and were able to, in aggregate, demonstrate a decrease in time spent. In aggregate, but at the unique nurses level, that's where we are probably struggling more, but in aggregate, yes, I agree that you can look in when you make a change to have documentation efficiency by optimizing the workflows that you can in aggregate demonstrate some improvement.
    - Chris
        - We do use it to evaluate a lot of projects at a high level, kind of as filter data to point you to something where you'll write a report that is a little bit deeper or user specific
        - We use it on a pretty regular basis for metrics related to Physicians. Or Physician Liaisons use to target certain doctors for ongoing training.
        - We use it pretty heavily for CareAware connect for monthly usage and then to target ongoing education there
        - The other thing we do, both Lori and I, is challenge our Cerner counterparts. It is on our agenda when we have our monthly meetings with them to have done the legwork, using LightsOn, and so it's one thing I would encourage you all to do too. Really push your Cerner counterpart until it gets a little more formalized to bring that LightsOn dashboard back to you. That is kind of what we're doing so proactively. We're not that substantiated yet with checking certain metrics or dashboards and LightsOn on a weekly or monthly basis outside of the ones I mentioned but what we do is kind of have our Cerner counterparts do that and we've have a lot of process improvements come out of that discussion and thankfully their still doing a lot of that leg work.
    - Julie
        - Our Clinical Informatics Team has the hospital divided by providers and nurses and they each have assigned units and names of staff that they are monitoring.
        - They send Sprints out to each other and are able to communicate poor adopters, slow users and then go and coach them one-on-one
        - The other thing that we have identified by looking at reports in Advance and LightsOn is seeing that there is some back charting so we have been able to start monitoring that where providers, nurses don't document until the end of the day, so we're working on about 25% of the users that are in that Category, so we are trying to move the needle on that.
    - Brian
        - Julie, you mentioned you using sprints when you send out people. I know LightsOn or Advance has the ability to actually do sprints within there. Are you using that functionality or something else?
    - Julie
        - Yes, we are using that functionality
        - That way there's no paper, no reports, then we are able to move quick with the information
    - Jenna
        - Would I be able to connect with you to better understand that workflow that you are using with those nurses, with that nursing time and chart?
    - Julie
        - Sure, I've moved to a different role but we can set something up to talk to one of the supervisors that does that.
    - Brant
        - It isn't easy, but you have to have those people get access and have a Cerner account (to Advance & LightsOn
    - Julie
        - That is easy to give access to them and then monitor. Everyone gets a different role: some are managers; others are users. So not everyone can do the same thing.
    - Brian
        - Julie can you spend a minute and talk about what Simmy had started talking about: the different acuity levels, maybe aren't represented from a timing perspective, so it may look like those ICU nurses are very inefficient when it's really they're spending more time with high acuity patients. How are you accounting for that and creating your baseline to know who to go talk to?

- Julie
  - It is actually that you develop some intuition. The more you look at the data the more you start to understand, you know the nurse. You give to people that work closely with the nurses
  - I guess it is really intuitive. There's not metrics for that. We know the players and it just doesn't look right
  - You know I was looking at all the PAs I knew ¾ of them, so it was just looking at where they are and how much time they spend just looking at orders. So it was going to them and helping them to organize their screens. You know that they can manipulate and look at things quicker in 1 page instead of clicking and looking. So I don't know if there's any one report that we could look.
  - We picked the metrics. We picked a number that what's a normal time and then anything that fell out we just said we're going to chase those people.
- Brian
  - Brant was saying you need to look at the data, and it doesn't really tell the whole story of what s going on. You can't really take at face value until you start digging into it and look at it.
  - It is a little bit of intuition and magic that you have to do as well in order to really understand who your staff is and then figure out who seems to be struggling. I think it is a good first pass in order to be able to understand where people may be sitting and then dig into it from there.
- Brant
  - As long as you have your nurses in an acute care nurse position and your critical care nursing in the intensive care nurse position, you can break it down in Advance, but I agree it's a starting point.
  - One of the best users, her numbers were through the roof one month when we looked. I called her and asked "what's going on", she said "oh, I'm precepting this month I've been navigating across all kinds of charts". So she was teaching, and her numbers reflected that, but as soon as she was done teaching, her numbers went right back into almost perfect. So it just gives you a starting point.
- Julie
  - Having people in the right role is the first thing. You are correct, having people in the correct role is the first step. Because we didn't have critical care nurses in there, so they how they work is not like a Med Surg nurse. So yes, you're right, that's your first thing is cleaning up your list getting the people in the right positions.
- Simmy
  - What is your benchmark time spent in the EHR by position? What do you expect? How many minutes are you looking at for a Critical Care nurse versus the Med Surg nurse as your "If they're above this, this number of minutes, then I'm worried about them"?
- Jenna
  - We haven't made it that far. What we've done is looked at it from a scorecard perspective in the aggregate. So whether it's an ambulatory, acute, or ED, we roll that number up. So our goal for the health care system in the aggregate is 10 minutes 27 seconds. It's not Cerner's aggregate national average.
  - We do look at that, but we haven't taken it to it. We do pull out our critical care in our Med surg and see what there where it looks like they're spending a majority of their time and we do the same thing for ambulatory and ED.
  - When we look at look at it from that perspective, our acute care nurses have a really robust governance structure and are making a lot of workflow changes through our governance, because it's bedside nurses that are that make up the governance to really have the opportunity to influence the system.
  - In ambulatory we don't have as strong of a governance and also in ED, and we're trying to mirror what that governance looks like on the acute care side. But you can see that our ambulatory in ED times are well over the national average, as Cerner reports them. So we are trying to focus and figure out what is happening and ambulatory and ED to try to drive that aggregate time down. We don't necessarily have benchmarks for each category separated out - yet.
- Brian
  - Does anybody use Citrix session recorder to go and look at anybody who may be an outlier? Watch their sessions before you go and connect with him in person?
- Jenna
  - We use Smart Auditor. Is that what you are talking about?

- Brian
  - Yes, I think it's changed into that. I know it's changed names a couple times. Smart auditor where
  - you can basically watch somebody's session.
- Chris
  - That is one of the steps the Physician Liaisons do. They look at the pointer day in LightsOn and then they'll do a Smart Auditor review as well, and I think our Smart Auditor goes back 7 days and then get purged.
- Simmy
  - We use Smart Auditor too. I think we primarily use it for the physicians as well, but honestly, we use Smart Auditor more for Safety event reporting and follow up and trying to identify where errors in navigation or errors in documentation might have occurred, or missteps related to Safety events that are reported. That typically where we use Smart Auditor primarily, not so much for nursing documentation efficiency but it's a good idea.
- Brian
  - I just have seen it used before you go out to somebody, probably more in the provider side than on the nursing side, but if you see somebody who's way up on their timings, take a look at Smart Auditor to make sure I have a full picture of what it is that they're doing. Because I don't want to go after the nurse liaison or the person who's precepting for that week and say “hey, what's going on” as opposed to say maybe they are struggling in using the old functionality instead of the new functionality.
- Lori
  - We had a hospital who it was in the perioperative round was trying to decrease time of throughput preoperatively, and we kind of use both tools of looking at how long is it taking this person versus this person and again knowing that this person takes care of ortho versus they take care of someone having vasectomy. But then we also did some Smart Auditor to see and found a lot of people doing Notes instead of doing other things which were increasing their time.
- Brian
  - It really sounds like from a LightsOn and Advance perspective, people are using it in different ways and the metrics in order to be able to at least get back out in front of their users.
  - It certainly is a difficult tool to get set up and running to make sure that you're able to use that data correctly.
  - So Julie, thank you for some of your insights. It sounds like you might be more robust than some of the other sites on how you're using it.
  - I will look as well through some of my materials and things that I collected on LightsOn in Advance over the
  - last couple years and I'll see if there's anything worthwhile that I can send out to the group that's sort of how I've seen other sites use it as well so we can continue to share information around that.

- **<u>IT involvement for hospital downtime operations; communications and recovery</u>**
  - Brian
    - The last item I had that was sent to me, but again this one came from Holly, so I don't know if I want to start this one without her because I think she may have some specific questions. It is around hospital downtimes in the operations and how you communicate to the staff in the facilities as you get into a downtime and sort of what that looks like, and then how you do recovery. But again, like I said, she had some specific questions so I may save that for a future meeting when she is able to join.
    - We have about 15 minutes left so I just wanted to circle back around again though and see if anybody had any questions or things they wanted to talk about with the larger group.
  - Jenna
    - I think considering our current state of where we are with the FBI alert, in regards to cyber security, and the threat that we are under in healthcare, that time piece is extremely important. We have worked last week and this week to really try to ensure that our acute care side of the house and our ambulatory side understand what the actual downtime procedures are. But what we are identifying is that our ancillary services, we have some opportunity there, to ensure that their processes are in place for downtime, and so I am curious, I know that Holly had this question, but I do think with where we are it is an important topic to understand how other healthcare systems are taking this on, especially under the current threat that we're under.

- Simmy
  - We certainly are definitely taking proactive precautions more recently with regards to this concern related to the cyber security. But historically I can tell you that are we have a downtime policy and procedure. We have a business continuity plan that's built into our emergency operations plan for the organization. I'm assuming Holly's question was probably more generally related to what if you had to take an application down and what's your process?
  - Organizationally we have a team that discusses is the timing and the scheduling. We have a notifier that goes out to staff on a weekly basis of all the planned downtimes. Uur leadership is informed during the administrator call on Mondays every week so that their situational awareness about all of the planned downtime.
  - For unplanned downtimes, obviously we mobilize quickly and we are able to put staff, clinical informatics staff, and make them available to the frontline staff to make sure, because I'm sure as most of you experienced this as we do at my hospital, many of our new hires don't know what to do in downtime. Even if you have policies and procedures in place, they actually don't appreciate what paperwork they need or what the workflow is and so in the last year what we've been doing is just doing scenarios and doing tabletop exercises with staff to remind them: this is the paperwork you need; this is where you document this; and this is how you do this.
  - As far as the cyber security threats that's occurring right now. Obviously at a high level we're communicating with our staff. We are using Proofpoint with regard to safe links and just creating an environment where our staff know what to do as far as external links are concerned and how to determine and, how to report suspicious email.
  - So those are the things that are happening for the frontline staff, and obviously in the background from an IT perspective is really partnering with the operational teams and making sure that in every area of the organization you have a solid plan on how you're going to make sure you have that readiness.
  - I know one of the challenges we're working on this week or the last week is all of our printing is connected to the network, and how do you move that so that you have a localized printer, so that if we went into a full downtime, how could people get copies of what they need? Or how do you have runners and other people so you can get specimens, labs etc., or medications to the right places? so that they know what the orders are and those types of things. It's really partnering affectively with your operations team.
- Chris
  - We have a similar program for downtime. I think one of the things that we do well with that is that we have one single policy for planned and one single policy for unplanned. Probably the difference is we have a procedure for each area: nursing; ancillary; physician, so they get a little dashboard when they go to downtime. If they're nursing, they just click on that one button and it it's very specific to nursing, the same for the physicians and so on and so forth.
  - We keep that kind of up to date by analyst. We put that back on our analyst and say, you know, you guys are responsible to make sure these are up to date through upgrades and then once a year we do a drill. It's a very much like a tabletop, but we load the steps for the drill into our learning management system. They go out and print that, and then you know some of the steps are: find your 7/24 device; make sure you can log in; make sure you can pull these two reports; and make sure these 2 reports print. Once they've completed that checklist, they'll go and complete that task and in the LMS, and so I think that helps us keep our folks up to speed that have been there for a long time, and then it's open to our new hires as well to take that course.
  - We are actually in the process of doing our end of the year drill now, which was pretty convenient. You know, with everything that that was going on in relation to FBI alerts.
  - Brian, I've also got some pretty good documentation. I think you may have seen it on some of our downtime stuff with that table top drill and some other things and we've got some folks that took that to the next level. So as far as printers, being offline or printers local for 7/24 and some of that is accounted for as well.
- Brian
  - If that's something you'd be willing to share, I'm sure others in the group would like to see that as well.
- Chris

        - Yeah, I think we did a presentation, maybe CHC, a year or two ago, so we we've got some stuff and I think it doesn't compromise any of our plans.
    - Tina
        - That would be great because I'm currently working on the same stuff and I really do appreciate the conversation. Thank you.
    - Brian
        - So it sounds like everybody has a planned and unplanned downtime procedure, but when I think about an unplanned downtime, you can have multiple types of downtime: you can have a Cerner outage; you could have a network outage; or you can have a power outage. Do your plans incorporate all three of those types of downtimes or that kind of a one size fits all and you just? Go and pull the fire alarm on these other items if you need to.
    - Chris
        - Ours does. We try to not be super specific because as soon as you are is all something different. But you know we do have kind of a different procedure for a network outage versus a Cerner cloud-based outage. That also fits into our communication plan that we have for how we send the message out. Which can also be dependent on the network, so the networks out so you have to communicate differently as well. We do have that built in there at a really high level: Cerner's out; STAR's out (for revenue cycle) - application versus the networks. Things like that are kind of built into the plan, and really around the communication the how you react. Hopefully we've built in non-network dependency on a lot of our processes and procedures.
    - Brian
        - Alright, great, thank you for that. Anything else around downtime that anybody wants to talk about. I know that's a big thing right now with some of the ransomware attacks that have been going on. And thank you for that, and we can always get into that in a little more detail on a future call as well. I know if you go pretty deep on those pieces we needed to.
- 2021 schedule and goals
    - Brian
        - I did just want to talk about the schedule for these roundtable discussions going into 2021 and if there's any specific goals or anything like that that that people wanted to talk about.
        - Currently we've been doing these every two months or next one would be in January and then March. Are people still good with continuing on with that schedule and does this time typically work for people to
        - 7:00 to 8:00 AM? Every 2 months, this time?
    - Group replies
        - [Yes]
    - Chris
        - I really like the dashboard as well. That's been a big benefit. When we get back to the rest of our leadership team, I think it's great that they can see where everyone's peers are.
    - Brian
        - I wanted to see if this group would be interested in doing that, not only hearing from other organizations but presenting on things that that you're doing as well in the nursing space? Would anybody like to volunteer to talk at a future meeting and discuss anything you're doing? [no answers]
    - Tina
        - We are in the process of improving a lot of our ambulatory protocols where we're trying to automate specific diagnostic testing, simple diagnostic testing and lab draws. If we're successful in getting one of those implemented through I would like to share that and get some input from the group on what they're doing and If this is a good thing to move forward, I'll be glad to do that.
    - Brian
        - Jenna, you were talking earlier about some of the new dashboards you're doing. Something like that might be good as well to bring back to the group. So I think we have some ideas and it certainly is not an hourlong discussion that we're looking for, but if you want to spend 15 minutes, I think those are perfect topics that would benefit everybody.
    - Jenna
        - Yes. I'm happy to do that if we are at a good point with it.

- Brian
  - Thanks for joining everyone, will get some notes out. Thank you all for your participation.
- Group
  - [Thanks]

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
- 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
Brant & Lori	Screenshots for negative numbers for dialysis for the entire group	
Julie	Set a time with Jenna to discuss using Sprints within LightsOn and Advance	
Brian	Look through materials collected for LightsOn and Advance across previous clients to see if there is anything of value to share with group	
Chris	Documentation of Downtime processes	

Meeting Cadence

- All meetings on the Wednesday of the first full week of the month. CMIO start at 1:00pm Eastern, CNIO start at 7:00am Eastern
  - November 4 – CNIO Roundtable
  - December 9th – CMIO Roundtable: Innovations – 90 minutes
    - Presenters: Penn State, Northside