EHR Governance and Optimization Processes

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About the University of Maryland Medical System

11 hospitals in Maryland; 5 live on Epic (about 75% of beds)

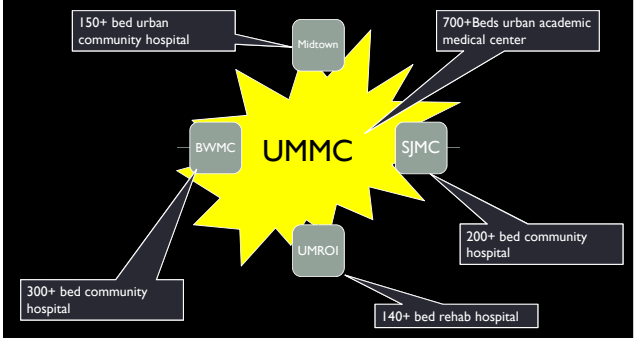
~600 employed physicians + ~600 faculty + ~ lots of private physicians

Large ambulatory practice – faculty + community
"Clinically integrated network" a newer concept

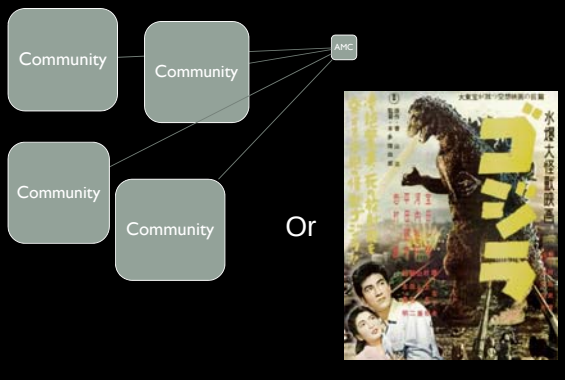
Relatively new Medical System
Epic = first attempt at "systemness"

Epic 2012 (2015 in Oct):
Inpt, Amb, Optime/Anesth, Rev Cycle, Stork, HIM, ADT, ASAP
Not Cupid, Beacon, Beaker, Phoenix

The way the AMC sees the system



The way the community sites see the system



Our structure and political reality "forced" us to create a system with:

- Checks and balances
- Transparency
- Chain of evidence
- Over-participation

Goals

Provide Clinical/Operational (Non-IT) direction to the maturation of the EHR

- Provide a unified "voice" for end users

Garner buy-in and direction from key stakeholders

Drive practice as much as process

Governance

UDC= User Design Center

The governance trade off

Fixed Number of UDC's (static)	Organic evolution of UDC's (messy)
Meetings that do nothing	No meetings or lots of minutia
Easy to discuss with Vice Presidents	Of the people

Critical to governance success

Real things to consider/real authority

Meeting "staff" accountable for productivity

The right leadership

Scale 1 hospital on Epic → 5

Pitfalls & suggestions

No-one shows up
- Actually implement changes suggested
- Kill the meeting
- Invite people closer to the patient

Lots of time spent on minutia
- Force meeting structure (10 minutes on big ideas)

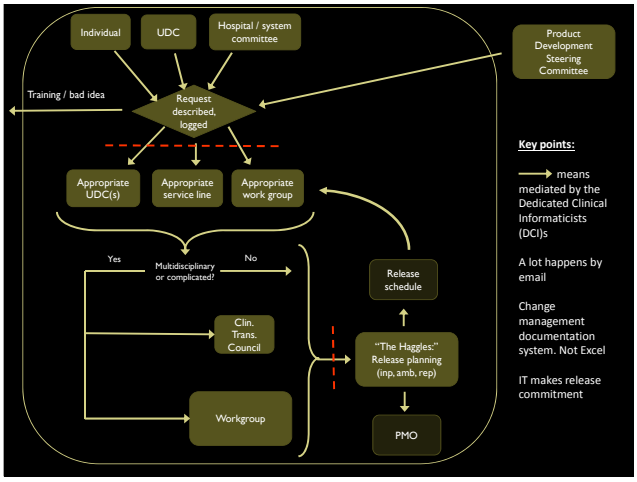
Lots of talk, no action
- Appoint meeting staff
- Choose leadership

What does DCI mean at UMMS?

What they are
a) Dedicated Clinical Informaticist
b) Process improvement specialist
c) All of the above

Clinical or Business specialists who receive special Epic training (fundamentals in an application or greater) and act as coordinators, translators, workflow analysts, peacemakers, troubleshooters, and governance staff.

What they are not:
a) Build decision makers/Policy creators
b) Technical analysts (no build access)
c) Full time trainers
d) Elbow support/desktop support
e) All of the above



Examples of small (tactical) stuff

Make heparin orders doctor-proof

Create a "change service" order

Add cell phone to demographics display in XXX navigator

Tweak work excuse note

Make DME order print in a more reimbursable format

Add visit counter to ED track-board

Examples of bigger (strategic) stuff

Clinical photos

State HIE patient lookup right in Epic

Print MOLST from code status order

Get rid of fancy prescription paper

Patient identification photos

Patient questionnaires / Patient reported outcomes

Palliative care coding

Streamline nursing documentation

Make blood administration documentation less awful

Systematically cut down on alert fatigue

You should release stuff in releases

Gigantic resistance at first
- Bringing candy home from grocery store

Makes way too much sense
- Avoid too much change at once
- Stay organized
- Communicate more effectively
- Breathing room for IT

Issues

Staff/informatics not available for all areas
- Show the power in "staffing" the meeting
- Operational staff will step forward

Issue tracking imperfect

Poor inter-team cooperation
- Keep individuals accountable for shepherding changes
- Appoint a Czar

Issue fatigue
- Some things you don't litigate, you just sign off

Standardization wars
- It's all about the journey?

Issues

Communication to end users
- Identify a professional
- But not too professional

Nonstrategic requests
- Let the process work

Process circumvention / end run
- Let us know if you figure this one out

Fire drills
- Emphasize process

If we got to do it over...

Identify "informatics" earlier
- for every service line / area- Clinical / Business / Inpatient / Ambulatory
- Clinical/Technical experts who are tasked with representing the end users as a group

Keep focus
- ↓ standardization of minutia ↑ strategic issues

Communications team

More NP/PA's on the informatics team

Remember...

- There are trade offs to over-structuring governance
- Identify governance and product development "staff" that are not part of the technical team
- Governance groups must have real authority
- People like structure. Releases help with that.

2016 process goals

- Focus more on BIG PICTURE, less on minutia
- Reduce redundancy
- Scale up for 3 more hospitals geographically remote
- Maximize areas using product development process
- Better release communication (Not CSPAN)
- Optimization throughput reporting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