South Island MSA

SOUTH ISLAND MEDICAL STAFF ASSOCIATION
Minutes
General Meeting – February 27, 2023
In-person (RJH PCC S150)/Virtual (WebEx)
Meeting 6:00-7:30pm

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1. **Call to Order at 6:00 pm** - Welcome by MSA Co-President Dr. Catherine Jenkins
    a. Welcome to special guests:
        - Annebeth Leurs – Engagement Partner, Doctors of BC (DoBC)
        - Dr. Pooya Kazemi (IHealth Site Lead, RJH)
        - Dr. Kellie Whitehill (IHealth Site Lead, VGH)
        - Dr Mary Lyn Fyfe (CMIO, Island Health)
        - Dr. Eric Shafonsky (IHealth Physician Lead)

    b. Approval and adoption of agenda and September 2022 minutes

2. **CPOE implementation at RJH and VGH**
    - Introductions from Pooya Kazemi and Kellie Whitehill (IHealth Site Leads) – they are the links between physicians and IHealth leadership team, connect with them to bring questions or concerns
    - Draft roadmap of Acute and Ambulatory activations shared – the upcoming Go-Live includes CPOE and Closed Loop Medication Administration, changing surgical information system tools, supporting Quality of Care in Critical and Complex areas, Ambulatory Clinic activation
    - First road map activities:
        - Order Set Harmonization – Sept 2022 to March 2023 (already happening; based on best practice)
        - Interdisciplinary Workflow Validations
        - 6 hours of compensation for CPOE (had 4 hours for ClinDoc); also get CME credits for training
        - VGH Go-Live will be first, several weeks later RJH will Go-Live
        - Order sets "smart sheets" include calculators for weight based dosing and decision support tools for drug interactions
        - Specialty Leads are engaged for each speciality, they are at different stages of harmonization (goal is end of March, extensions if needed); important for each specialty to engage in the process to ensure it fits their needs for Go-Live
        - A lot of learning from other activations; paid attention to timing and sequence of activities
        - Around 50% of order sets have been completed (about 1200 in total); sign off on order sets is by an interdisciplinary collective

3. **Questions/Discussion:**
    Is there an opportunity to introduce a component of CPOE like medical imaging prior to medication?
    - Based on an informal meeting with Mary Lyn Fyfe, this may be possible (Jan 31 conversation). The Emergency Working Group has considered it and has flagged concerns that any unforeseen problems could set a negative tone for the full roll-out
    - There's an opportunity to leverage Nanaimo's work here: connections are already up and running,
    - IHealth specialty leads for Medical Imaging (Jeffery Hu) and Emergency Medicine (Drew Digney) would be good to have on board
    - Exploring Medical Imaging activation for EDs (would be contained to physician workflow) – under evaluation because of challenges with magnitude of change, want to have this set up for other sites

- Exploring resources required and potential benefit of ED Med Imaging CPOE activation
- Key factors: workflow, support resources required, degree of interdisciplinary involvement

What is the basis for not allowing NUAs to enter orders as proposed orders for physicians to sign off on?

- If nurses can submit a proposed order, why couldn't NUAs do it also; currently in emerg, verbal orders are entered by NUAs. This is not currently the case on the wards where verbal orders need to be entered by nursing
- If NUAs aren't allowed to, they will have to rely on RNs, who are already working hard and it takes them away from direct patient care; enabling NUAs to enter proposed orders will lighten the load on locums, who would otherwise be highly challenged by CPOE
    - Per Professional Practice – CPOE represents direct order entry into the clinical info system

How do we handle differing expectations and assumptions with respect to lab orders?

- There was an issue in Nanaimo with respect to ordering urine samples, they were being canceled by the Lab because nobody triggered collection of a sample
- There have been examples where adding Ca+ to a bloodwork order triggers a new order, rather than adding the test on to an existing blood sample
- Can we see pending orders?
    - CPOE introduces a number of practice changes, standardized ordering practices will be introduced
    - Support lab practices for lab techs on the floors and analysis island wide
    - Every order set can be individualized and orders can be used and modified
    - Dr. Michael Chen is IHealth Lab Specialty Lead

Will there be enough PharmTechs?

- IHealth has been given the green light to hire more PharmTechs to support the CPOE rollout at RJH and VGH. Our understanding is that they have based the number of techs required on the model used in Nanaimo
- Job posting is an important step and we are grateful that this concern was heard but it is possible there will not be enough applicants to fill these positions
    - Island Health is evaluating a proposal to hire PharmTechs to bring eBPMH completion target to 95%
    - Challenges hiring PharmTechs, currently a shortage
    - Med Reconciliation is foundational to Med Safety and is a required Organization Practice for Accreditation

How are the current Health Human Resources challenges being considered?

- What contingencies are in place for physicians, nurse, allied care provider, and IHealth team member attrition?
    - Working at sites to develop strategies for change readiness, education and activation that consider these challenges
    - Leverage NRGH expertise, staggering two sites
    - Already completed the ClinDoc portion, now moving to medication management
    - Implementation will ultimately support HHR recruitment and retention
    - Think of how we can leverage residents and medical students for support through activation
    - Plans for reducing elective procedures; currently running at over 100%
    - Had reduction of slates during ClinDoc; without slow down during activation won't be able to run at full capacity, but surgical patients are already getting cancelled and bumped
    - Exploring possibilities of shifting some procedures to RJH during VGH activation, and vice versa
    - Not just the surgical slate that will decrease if we can, also can reduce ambulatory clinics

- Clinical Operations team try to decant/place people in different locations to balance site volume
- There will not be an ability to have a significant reduction
- Burden Solution Tool – goal to support physicians to do they work they are supposed to do at their scope
- Need Scribes to help support physician time and orders
    - Scribes in Canada are still being explored and evaluated
    - Fraser Health in ED may be using Scribes, hard to get information
    - Front-end voice recognition is a digital scribe technology; at pilot stages
    - Scribes cannot enter orders, remains responsibility of physicians
    - Scribes do ClinDoc in the United States, not orders or medication management
    - Conversations occurring but not current plan to use them at Island Health at this time
    - Request organization to explore other auxiliary support physicians (i.e. Pharmacists, care team)
- Verbal orders and telephone orders won't go away, dictation won't go away
- Owen Haley back supporting us, once we pick a date we won't change the date – finite period of time we can do it in (winter surge, summer vacations, accreditation)
- Discussing how to support recurrent learning for new staff/physicians and people who work intermittently (e.g. locums)

What will the education and onboarding of new physicians look like?

- A year in, some physicians are still relying on ClinDoc refreshers.
- Building operational support through Help Desk
- Plan to have provider support available Monday to Friday (RJH – Royal Block 2nd Floor, VGH – next to physician lounge); will be able to find someone to support new or intermittently working physician
- Pharmacy support 24 hours a day; educating Clinical Pharmacists with physicians – as we increase PharmTechs and Pharmacists, they will be able to provide support for Med Rec
- Every activation has some people who leave the organization, but we are working to support people through the change
- Many locums and residents are used to CPOE from activations across the country
- Will have physical and virtual support

What is the education and support plan for physicians who work intermittently in the hospital setting?

- Locums and FPs who do not have much opportunity to use CPOE may require re-education if they work intermittently
- This is an issue of retention: Locums who find themselves overwhelmed by CPOE may choose to not return to Island Health sites
    - Intermittent people could "suggest orders" and have other MRP enter them
    - Within specialty services, will need to make sure there is understanding of what is expected
    - All physicians, including learners and locums, will need to be trained on CPOE once activated

What will surgery cancellations look like in anticipation of Go Live?

- Surgeons need to know ASAP so they can make alternate arrangements
- The desired 85% hospital capacity will not be possible here

We need to know more about the two-site plan, especially for the Hospitalists, ICU, and Surgery teams.

- Working out how transfers to and from other hospitals will happen, including will the MAR be sent in a way that is up to date
- There is an added level of complexity with transfers from community facilities, such as Seven Oaks

- Designing for partial implementations

What kind of elbow-to-elbow support can we expect when we go live?

- In Nanaimo, Go-Live supports were computer savvy and could help connect to a printer, but knew nothing about healthcare or Cerner. We need people who understand the context, who can support physicians to create orders, and who can sort problems out quickly.
    - Evaluating elbow-to-elbow needs for all disciplines
    - Support from Informaticists, physician champions, NRGH and Lower Mainland colleagues
    - Support teams who use SLACK, some physician groups may choose to use this as well

How long will support be provided for?

- Hope there is recognition that the current environment and staffing levels will mean that the timeframe for a successful rollout will likely be longer and harder than ideal
- 4-6 weeks with tapering to operational supports

What hardware requirements have been determined?

- When consultants come to the ED, all the computers are being used by ERPs and learners. What can be done to support consultants?
- What about physicians who are on call in various parts of the hospital?
    - Do walkthroughs; have not done final walkthroughs yet
    - Additional and new devices will be deployed
    - If there is a workstation concern, contact Pooya or Kellie to flag it for them
    - Designating device depot space for Go-Live

What are the plans for workstation maintenance?

- During activation, additional individuals onsite to support
- Provincial program for maintenance
- Have workstation people who round twice a week and check in with clinical people; every month check each device

What about Wi-Fi bandwidth?

- If people need to bring their own computer, Wi-Fi needs to be reliable in all places in the hospital. Will this be upgraded? How do we let you know about dead zones?
    - Has already upgraded VGH; RJH – completion summer 2023
    - Also assessing Wired internet needs

Overall, what is planned in case things don't go smoothly?

- There will be bumps and challenges
- We are in a different place than we were in 2016; have learned a lot and changed our approach
- Have learned to layer on change often and frequently over time
- Want to expose what it looks like more often so the fear/mystery/concerns get addressed
- Really hard to pull back once have changed to activation but have never seen a need to stop an activation
- Readiness dashboard: data will signal whether we are ready to go-live or not, based on framework of data
- SIMAC will send recommendations to HAMAC

How are Decision Support tools being built in to prompt decision making?

- Clinical Decision support is very basic right now; reviewing a list of needs
- Have seen some tools that make suggestions based on medical needs, that is for the future
- Change Management – this kind of tool should be available, would get physician buy-in
- Presentations on loss of efficiency ~15%
- Part of challenge, don't have infrastructure to have this level of support, need cloud based level of technology, implementing what we have now and will build in the future
- Use of templates, Quick Orders, tap-and-go, trying to decrease the time at every step of the way
- Purpose of Closed Loop Medication System is to prevent errors and increase safety; Med Errors in a non-CPOE environment occur at higher levels
- This effort services best practices
- Helps individual physicians to hear this is Quality initiative and there is more going into it than efficiency
- Mapping total time to patient shows improvements; measuring time pre and post
- Lots of things have changed since Nanaimo
- We don't know how well we are doing or not doing without a way to measure ourselves
- Not thinking about it as order entry, but improving the system
- Can we turn off some clinical decision support making that slows us down? Shouldn't pharmacy be responsible for drug interactions?
    - Evaluating how tools work as we go along and can turn off some alerts as needed
    - Pharmacy is responsible for drug interactions, they see much more than the alerts

How can we suggest improvements for ClinDoc?

- There is still room for improvement in ClinDoc in terms of user friendliness and system improvements
- Can share who are the contacts are to follow-up with to make improvement to ClinDoc

Will dictation continue? It would be helpful for certain types of consults.

- Yes, will likely always be available due to downtimes

Can Clinicians learn what the rate limiting steps were from other parts of the country to better understand how to avoid them/get around them?

- Can help make connections with other Clinicians; have someone come speak to groups
- Several groups of physicians are willing to help; Mainland and Ontario with same system
- Any group who wants to send a physician for a day up to Nanaimo, we can help with that

Value of having simulations? "Rehearsals for regular things we do"

- Would be great to think about simulation
- Would need help from groups to determine what they want to simulate and we can design it
- Could create learning videos with your group and informaticists

Running into trouble with other team members – how are we identifying hot spots in teams so we can iron them out ahead a time

- Will have to work step by step and address concerns

Can we take what is learned from other groups and streamline same order sets from different areas?

- Leads can look at what is out there and adapt it for our local needs
- Working Group making sure work is accountable

4. **Next meeting**: April 12th looking at Medical Staff Engagement Survey and at physicians feelings with interacting with the Health Authorities

5. **Other Business:**
   Upcoming Events – details on South Island MSA website :
   - Mindful Monday – Here tonight
   - Lunch in the Lounge – RJH and VGH – Thursday, March 16
   - South Island Physicians' Walking Group – Saturday, March 18
   - Special MSA Meeting: Doctors of BC Health Authority Engagement Survey – Wednesday, April 12
   - South Island FEI Society Working Group Dinner – Monday, May 29
   - Welcome and Thank You Evening – Tuesday, June 13
   - Also check out the Lending Library in the RJH & VGH Doctors' Lounges anytime

Adjourned at 19:35