Humber River goes beyond EMRAM to achieve better patient outcomes

**BY JERRY ZEIDENBERG**

ORLANDO, FLA. – It drives Peter Bak nuts when hospitals tout their HIMSS Analytics EMRAM scores and make reaching Stage 6 or 7 the object of their I.T. strategies.

Not that he’s against the EMRAM program. It’s just that he believes there’s more to healthcare I.T. than dreamt of in the HIMSS Analytics philosophy. “EMRAM doesn’t cover what’s going on, above and beyond the patient charts,” he said. “It’s limited.”

Bak, CIO with Humber River Hospital in Toronto, gave an interview to Canadian Healthcare Technology while at the annual HIMSS conference, in Orlando.

For its part, Humber River Hospital – which calls itself North America’s first ‘Digital Hospital’ – recently invested in a predictive analytics Command Centre. It presents real-time data on screens at the front of the room, called tiles, and alerts the staff if too many patients are waiting for care in the ED, if there are delays in diagnostic tests for patients on the floors, and if patients are waiting to be discharged.

Once they are apprised of these delays, staff in the Command Centre can provide solutions. That’s made the hospital much more efficient. Since its opening at the end of 2017, the Command Centre has led to the creation of 23 “virtual beds,” which means extra capacity for the hospital without the cost of extra nurses or staff.

Yet, this kind of project isn’t part of the EMRAM ladder.

“Where’s the Command Centre in the EMRAM score?”, asks Bak. “It’s nowhere.”

Another example: outside of each patient room at Humber River is a large-sized computer monitor and a supply cabinet. The computer screen is connected to the patient electronic chart, and it displays icons of note to the nursing staff. So, if the patient has special needs or conditions, like an infection or risk of falls, the nurse sees a warning right away.

Moreover, if there is a particular precaution that requires gloves or gowns, as indicated on the monitor, the nurse doesn’t have to trek to a supply station – the supplies are right there, in the cabinet.

“This saves time for the nurse, and saves steps,” commented Bak. “And it’s not in EMRAM.”

Neither are the integrated bedside terminals that are used throughout the hospital. They enable the patient chart to be displayed, and also connect the patient with a nurse, when needed. They allow the patient to control the lighting in the room, temperature and window shades, and also offer entertainment services.

They contribute to both better patient care and patient satisfaction. “But they’re nowhere in EMRAM,” reiterated Bak.

He observed that lab orders, which used to take two to four hours of turnaround time in the old hospital, are now completed in one hour, with zero labelling errors. “This is what digitalization is all about, and it’s not in EMRAM.”

Bak said that planning for I.T. should start with the healthcare and administrative improvements an organization wishes to make; it should then acquire the right technology to achieve these goals.

In the case of Humber River Hospital, the planning started with a strategic vision that included the elimination of “never events”. These are medical errors or adverse events that experts say should never happen. The Canadian Patient Safety Institute says they include surgery performed on the wrong patient or body part; the wrong tissue of blood type given to a patient; an unintended foreign object left in a patient after a procedure; patient death or serious harm as a result of pharmaceutical errors; and several others.

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Virtual house calls

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hospice care at her request, where she died peacefully. There are many other anecdotal stories like this one, including one Virtual House Call that we performed for a patient who had neither heat nor electricity. We conducted this visit by flashlight!

I imagine as other front-line providers read this article, patients will come to mind who would clearly benefit from this technology and service.

In time, it is my hope that we can find more resources and opportunities for collaboration to make this service more widely available.

I should note: When the first version of this service was offered, in 2017, the discussions were not overly reliable, especially for remote use in real-time (asynchronous remote care is another topic entirely). The quality of the acoustic information was good, but unreliable.

Basic USB enabled stethoscopes, such as the one that we ultimately used, offered easy connectivity (to REACTs, not all platforms) but limited quality of information. These stethoscopes do not offer the ability required for security for this encounter. The challenge, however, lies in the physical exam. Early stethoscopes proved technically limited in several ways. Higher level Bluetooth stethoscopes that are very similar to traditional stethoscopes promised connectivity, but in practice, they were not overly reliable, especially for remote use in real-time (asynchronous remote care is another topic entirely).

I believe that what is needed now is a higher level of ambition to try new approaches in procurement. It is my hope that we can find more resources and opportunities to make this service more widely available.

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produces is often startling and makes the exercise worth the extra effort.

So effective is this approach that the health system’s procurement council should be asked to structure a robust dual-track negotiation process and be prepared to put his (her) fees at risk in the event of a disappointing result.

There is also reason to doubt the accuracy of the guide’s assertion that negotiators are legitimate provided they do not “result in a material change to the scope of the RFP and the terms of the legal agreement.”

What if the RFP explicitly reserves a right to materially change direction as the health systems learn of the solutions being offered during the procurement process? Particularly where the health system is timing the market for a highly innovative solution and cannot define a new path never seen before in the industry, there is nothing sinister about an important change in direction. There is no process unfairness. As always, providers the language of the bid call document properly anticipates the possibility of an important change, the rule on transparency is honored.

It is noteworthy that the misconception around the bar on negotiations with vendors precludes the arrival of the BPS Procurement Directive by precisely 30 years! Clearly the Directive is entirely right in this misconception, and the guide – while usefully clarifying that negotiations are prohibited by the Directive and despite the best intentions of the myth busters – may well contribute to new misconceptions, as can be seen by point no. 12.

To have called the guide “The Art of the Possible” is apt, as it connotes the goal of trying to achieve something that is good enough rather than being driven into complete paralysis by a desire to achieve perfection. To be sure, the procurement regulatory framework is complex and will continue to provide endless learning opportunities for all of us working in the field. But waiting to have mastered everything before innovating is unrealistic, will not produce the results hoped for, and will unnecessarily slow the pace of innovation.

As a procurement specialist who has worked in public procurement in many industry sectors over many years in Canada and abroad, I believe what is needed now is a higher level of ambition to try new approaches in healthcare procurement. The guide purports to be “for hospital executives”. If significant new innovative outcomes are to be achieved through healthcare procurement, it will fail on such executives to see their way through the barriers to innovation, real and imagined, and ambitiously lead the way.

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