How to create a unified communication initiative using Epic Secure Chat
AMA STEPS Forward® podcast

How to Create a Unified Communication Initiative using Epic Secure Chat

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Featured topic and speakers

Kelly Bookman, MD, vice-chair of operations for the Department of Emergency Medicine and a senior medical director of informatics at University of Colorado Health, discusses how she built a unified communications initiative using Epic Secure Chat.

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Speaker

- Kelly Bookman, MD, vice-chair of operations, senior medical director of informatics, Department of Emergency Medicine, University of Colorado Health

Host

- Kevin Hopkins, MD, family medicine physician, primary care medical director, Cleveland Clinic; senior physician advisor for practice transformation, American Medical Association

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Transcript

Speaker: Hello, and welcome to the AMA STEPS Forward® podcast series. We’ll hear from health care leaders nationwide about real-world solutions to the challenges that practices are confronting today. Solutions that help put the joy back into medicine. AMA STEPS Forward® program is open
Dr. Hopkins: Hello, and welcome to this episode of the AMA’s STEPS Forward® podcast. I'm Kevin Hopkins, a family physician and operational leader at Cleveland Clinic. I also work as a senior physician advisor to Practice Transformation at the AMA, and I'll be your host for today. Today we're joined by our guest, Dr. Kelly Bookman. Kelly's vice chair for operations in the Department of Emergency Medicine and a senior medical director of informatics at the University of Colorado Health.

Dr. Bookman, thanks for being with us today. We really appreciate you joining us. If you don’t mind, could you start off by telling our listeners a little bit about yourself and your background?

Dr. Bookman: Sure. Good afternoon, and thanks for having me. So I'm an emergency medicine physician by trade, but I'm also a board-certified clinical informaticist, and I've been that for almost a decade now, and a physician builder within the Epic electronic health platform. So I bring a couple of different hats together to try to do some of this work that we're going to talk about.

Dr. Hopkins: All right, fantastic. How long have you been at University of Colorado?

Dr. Bookman: I have been at University of Colorado for almost 20 years now. Post-residency I trained in Chicago at Cook County in the mid '90s, and have been back in Colorado ever since.

Dr. Hopkins: All right, terrific. Well, today our topic is going to focus on something that is necessary to success in really any business or job or industry, but it’s especially critical where we work and that's communication. Efficient, effective communication across care teams is really, really imperative to the work we do, not just from a quality perspective, but patient safety and effective communication leads to better outcomes.

We're going to talk about communication today and specifically something that you and your team have built at UC Health called the Unified Communication Initiative using Epic Secure Chat. So can you tell us a little bit about how this project came about? What was the problem that you and your team were trying to solve for?

Dr. Bookman: So I'm going to start with the second piece and then come back to the first piece. So the problem that we're trying to solve for is exactly as you described. Communication is one of the most important things that we can do to help us to give the kind of care that we want to give to our patients. And when we do quality reviews or safety reviews, it always comes up that communication was one of the pieces that led to either the near miss or the bad outcome.

And so that's the problem that we were trying to solve is how do we improve communication amongst caregivers, cross disciplines and within disciplines, so that we could actually get to the right person at the right time with the right message, recognizing that that's not so easy. But into the 21st century,
we've been able to grow logarithmically in the way that we can use tech to help us to do that, to make our lives easier.

And a lot of the communication we've been doing within health care hasn't followed that same logarithmic growth. And the way that we got to it was about, I would say, six or seven years ago, we recognized that there was a functionality within our electronic health record, which happens to be Epic. They brought in a texting platform and we let it out into the wild. I say we, as in the royal we, not that I actually had a hand in that decision-making, but we didn't put a lot of guardrails on it and it became an impediment to communication in and of itself.

And so, about a year and a half ago, two years ago, I was approached with the idea and the opportunity to transition away from the use of pagers in favor of using some 21st century technology instead of legacy 20th century communication modes. And I took that on as an opportunity to improve what was out in the wild with Secure Chat and a lot of the other functionality that's within the electronic health record and try to see if we could tackle communication and make it better.

Dr. Hopkins: I think the first time you and I met and spoke about this topic you had mentioned about pagers, and I think I commented then and it pops to mind now that the health care seems to be the last remaining bastion of paging that remains in the modern world today. And you're right, it's an antiquated technology that we have better solutions for now that we should feel free to abandon when we discover something new and better.

Dr. Bookman: Absolutely. And I think one of the things that has hampered that is that I think a lot of us providers think that that's a way that we can control the communication that comes into us in terms of the time that we receive it, the time that we respond to it. And I think we'll talk a little bit probably more as we talk about some of the nitty gritty here. I think that's one of the reasons pagers have persisted because it's a locus of control of the way that we get communicated with.

Dr. Hopkins: That's a great point. And so, I'll ask you maybe a follow-up question to that now is the relative advantages and disadvantages of synchronous communication versus asynchronous communication. So synchronous communication is both parties either being physically present or remotely or virtually present at the same time, like talking on the phone or a face-to-face conversation. And asynchronous is I message you when it's convenient for me, you message me when it's convenient for you, and it's an ongoing back-and-forth dialogue that isn't necessarily instantaneous or bound by time constraints.

So, what have you seen to be the relative value of maybe each of those modes of communication in your experience? And how did you end up choosing what your team did as far as using the Epic Secure Chat feature?
Dr. Bookman: One of the things that we recognized is that the sender and the receiver have two fairly different agendas. The sender of whatever message wants to get a message to you when they're ready to send a message and the receiver may not be ready for that message or may not have an opportunity, might be doing something else that is more important than the message that's being sent and isn't ready to receive it.

So one of the big things that we grappled with was trying to understand what the senders are trying to do and marry that up with how the receivers want to get the message. So as we chose to use Secure Chat for our primary means of... It's synchronous, but asynchronous at the same time, so you can choose when you respond. We actually built that right in, and so we chose to use three different priorities in order to allow for senders to go ahead and send a message, tell the receiver how important the message is and when they expect a response back or when they need a response back.

And then it allows the receivers to know what to do. In the inpatient world, for example, we say if you get something with a normal priority, feel free to finish what you're doing, finish a lot of what you're doing, take an hour or so if you need it, and call back.

If you get something that is urgent, which is the top priority, drop what you're doing and start heading to the place while you're figuring out who to respond to. And then we have an in-between, which is around 15 minutes. Finish what you're doing, assuming that's important, but I do need you to get back to me soon.

Dr. Hopkins: Okay, that's helpful. So obviously identified a problem, challenging communication, difficulty prioritizing means and methods of communication, and reliable communication. So what was your next step? How did you actually get started working towards a solution?

Dr. Bookman: So what we do is what I like to do in terms of managing change across the board, we just took this to a very large stage. So we started by doing a large event where we pulled in all of the people that we thought would potentially have input, thoughts about, opinions about what we were going to do and brought them into a room and spent an entire day figuring out what is the current state of communications, what do we think that the future state of communications are?

And in between those, what are the barriers to good communication in current state and if we could build ideal state at the end of the day, what would that look like? And that's sort of how we manage process improvement across the board, very typical. I'm sure those are some buzzwords that you've heard for other initiatives, but we took it really seriously and when somebody came to me and said, when can you transition away from pagers at your large academic center, which has 30 departments and multiple divisions and 700 beds, and when do you think you'll be able to do that?

Can you do it in a month or two? I said, I need a year. I need a year to do the whole thing. And we started with this first group and then we were very deliberate about how we marched through the year.
with very specific groups of people. We had a change management group, how we were going to manage the message, and then we were going to manage the education. And then we obviously had the tech group, so the design, the workflow, and the build group.

And so we tried to be very deliberate to in parallel get the message out that this is coming and make sure that we had end user stakeholders participating in not just getting the message out, but actually the build and the design. So we've spent months and months bringing in accountable champions that were identified by operational leaders, not just doctors, not just APPs, not just residents and fellows, nurses, techs, everybody around. We brought them all in and we got accountable champions and then we met with them so that they could design the workflow. So that's how we started to get through and really get all of the specs built out.

**Dr. Hopkins:** Awesome. So it sounds like you got most, if not all the key stakeholders in the room and started hammering some things out. And we all know anybody that's gotten more than two or three, especially docs together, to try to get a consensus on anything is really challenging. So how did that process go? How did you navigate differences of opinions or differences of priorities?

**Dr. Bookman:** So we deliberately got small groups together that had like-workflows. We knew that surgeons weren't going to agree with hospitalists on what the workflow should be, and emergency medicine docs are going to think about something completely different, and that nurses may look at things in a different way than physicians and/or administrators. So we really try to get pockets of groups together. So periop is a good example. So I've been meeting, and my IT team, as well as my change management team in meeting with and working with periop folks, what is your workflow? You tell us. And our message to them was, you tell us what your workflow is with the caveat being we're not going to just build the exact workflow that you have so that you bring bad processes into this new 21st century plan that we have. So with that in mind, we're going to show you what the tools are, but you tell us which tools and which workflows are going to work for you.

And that's how we did it. So we didn't actually have to consensus build as much as we allowed them to drive within reason, with what functionality is available, we let them drive what the workflows would be. So periop looks totally different. Even anesthesia within periop looks different than what it looks like for the hospitalists, and neurologists look a bit different than regular hospitalists, and we allowed them to do that. And it's nimble. What's great about working in 21st century electronic health records, we can be very nimble with that, so workflows can look different and work for different people in different ways.

**Dr. Hopkins:** I liked one of the phrases you said earlier in our conversation, you said we sort of released it into the wild. So full disclosure, I work at Cleveland Clinic and I'm a family doc and we use Epic as our EHR system as well. And I'll admit, I had never heard of the Epic Secure Chat function until probably, I don't know, a year and a half ago, but the tool was available prior to that. I had just never used it, and I'd heard somebody explain it as like an instant messenger.

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And then I started getting incoming messages from some of our hospitalists who were taking care of my patients in the hospital, and they were starting to use that as sort of a preferred method of communication with the ambulatory docs around handoffs because it wasn't urgent. It didn't require an immediate response. It was, hey, I'm sending this patient home and they're going to see you in a couple of days. Here are things to follow up on.

And so, did similar things happen in your system where certain pockets or subsets of caregivers were using that feature in a specific way that then helped to build a little bit of a grassroots movement towards how you might use it in the future?

**Dr. Bookman:** So that's what we were hoping when it was released into the wild. We measured what the adoption was and where the adoption was. And there were definitely pockets where their workflow was perfectly suited to use this functionality as is. One of the problems became, and this is a great example of sender versus receiver, that's great, the hospitalist communicating with the ambulatory provider, but the receiver being the ambulatory provider doesn't actually need that message right then when that patient is being discharged, they need a message. So to me, that's actually an inappropriate use of an interruptive alert, which is what Secure Chat is.

So what we did was we decided we were going to back up a little bit and try to do a bit we called Message Wisely. So if you need a time-sensitive response, even if it's four hours from now, think about whether or not you should be interrupting somebody and their workflow. If you don't need something, a time-sensitive response, you shouldn't be sending an interruptive message at all. So we came up with using, Epic speak, in-basket for something like that. So we taught people to use in-basket. If they're communicating out with an ambulatory provider, you don't need a response. You need to know that they're going to get it, they'll get it that way. And we came up with a different thing for inpatient communication that is FYI, I don't need a response, but you need to know it. Don't interrupt somebody's workflow for that.

**Dr. Hopkins:** What you just said is a significant point to me because I think of all the disruptions throughout our day as a clinician, and a big part of that is alerts in the EHR or I turn off popups on my screen when I'm in clinic so that I don't get a popup in the bottom right corner every time I get a new email or I turn off the alerts on my phone because every time I have to task switch or get interrupted, it adds to cognitive load and that has significant impact on efficiency. It takes me so much longer to do something when I'm distracted because I don't have that working memory because it's being distracted by other things.

So I like what you said about having those messages come to the in-basket as a message rather than an interruptible alert. Did I understand that correctly?

**Dr. Bookman:** That's exactly right. So upstream from rolling out all of the rest of the infrastructure around our unified communications initiative, the first piece that we rolled out was getting everybody to
understand the philosophy of if you don't need any response, don't send an interruptive alert, which would include a page, which would include a phone call, and it happens to also include Secure Chat. It's just that Secure Chat was such a low bar that you could offload if you were a nurse or maybe a hospitalist discharging a patient, you could offload that task right away for you by throwing it into a Secure Chat, but yet you're interrupting and disturbing a task that somebody else is attending to and therefore disrupting their productivity. So we did that very deliberately as one of our precursors to the entire initiative.

**Dr. Hopkins:** Great. So is that a setting or a button that if I'm going to send a message to somebody I can click so that it doesn't interrupt their workflow or that's just standard in the procedure?

**Dr. Bookman:** So it's standard. So what we're trying to tell people is use the right modality to communicate at the right time. So if it's an FYI, we built a process whereby it could go to in-basket in the circumstance we were describing, or you could use a sticky note, which is an inpatient thing that you can use. So it sits there on the chart and just waits for somebody to open the chart and then you can see it, that way you receive the message when you need to receive the message, when you're ready for your in-basket or when you're ready to open the chart. Anything that needs to be interruptive is something then that we gave those priorities like I described. So if you send something as a sender, I need to know this, but it can be an hour or so, that is a click of a button.

So that can just be a normal and they'll get it, but they don't have to respond to it. And what the beauty of this is, which is different than something like a pager or even potentially a phone, is as the receiver, you can control whether it makes a noise, whether or not that noise repeats, you can change the noise so that normal sounds different than important or something that's critical or urgent, and you can make those all different. So one, you can say that normals never make any noise for you so you don't see them until you're ready to see them, but an urgent or a critical makes a very specific noise that's going to repeat until you get to it and it breaks through all of your phone settings. So you, as the receiver, have a lot of autonomy about the way that you receive messages, which is different than our old technology.

**Dr. Hopkins:** Sure. So the fact that you just mentioned phone, so it made me think, when I think of using my EHR, I typically am at my desktop computer or maybe on my laptop computer that I'm using now, but I do have the Haiku app, the Epic app on my phone that I use, so how do these chat messages get delivered when I'm not sitting at a computer?

**Dr. Bookman:** Yeah, so it's a great question around mobility, and one of the things that this allows, and one of the things that we are touting with this is that whether you're a physician or a nurse, it allows you to be mobile. So it allows you to carry around the electronic health record and your notifications in this multipurpose device, which is a smartphone, which we all carry around and we're so used to anyway. It really gives you this flexibility to do a lot of work. So within Haiku, not only can you get messages and you can do all of this control about the messages you're getting, but you can
You could dictate your note in between patients that you see, you can place orders, you can look up another patient so you can see what's going on. So there's a lot to this being allowed to be mobile. So it's actually even more powerful on the mobile platform, in my opinion, than it is sitting in front of the computer because you can control the sounds and when it pops up. Whereas in hyperspace, which is what Epic calls its computer, it just pops up whether you kind of want it to or not. With Haiku or the mobile app, for nurses, it's called Rover, you can control those and then be off on your way.

**Dr. Hopkins:** Okay. So, I use that on my phone. In fact, I was working from home today and I got the ping notification on my phone that my APP partner was sending me an Epic chat message about a patient she was seeing in the office. So then that triggered me to respond to her and I've used that functionality when I'm on call. In a world where we're so wired and so connected, that's a good and a bad thing because the good thing is I can get my electronic health record on my phone. The bad thing is I can get the electronic health record on my phone. So how do you handle that and did anybody push back on that as a, hey, we're going to use this as the main means of communication now?

**Dr. Bookman:** There here was tremendous pushback, without a question. And the concern was, I'm already so connected and now you're telling me my personal phone is the way they're going to keep talking to me, and I have a life. I need my work-life balance. How am I going to do this? And what's nice about this is that there are settings that you can actually change whether you're completely available, whether you're just busy, so know that I'm busy, but I'm going to get the messages, or full all the way up to I am offline. You can't even send me a message.

So you can actually set it, so I'm gone, I'm off shift, don't send me or I'm in Hawaii, don't send me. And what's better about this than the other things is that this actually tells the sender I'm not available, find somebody else, which is different than if a nurse sends out a page and it just goes out and you don't respond because you're done and you're out. They don't know you didn't get the page. They are going to try paging you again. They're going to wonder what happened. Maybe they'll even try calling you. With offline, you can really detach. So I think, in my opinion, this allows us to truly untether ourselves more than some of the other tools that we used to have.

**Dr. Hopkins:** And I am certain I'm not the only one listening to your voice right now that is sort of shaking their head thinking, yeah, I get paged when I'm away on vacation and I don't like that. And this might be a means to mitigate that, right?

**Dr. Bookman:** Exactly what we were thinking.
Dr. Hopkins: All right, terrific. So what other challenges or roadblocks did you run into as you moved along throughout this process of developing this program?

Dr. Bookman: So probably one of the biggest technical hurdles or workflow hurdles is what do I do if I'm a proceduralist and I scrub in and then everything's coming through my phone? I'm used to setting down the pager and then a circulating nurse picks it up when I get a page and then they call back and hold the phone up to my ear or whatever. What's great is we are now in the 21st century, there are solutions to this. So what you can do, for example, and this is just an example, so we said, guess what? We can build it so that every time you walk into your procedure, whatever it is, the OR, or GI suite or cath lab, as soon as the nurse clicks the button, Dr. Hopkins' here, that auto-forwards your message.

So you don't have to remember to do it when you get there, but it will auto-forward on your behalf with the click of a button from somebody who's already clicking a button because they're documenting that you came into the procedure and on your behalf, if you accidentally had it auto-forwarded and it was supposed to go to one place, but you realize it's going to the wrong place, they can change it on your behalf.

So there's so much sophisticated functionality behind it that once they heard that, then all of a sudden the proceduralists thought this was even better than what they had before. Because before you get a page, you don't know what it is. This way you get certain sounding alerts, you know how important they are, you can actually have a nurse on your behalf tell you something from the patient's chart and then you can have a much more productive and efficient conversation.

So that's the kind of stuff that we were really working towards. And as soon as we got in front of people and they saw that functionality, then all of a sudden they actually did me one better and said, well, if you can do that, can you do this? Because we've been suffering with this other workflow and a workaround that didn't work for us, but now I'm hearing that the machine can do this, can it do this other thing?

And then they got engaged because they're the ones who were actually driving an improved version of the workflow once they got to see that technology. So that's an example. Probably the proceduralists were probably our biggest barrier. And then the second biggest barrier was this notion of I can't untether, if you can get to me through my personal phone, you're always going to know where I am. But then once they heard the functionality, then all of a sudden they recognize, oh, this is actually better.

Dr. Hopkins: It sounds like the smart technology that has capability linked to this is really helpful. I love what you said about somebody's already clicking this button anyway and if it also does another action to forward your messaging to somebody else or to turn it off, it just seems really smart in that way. So were there other problems that you were able to solve or at least favorably impact that really
weren't included at the outset in this project of, like you said, some people had workarounds for communication and did this help solve other things that really you didn't set out to accomplish in the first place?

**Dr. Bookman:** There are so many I have to think about. It was amazing to watch people come into the conversations and were absolutely sure that this wasn't going to work because they came in hating Secure Chat because they were being driven crazy by it and thinking that we were just going to say, thou shalt use this technology. And then when they got to see the inner workings, one of the things that we did not plan on doing was integrating some other third-party vendor scheduling platforms into Epic.

So one of the things what we realized was if you were already inputting information into a third-party vendor scheduling platform, we could actually make that platform interface with Epic, and then Epic knows who's working, when they're working, what the phone number is, and you can tell at the hierarchy of who should be the first contact. So by doing just this, we've allowed for our nursing colleagues with a single click within Epic to say, oh, for this patient, this patient's followed by this service and for this service, I'm supposed to call this person first. That gets rid of any guesswork as to who I'm supposed to call.

So it fixes a problem that the nurses had, and it actually fixes a problem that the providers had as well, which is you call the chief resident when you were supposed to call the APP or you called neither one of those people and you called the attending first. Those kinds of problems just naturally got solved when you built the entire communications infrastructure.

**Dr. Hopkins:** Okay. So, I had a similar experience, and I may have shared this with you before where I wanted to get ahold of whoever was taking care of a patient of mine that was in the hospital, and I had the option to send a secure chat message to that whole team and not knowing who was on, who wasn't, who's first call, second call? That's what I did.

And so probably 14 people got the Secure Chat message that I sent out asking a question about this patient. And to their credit, somebody from that team did get right back to me about my question, but probably 13 other people saw the message who didn't need to see it. So it sounds like you've been able to solve for that.

**Dr. Bookman:** Yes, exactly right. So that was 14 people who got disrupted when only one person should have gotten disrupted, which as you were saying, when you task switch and you get disrupted, you actually provide, at the very least, less efficient care, and at the very worst, maybe you make an error that could cause downstream harm. So yeah, so there's patient safety issues, there are quality issues, all of those things are all wrapped up within being able to communicate better to the right person at the right time.
Dr. Hopkins: So question that has been on my mind, and it's going to take me probably just a moment to set it up, so sorry, be patient with me, but I mentioned I'm a family physician, so I value relationship. And while I also value technology, I value relationships. So face-to-face conversations or telephone conversations. And so this route of communication continues to leverage technology in an asynchronous way. And in my mind it's a little challenging for me. And then I think of how it's linked or embedded within the electronic health record, and we know levels of burnout are super high, electronic health record use and being tethered to it, as we've said a couple of times, and the administrative or documentation burden within the EHR is a significant contributor to caregiver burnout.

And so I have a little hesitation when I think of basically all communication, work-related communication coming to me through the EHR system. How did you address that, overcome that? Do you feel like you were able to overcome that and what's been the outcome?

Dr. Bookman: I think one of the errors that we made early on was some of the verbiage and we said, Secure Chat will now be the primary means of communication. And everybody went exactly where you just went. And so as we pulled back and then we were more clever about thinking about how the message might land, and we went with the Message Wisely campaign, it wasn't actually about Secure Chat, it was about what is the time sensitivity of the message that you're trying to communicate, which we've talked about, but it resonated because we didn't just put a picture of Secure Chat.

We said, you can Secure Chat or you can call somebody or you can wait for them to walk by and you can do this at rounds. But we very deliberately detached it from Secure Chat is the primary way of communicating. We said Secure Chat is a text platform that is HIPAA-compliant and actually is much better than when you get it on your phone, which is completely bad because it's HIPAA non-compliant.

But when you get it this way, you've got connection to the patient chart and you can actually do things, so it improves your ability to be functional and get something done. But we very deliberately took it away from now the only thing you can do is communicate tapping buttons into a computer or tapping buttons into a cell phone app. We want people to pick up the phone. We said, pick up the phone, please do pick up the phone. We wanted to talk on the phone. This is just a way to do text HIPAA-compliant messaging and use it as it benefits you. That worked a lot better.

Dr. Hopkins: Terrific. It's the old adage of it's not exactly what you said, it's how you said it that makes a difference and how you communicate it. And something else you just mentioned is the fact that the patient's chart can be attached. The days of paging somebody and typing in their medical record number because you know they're going to have to look it up in another program, probably on another device. Now I get that message and that patient's attached so I don't have to go looking up a chart.

Dr. Bookman: Right. I didn't actually know this when I started, pagers are not HIPAA-compliant. So in theory, we shouldn't have been putting in that MRN or if we say patient in room 12, and it's clear that
you're working at University of Colorado Hospital emergency department, that busts HIPAA. So we actually couldn't, shouldn't, and wouldn't have been doing that had we all known that. This just makes us so much more efficient when we can get the patient chart. So you can take a moment, figure out what the answer should be to the question, and then it helps everybody to be a little bit more high quality in the way that they're communicating.

Dr. Hopkins: So did you get rid of pagers?

Dr. Bookman: We have, yes. So the way that we played it is we said there's a drop dead date and this is what the drop dead date is. But what we did was we rolled everything out upstream, all of the infrastructure and all of the Message Wisely, and we said well, we want it to be the day that we tell you drop dead date, these are gone. We actually wanted you to say, no problem, because it's been collecting dust already because I've been using this other functionality. That didn't work for everybody, obviously.

And so our thou shalt date has not come yet, but our thou shalt date we're hoping will be much less of a big deal to folks. We have early adopters doing it, but we actually also have people watching the early adopters and then moving right along. So there will be some people who don't do it until they absolutely have to, but it's working really well so far.

Dr. Hopkins: All right, so the final question for you. If others are listening to this podcast and they're leading in another health care organization and they think this is a really good idea, I would like to think about how we could pursue this within our own organization. What advice would you give to them and how would you recommend they start?

Dr. Bookman: This'll sound a little cheesy, but you really have to get the right people on the team in the first place. So having really good IT project management coupled with subject matter experts in operations, one of the biggest things that I feel like we've done in anything electronic health record initiative is not have the collaboration with the operational leadership that you need. So then it feels like it is driving some kind of thing that we're doing to clinicians. And really it should be the other way around. It's like the tail wagging the dog.

So having that collaboration in the first place is paramount to me. And we did that. So we had a whole lot of people who don't know anything and don't want to know anything about the way the technology is built, but they certainly have opinions about the way that they want to function while they're in the clinic or they're in the hospital. And that has been really key to our success of having people feel engaged and like they own the process rather than just trying to get them. So that would probably be my biggest thing.

And this is very, very easy to say and hard to do, but managing the change is much, much harder than building the tech. And if you recognize that early and begin that change management process, that will

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serve you very well.

**Dr. Hopkins:** There’s a quote I appreciate from Woodrow Wilson, former President of the United States, and he said, "if you want to make enemies, try to change something." Even if it's for the better, and it turns out really well, it can cause disruption. But as we all know, sometimes disruption is a good thing and does end up well.

Dr. Kelly Bookman from the University of Colorado Health has been our guest today. Dr. Bookman, thank you so much for your time and your expertise. Thank you for joining us on the podcast today.

**Dr. Bookman:** Thank you for inviting me.

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