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HIMSS Innovation Committee and Introduction

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The Healthcare Information and Management Systems Society (HIMSS) is “a cause-based, not-for-profit organization exclusively focused on providing global leadership for the optimal use of information technology (IT) and management systems for the betterment of healthcare. Founded 51 years ago, HIMSS and its related organizations are headquartered in Chicago with additional offices in the United States, Europe and Asia. HIMSS represents more than 44,000 individual members, of which more than two thirds work in healthcare provider, governmental and not-for-profit organizations. HIMSS also includes over 570 corporate members and more than 170 not-for-profit organizations that share our mission of transforming healthcare through the effective use of information technology and management systems. HIMSS frames and leads healthcare practices and public policy through its content expertise, professional development, research initiatives, and media vehicles designed to promote information and management systems' contributions to improving the quality, safety, access, and cost-effectiveness of patient care.”

HIMSS has seventeen standing committees through which its major work is accomplished. Effective July 1, 2012, HIMSS has inaugurated a new standing committee entitled the HIMSS Innovation Committee. The Committee’s work is led through ten members to be expanded to twelve, three HIMSS staff members and a liaison from the HIMSS Board of Directors. An Innovation Committee community is made up of over 800 members. That number is rapidly growing as this is a critical part of the future of healthcare. Any member of HIMSS can join the HIMSS Innovation Community. SETMA’s CEO, James L. Holly, MD, is one of the current ten committee members. As the committee works to define itself, Dr. Holly prepared the following introduction to the concepts of healthcare innovation. Dr. Holly’s note, written in the first person, follows.

Utilizing one of the most creative, modern innovations, I looked up the definition of the word on Wikipedia. I found the following:

“Innovation is the creation of better or more effective products, processes, services, technologies or ideas that are readily available to markets, governments, and society. Innovation differs from invention in that innovation refers to the use of better and, as a result, novel idea or method, whereas invention refers more directly to the creation of the idea or method itself. Innovation differs from improvement in that innovation refers to the notion of doing something different (Lat. *innovare*: "to change") rather than doing the same thing better.”

The most important book in my library, other than the Bible, is the dictionary. I find that knowing the precise nuance of a word is important to the creative process. By the way, there was a time when a “dictionary” was an “invention,” and then it was “improved,” and there have been “innovations” related to the “dictionary.” (If you have never read *The Professor and the Madman*, you should. It addresses the time when there were no dictionaries.) The definition of

terms is a critical, foundational element of our task. Most often, we describe things rather than define them and we may find that is our best way to begin. Like the famous statement, “I don’t know how to define pornography but I know it when I see it;” we may find ourselves in that same conundrum with innovation. It is difficult to define, or even to describe what it is, but when we see it, we’ll recognize it.

We will find, I think, that in healthcare, innovation is taking place frequently, often without people knowing that they are innovating. One of the prime reasons for making innovations transparent is so that we can communicate what innovation is, we can then analyze it, encourage it, and then improve the process of innovation by making it intentional rather than accidental. This notwithstanding, most seminal (“of or relating to seed or semen; creative, or having the power to originate; highly influential, especially in some original way, and providing a basis for future development or research”) innovations are more often the result of serendipity rather than design.

Innovation is more often the result of problem solving or process analysis, than it is a conscious attempt to innovate. “Innovation” by its very nature involves the willingness to question the accepted and to be willing to be surprised by new ways and means of doing old things. *In The Fifth Discipline*, Peter Senge states the following:

“The most accurate word in Western culture to describe what happens in a learning organization is one that hasn’t had much currency for the past several hundred years...The word is „*metanoia*’ and it means a *shift of mind*...For the Greeks, it meant a fundamental shift or change...In the early... Christian tradition, it took on a special meaning of awakening shared intuition and direct knowing of the highest, of God. „*Metanoia*’ was probably the key term of such early Christians as John the Baptist. In the Catholic corpus the word *metanoia* was eventually translated as „repent.”

“To grasp the meaning of „*metanoia*’ is to grasp the deeper meaning of „learning,” *for learning also involves a fundamental shift or movement of mind*...Learning has come to be synonymous with „taking in information.”...Yet, taking in information is only distantly related to real learning. (p. 13)

“This then is the basic meaning of a learning organization...continually expanding its capacity to create its future. For such an organization, it is not enough merely to survive. „Survival learning” or what is more often termed „adaptive learning” is important – indeed it is necessary. But for a learning organization, „adaptive learning” must be joined by „generative learning,” learning that enhances our capacity to create. (p. 14)”

In the Wikipedia definition of innovation, this phrase was used, “doing something different.” It may be that the more accurate phrase would be “doing something different~~ly~~.”

With this very brief conceptual framework, it would be possible to make the following comments about “innovation”:

1. **Innovation is change** – but it is “change which will make a difference: by definition of the concept of innovation. A requirement of true innovation is governed by the principle that “if you are going to make a change, it had better make a difference.”
2. **Innovation is creative** (generative) – as such it is transformative and is thus self-sustaining, not requiring external pressure (reform) for its success.
3. **Innovation is a challenge** – in that it does not accept the status quo and in that it requires a “shift of mind,” innovation can be uncomfortable.
4. **Innovation is chance** – innovation does not requires the taking of a chance (a circumstance where there is no guarantee of success) but innovation most often happens “by chance,” almost by accident.
5. **Innovation is a continuum** – a process which began as an improvement can become an innovation and an innovation which began as a small change can become a major transformation.
6. **Innovation is compelling** – a true innovation will not requiring selling, it will become its own imperative contributing to its on sustainability.

It was for these and other reasons that SETMA has changed the phasing of the Triple Aim (The three-fold goal of health improvement defined in 2008 by the Institute for Healthcare Improvement [IHI]) as follows. We think it is easier to think about and to measure our progress toward the triple aim with the new phrases.

1. Improved care has been change to “*improved processes.*”
2. Improved health has been changed to “*improved outcomes*”
3. Lower cost has been changed to “*sustainability,*” as there is more to sustainability than just reducing the cost of a procedure or test.

It is my belief that effective innovations will be large and small, local and national, simple and complex, exportable and unique to a particular situation. The HIMSS Innovation Committee has a task, I think, to define, encourage, promote, circulate, publicize and create healthcare innovation. Innovation is and will be an integral part of healthcare transformation which is what ultimately will effective change in healthcare, while healthcare reform will be the result of statutory requirements and will always require pressure and reward to be sustained. Transformation will become a part of the system and is self-sustaining; reform will always be outside of the healthcare system and will always require more and more pressure to gain new benefits.

This contrast between transformation and reform is a reflection of an observation which Senge made when he said:

“As I began my doctoral work...I felt that the solutions to the Big issues lay in the public sector. But I began to meet business leaders...These were thoughtful people, deeply aware of the inadequacies of prevailing ways of managing. They were engaged in building new types of organizations – decentralized, nonhierarchical organizations dedicated to the well being and growth of employees as well as success. Some had crafted radical corporate philosophies based on core values of freedom and responsibility...Gradually I came to realize why business is the locus of innovation in an

open society. Despite whatever hold past thinking may have on the business mind, business has a freedom to experiment missing in the public sector. (p. 15)”

While AHRQ has published subsequent SETMA Innovations on their Innovation Exchange, i.e., SETMA’s LESS Initiative (Lose Weight, Exercise, Stop Smoking), our most fundamental innovation occurred less than four months after we began using the electronic health record (HER) in January, 1999. It was through the recognition that EHR was too hard and too expensive, if all we gained from EHR was the ability to document a patient encounter electronically. If we could not leverage the power of electronics to improve the care of individuals and of populations, we judged, then it was not worth it. That realization led us to develop the following principles which have guided Southeast Texas Medical Associates’ development of a data base which supports the requirements of transformation. These principles were presented at HIMSS 2006 (see at [Spanning the Specialties to Bring You the Best Standards](#)).

Those principles are:

1. Pursue Electronic Patient Management rather than Electronic Patient Records
2. Bring to bear upon every patient encounter what is known rather than what a particular provider knows.
3. Make it easier to do it right than not to do it at all.
4. Continually challenge providers to improve their performance.
5. Infuse new knowledge and decision-making tools throughout an organization instantly.
6. Establish and promote continuity of care with patient education, information and plans of care.
7. Enlist patients as partners and collaborators in their own health improvement.
8. Evaluate the care of patients and populations of patients longitudinally.
9. Audit provider performance based on the Consortium for Physician Performance Improvement Data Sets.
10. Create multiple disease-management tools which are integrated in an intuitive and interchangeable fashion giving patients the benefit of expert knowledge about specific conditions while they get the benefit of a global approach to their total health.

It would be seven years before we realized that these principles incorporate many of the ideals of patient-centered medical home. It was the pursuit of these principles which prepared SETMA to become a Tier III NCQA Patient-Centered Medical Home and a AAAHC accredited medical home.

These principles were the foundation of many little innovations which collectively have enabled SETMA to address the larger issue of reducing preventable re-hospitalizations. The following are some of those lesser steps:

1. Connection of SETMA’s EHR to the clinic, hospital, nursing home, hospice, etc, so that all patient documentation is completed in the same data base.
2. Completion of Admission History and Physical Examinations in SETMA’s EHR.
3. Completion of Hospital Discharge Summaries in SETMA’s EHR.

4. Design and preparation of a patient-care follow-up document which includes a reconciled medical list.
5. Changing of the name of the “discharge summary” to “Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan.” This is a longer name but it is highly functional defining why it is imperative for the Summary to be prepared and given to the patient at the time of leaving the hospital. (Over the past 36 months, we have discharge over 14,000 patients from the hospital and 98.7% of the time this document has been given to the patient before they leave the hospital.
6. Care Coordination and Care Coaching of all patients discharged from the hospital.
7. Compliance with Physician Consortium for Performance Improve Care Transitions Data Set
8. Calculation of risk of re-hospitalization electronic through an algorithm
9. Completion of a Hospital Admission Plan of Care and Treatment Plan which is given to the patient upon admission
10. Contrasting patients re-admitted and those who are not through adaptation of Business Intelligence software package to analyze morbidities and co-morbidities, age, gender, ethnicity, socio-economic status, etc. to find leverage points for reducing re-admissions.
11. Design of a ten-step program for those who are at high-risk of readmission.

It would be useful for our task, I think, for the HIMSS committee to determine which of these steps, if any, are innovations and which are simply improvements.”

As the work of the HIMSS Innovation Committee grows work groups will be organized to fulfill the charge given to committee and to contribute to HIMSS” mission.