Command Clinical Champion Position Description – Pre-Implementation

General

The Command Clinical Champion should be a physician with at least good, if not excellent, computer skills. In addition, the Command Clinical Champion needs to have good-to-excellent clinical skills. The third characteristic of the Command Clinical Champion is a desire to teach & the skill for it. The next characteristic is a "thick skin" and the ability to take criticism without internalizing it. The criticism will be of the system, not of the Champion and his/her efforts. Does the Clinical Champion have to possess all these skills to be successful? No, but they do help.

One item that is a must for the Clinical Champion to be most effective is adequate time… that is adequate time to do the job required. This includes preloading templates, talking with the individual department template managers, talking with Department Heads & coordinating with the Regional Champions and/or the BUMED Champion. I would recommend that the Command Clinical Champion be a 0.5 FTE for the period starting 2 weeks prior to implementation until 2 weeks after training is complete. After that period, the Command Clinical Champion still needs at least two half-days per week (probably more at a Medical Center) to troubleshoot & assist new users.

One of the biggest problems the Clinical Champion faces is template management. The AHLTA trainers teach providers and nurse wellness role holders to create their own templates. There are >700,000 templates on the CDR (Clinical Data Repository). Providers and nurse wellness folks do not need to make more. One possible way to stop this proliferation is to create a Command AHLTA template library. All templates have to be in the library or they will not be allowed. That could be a tough sell after the fact, but may be doable up front… especially if the trainers are informed of the requirement.

With the new consolidated template management tools in Build 841 and beyond, the Clinical Champion's task to manage templates and help others to find templates will be much easier.

Pre- Implementation

The Clinical Champion needs to have AHLTA installed by no later than the 90-day PIM. This is to allow them to use the system and get used to it in advance of training. If the Command can afford to do so, the Clinical Champion should receive user training in advance as well. If not feasible, the Clinical Champion needs to be familiar with the available tutorials & learn the system as much as possible. Also, by NLT the 90-day PIM, the Clinical Champion needs to be communicating with the Regional Champion on a regular basis… at least weekly.

By the 30-day PIM, the Clinical Champion should have all clinic folders populated and have started working on order sets (if notable to import them directly). This goes much smoother if the Project Manager discusses with the Directors the advantages of the Department Heads working with the Clinical Champion in creating these order sets. Get permission to email all the

Department Heads and let them know what you can do to help them. Do not be passive about this. You must be active without being either pushy or disrespectful.

During Implementation

Ensure all assigned staff are trained as scheduled. There should be a designated training coordinator; however, at small commands, that may be a collateral duty for you. Ensure that the training is done by functional areas (Family Medicine, Orthopedics, OB/GYN, etc) with all user groups from that area trained in close temporal proximity (within 1-2 days of each other). This will minimize disruption brought about by using multiple systems for patient care.

Work with the Project Manager, the Lead Trainer, MID and the lead Coder to ensure time for the Clinical Champion and the Lead Coder to speak at the Provider and Nurse training classes. You need to be involved in teaching the providers what you have learned from using the system for the past three-plus months. The Lead Coder needs to speak not about coding but rather about documentation. The focus needs to be not on what the training contract says but rather on what the Command needs to be successful. Have the trainers de-emphasize template creation and emphasize finding templates you have populated into the folders. Have the trainers talk about the pros and cons of regular MedCin templates versus AIM forms. You need to do the same from the provider perspective.

During over-the-shoulder training direct providers and nurses to the pre-populated templates, both MedCin and AIM forms, and let them determine which type they prefer to work with. Once they make a choice, work with the trainers and the providers/nurses on efficient documentation. There are different styles and approaches. One approach is to place all pertinent positive history into the HPI section and have it flow more like a dictation. Still use the MedCin terms (MedCin template or AIM form) for coding and searchability, but add the 2-6 lines of prose to “tell the story”. Click and elaborate as needed in the ROS and PE sections, then go to the A/P section and get your diagnoses/ICD-9 codes. Use the Comment box (2000 character limit) under each ICD-9/Diagnosis to provide information to yourself and others about what was found, why you arrived at this diagnosis, your plan and follow-up. If any counseling was done, document it here before clicking the “>50% of time for counseling” box.

The key is to help the providers and nurses find their most comfortable and efficient method of using the system. Ensure you also help the clerks and HM’s/MA’s to learn their pieces of the system and contribute to the smooth patient flow by using questionnaires, vitals, screening and the S/O portion where appropriate.

Post-Implementation

At the two weeks post-implementation point, make sure to talk with Department Heads to identify problem areas and address them individually using yourself and any remaining trainers to make headway/rectify outstanding issues. If some providers are having great difficulty using the system, watch them do an encounter to see it you can identify problem areas to address.

For the next several months, you will need to be available for troubleshooting problems, helping enter trouble tickets & identifying system problems that need an SCR. This is also a time to be actively managing your Command template library to add new diagnoses, order sets, procedures. To the templates you hold. Also, it is time to keep searching for new templates you may want to add.

You will also want to be monitoring your Command statistics about AHLTA use and MedCin term usage. It is important to have the discussion about target goals for the Command prior to implementation, and it is vital to monitor how things are going after implementation to see if the Command is on target and to spot problem areas/departments early to provide assistance.

Another area of vital importance is updates. Either the BUMED or Regional Champions should be providing you with monthly updates as to the deployment schedule for updates and the features contained therein. This allows you to keep the Command informed and is a visible way to maintain your value. The goal is to ensure the Command continues to see the value added in having a Clinical Champion after implementation rather than protecting a non-value-added position to get some extra “admin” time.

Regularly liaison with the “advanced users” (formerly known as “superusers”) to keep them up to date on upgrades and new features. Using either formal or informal meetings to identify problem areas, identify best practices and share information throughout the Command regarding AHLTA. It is important to communicate commitment and support for AHLTA during these meetings and other interactions; however, be honest about the strengths and shortcomings of the program. Maintaining your integrity is very important.