CHIO interview 1:00 PM June 15, 2020

Understanding a day-in-the life of a CHIO

**Q: We want to understand your environment and how things will move ahead in the future.**

A: The discussion of informatics has been an ongoing process since we had a new person take over. We have had several conversations because there are several definitions of what informatics is. I don’t think we have a definitive definition of what informatics includes. Maybe I’m looking at things from a simplistic perspective. I think of data analyst as pulling and analyzing data.

Our role when I first got here 6 years ago didn’t use data very much. We were doing this from a perspective of how often are things used and how well are they used. CRPS was a limiting factor in that. We didn’t have the ability to do keystroke tracking and some semblance of eye tracking. There is limited functioning within CPRS for developing an environment that is truly for the 21st century.

As a result, of Cerner coming online there is more discussion of informatics. I’m not sure where CACs fall into this because it’s been such a mixed bag. We haven’t had a standardized PD. Not every site has used a nation PD. The other problem is that the PD is inaccurate. There are some things in there that we never did and never would do. Then it is missing some things that we do on a daily basis. It was a start, but the VA does not standardize. I’m concerned about it because it doesn’t ensure repeatability. It makes it inconsistent and difficult to enforce and not repeatable.

Everyone has different ideas. The use of the term HCD is new and the exposure to the org is limited. From my background, I’m not accustomed to hearing a term and saying this is what it is without training people. Everyone has their opinions about what it is or isn’t. I think Cerner will change a lot of things because of its structure. It’s going to be proprietary. We’re going to make large scale changes. We’re going to a more standardized, recognizable system. That potentially helps, but my issue (I’m not a clinician) is that when you try to get them to do something one way as a standard there is always lots of resistance. They don’t like how it’s said or want to do it their way. Then it disintegrates into something that doesn’t really benefit vets.

My perspective coming here was that here are thousands of vets that we could help, but I question if we’re doing that as a whole.

**Q: When you mention Cerner is coming and it will impose standardization…do you have ideas of things right now that could be beneficial in applying HCD concepts to. Would it be of value and how would you determine that?**

A: For a large portion of post navy career, I’ve done human error management. When we talk about doing human centered design it requires a lot of work. And it requires people who are focused on nothing but that. And unfortunately, I don’t see a willingness at the VA to invest in that.

We don’t do time-merchant analysis (?) to determine if products we develop are improving workflow and work process. When you start looking at HCD you start looking at all those things and we haven’t. Portland is lucky that we had something along those lines, but we never effectively implemented a standardized version of how to implement these things.

I used to have 8 CACs, now down to 5, then soon to 2. Hopefully moving to Cerner won’t create an unmanageable situation. But out group was all non-clinicians. But other sites have nothing but clinicians. There is a huge disparity as far as what qualifications make a good CAC. If you can teach people analytics in general, that doesn’t mean they’re going to have the competency to do critical analysis. This is where we again get to the definition of what informatics is.

\*\*If we can get a national definition of what informatics is and what this job is then that would be great. That would be a better starting point.

Things are so varied; how do you begin at square 1 and create a level playing field and tell people to forget what they know and take your new way. It’s impossible to do without a definition. But if you want one hospital to be able to take information and analyze it, then that’s where you have to go. I worry that we still have not made the transition to standardized care, practices, approaches. I’ve seen it in data at meetings that you can have 2 people with the same data and end with 2 entirely different perspectives. How do you create an environment that works off those different places’ strengths but don’t go in 2 different directions trying to solve that same problem? That’s what we tend to do now.

We don’t do business case analyses when we do something. We don’t determine if it’s better to create a tool or modify practices. We don’t look at efficiency or effectiveness of a tool. We just look at if people like it.

Portland has built thousands of products and, from my background, I didn’t know why we had 10 tools that were generally the same. Can we consolidate? But they would be like no no no, justifying why each one is different. The system also didn’t afford us flexibility to do early direction.

When we start to analyze stuff, people pull stuff from different systems; they pull it in such a different way, unless there is someone attuned to data gathering, which is rare. We’ve had instances where people got data, made a statement, and said what we’re going to do and then someone else says, well that’s not what the data said.

So, there are foot-holes. I think it’s because we as an org don’t invest in people to do the HCD piece as part of the business.

**Q: What do you see as issues with Cerner when it comes? What do you think is going to happen with data collection when Cerner comes in? What could our tools help with?**

A: Cerner is going to help us with capabilities that is lightyears ahead of where we are. User interaction with a tool down to the individual user. Number of keystrokes, path, what they skipped or did not skip. So much more capability. Problem is that we have not prepared the workforce for what is coming. There is the ability to evaluate performance within that system and you can look at an individual provider and determine if they are using the right tool, etc. There is an incredible amount of detail.

**Q: I’m wonder about the role of the CAC. Will they be tasked with generating reports and performing critical analysis to figure out where things might be improved?**

A: Now we go to the really uncomfortable part. When Cerner was defined it has no intention of allow CACs to touch their tools. They have already made their statement that they don’t want them in their system. It’ll be any other software system. Someplace somehow information will need to be funneled to Cerner. Then there will be a panel to make a decision based on value (I assume) the cost-benefit analysis. I assume they’ll be looking for the best bang for their buck. CACs from early on have been told that their job is going away with the advent of Cerner. The emphasis on informatics is the result of that. In addition, there have been very limited roles for informaticists within the broad spectrum of facilities. In other words, there weren’t people really doing informatics work. There are nurse informaticists, but they are nurses first.

It’s not effective use of people to have NIs do HCD work. You don’t have to be an expert but you have to be working to facilitate the process. It takes people and time. My observation is that the VA is looking for a band-aid to put on their problems. I’ve had discussions of “we should have done this or that.” We don’t review our products. We have hundreds of order menus that have no scheduled review process. There are things that are clearly out of data. We only work by exception. That’s true for the majority of the VA. We only know things are out of data or incorrect when someone points it out. But it doesn’t always get pointed out.

**Q: Can you share an example of one of these situations? Like a product that was designed in Portland. Tell us who was involved, what their roles were so we can get a better grasp of how these things happen.**

A: Normally we establish a work request to determine what work we do. The person that submits a work request must have it be approved, then it goes to CHIOs we look at complexity and priority. Then I need to establish complexity and priority level. Then I pass it off to a CAC who directly interacts with the customer. One of the major issues is identifying requirements of the build. Some people build without requirements. We build a lot of things with scarce requirements.

Part of the initial process is working with the requester to formalize requirements for the product to be built.

Then the CAC begins the build process. If they run into issues, they communicate with the requester.

Then they provide a first draft for review. The review is normally not a live review with patients or a review in a test environment. It’s not evaluated based on any criteria. All they are looking for is specific line items, do the buttons feel right, with the limited functionality can we add a line here? We can put color, so the usability factors are significantly impacted.

Once we received their noted modifications, CAC goes through and makes changes and presents it one more time.

Then it gets an implementation date. Ideally there would be education for each one, but that doesn’t happen, it just goes into live environment and gets socialized by word of mouth, not training.

**Q: You mentioned getting the formal requirements is something that doesn’t happen right now. Thinking about what we’re interested in offering, I wonder if you can see where there would be value? Are there any steps we can affect?**

A: Requirement definition.

**Q: You mention there is not a willingness to invest in the CACs to make them more efficient and more aware of the tools. Do you think that something like the requirements definition is a place where training would also be needed in addition to tools?**

A: Our CACs do requirement definitions. That’s the first step. They don’t know what will or won’t work within the system, so they work with the customer to refine the product using and having knowledge of the system capability and functioning. They tease out the information for the requester to make the product better.

But they don’t have a process where things are vetted before they get to the CACs before they get to a group. Even talking to them, that process is flawed. There isn’t a class or anything that begins to educate providers on how to improve their work.

Example: provider x is supposed to see x number of patients a day. I tried to get to a usable workflow for LIPs (?) and it was an insane process. I talked to 10 different people and I couldn’t get 1 person to understand what a constructive work year was. Everyone attends meetings, training, other things that take away from a standard work year which builds to a constructive work year.

It’s that same process. I think people from different domains have different focuses. Not all doctors can be informaticists. And vice versa. There are some traits and competencies that individuals need to be able to do that. And it has to be proven that they can do it.

If we’re going to do HCD then you need to train a group of people and each site has to invest in a “winning horse” so that if I invest in this, I’ll see some return from it. The enthusiasm begins to wane over time. My observation is that we don’t look at things from a workload efficiency perspective. How can we look at a process and ensure that it is most efficient and most effective? This is huge in medical. EX: everyone does cancer review boards differently. We don’t come together to use one set of tools. This is where we get to the culture that if you’ve seen 1 VA you’ve seen 1 VA.

**Q: Starting point should be training and working with people on how to do requirements?**

A: We need to begin to talk like a Fortune 500 company. We need to focus on efficiency. Unless someone is looking at people within the VA and you have a motivated person who thinks they can make a change, we don’t have the culture that says to work like a fortune 500 company to improve our theoretical bottom-line.

I see people being distracted by too many people and not enough time. We need to start talking about the importance of the org and how to be efficient and effective. We need internal improvement.

**Q: What do you see going forward? Do you think that culture change will be facilitated? Or will they just move on and not train people? What will be different?**

A: The only thing that will be different is the tool. That’s the problem. The culture change is necessary, but it won’t happen. People generally talk about these things at the top of the org, but nothing is implemented to effect change. This is where change management should come in.

We tend to do corporal punishment. Put it on everybody and tell them they have to do this. Some people never touch it. How do you, in an org like this, get the cultural change that is necessary? I think it’s a change management process and starting with this is where we are, this is where we’re going, and this is how we get there.

They are doing that with Cerner to some extent, but I think it needs more. We’ll see how it goes.

**Q: Is there change management happening with Cerner?**

A: Yes. Cerner is asked by contract to provide change management.

**Q: From your perspective, after Cerner comes in, what kinds of user centered tools will still be useful to employ in medical centers, even unrelated to Cerner. Like building a business case or workflow analysis?**

A: It’s an investment that people aren’t willing to put the effort into. There aren’t always huge gains.

I think it’s clear that we don’t do change well. It’s communicated so broadly that it usually comes out after the analysis. Things get filtered so that specifics of the change don’t get done with enough variance to be implemented. We allow variability.

**Q: Do you think that will continue to be true going forward? Variability?**

A: I don’t see it changing. I don’t see us emulating practices on a larger scale that are consistent with fortune 500/100 companies today. There are things going on to improve the business rather than just doing the business and that takes special people. Definition of what it is. How the implementation will occur. Benefits of doing it. How it will affect business. Who’s responsible and accountable. This is where we get into directors who are accountable but don’t do anything. Then you need people on the ground who understand, and they have to be empowered to implement.

**Q: Benefit of doing it. What kinds of things can you imagine that would make a difference that might be based on improving how CACs do their work right now? If they started doing something different what would be a positive change?**

A: To be able to force standardization. Portland has 16 different check-in procedures. We tried to consolidate to 1 so the veteran could go from 1 place to another and have expectations of what would occur rather than every place be different. That’s where we attempted to standardize and create repeatability, but the clinicians wouldn’t take it.

EX: replacing a drug at a pharmacy meeting. Look around the room and see who’s in the room. Never in those meetings do I hear about the efficacy of the drug nor do they communicate with vets in advance of changing the drug to tell them that efficacy was equal or better and this is why we’re changing the drug. The first time the veterans see the change is when they get the pill and see it’s different. They don’t tell the vets upfront. That’s what I see from a vet perspective that could be improved.

**Q: Knowing that Portland will go through the Cerner transition sooner than other sites. What are some of the ways that your position has evolved? Knowing that many of our informatics or stewardship work is in addition to our job descriptions, what are some good subjects (human centered design, QA, process improvement) that we can focus on to help standardize an approach?**

A: It not evolving.

**Q: What advice would you give other sites to prepare for the change as far as standardizing our processes?**

A: Begin to talk on a larger scale at each site about eliminating various practices and procedures. There needs to be a constant effort to standardized based on what is of value to the vet. It shouldn’t be based on value to the employee. I get push back when I start talking about this. You need to start making changes before Cerner comes out.

**Q: Has there been talk about what life will look like for projects outside of Cerner?**

A: Only in the sense that this equipment won’t work within the Cerner system. Hopefully that’s getting out to other sites in advance. One of the problems with Cerner is that it was a Cox product but it’s not and needs to be built to meet VA standards. All of the notes and everything has to be reviewed or built.

All of that contributed to the process. I don’t think there is anything out there that says here is the list of everything you can be doing in advance. Most of it is mechanical not individual process driven.

**Q: Can you think of bite size nuggets that would be helpful for people who have been asked to be on committees to look at a process or work with a multidisciplinary group. Can you think of any 101 subjects that we could focus on to try and improve what we can regardless of their experience?**

A: I’ve observed that they aren’t really doing it the way it should be done. They don’t do cost-benefit analysis. They make recommendations and the org decides not to do them because they get pushed back by someone on staff. Unfortunately, with the LEAN (?), they push it more for promotion and advancement than for systems improvement.

They’ve done some work and made some changes but it’s not in the culture of the org.