Interview with CHIO at National 3:00 PM June 25, 2020

Participant disclaimer: My comments are not in any way related to VAs. They are my own comments.

**Q: We want to understand the bigger picture. What would be a benefit to those people? What would provide the most value? How would that value be determined?**

**A:** I’m coming from the point of view of the future EMR. I’m guessing if you spoke to our facilities, they are speaking from the legacy point of view. Their world is going to change a lot. There are going to be some big changes and we’ll try to make it as smooth and painless as possible.

**Q: Talk to us about that. We want to know if we can provide tools to make that easier.**

**A:** At the basic level the message from Secretary of VA is that we are no longer going to customize EMR software, we will configure off-the-shelf software. For the CACs this means they will not be writing templates or code alert rules for various conditions. They will be recommending changes to a vast nationwide EMR that is used at the Department of Defense and VA. It’ll be one database. One set of templates, clinical workflows, best practice guidelines. They have a voice in those things, but they won’t be building them. Technically my team and I are not building it either. We’re using the mock domain and putting things in there to see if it works, but we don’t make the change. After we give our recommendations and know it’ll be good for providers and patients, we go forward with making the configuration changes.

Cerner provided the code and software environment. It requires the solution experts to have an in-depth knowledge of what the code does and what the database requires, etc. With that we can offer configuration changes for our stakeholders.

The CACs in the facility within their domains will need to understand that and they’ll be trained to understand the capabilities of the configuration and they’ll have a list of things they can make changes to without coming to National. Those things are open to them to directly contact the Cerner support group to recommend configuration changes. If they are within the local configuration list, they will change them. If they are not within that then they go to whatever team is responsible to make sure the change won’t mess anyone else up. It’s such a big system that we still don’t know what we need to know

CACs will know everything about workflow and solving problems. But right now, they can go into the system to make the change. Problem is that having so many installations with different changes. National is trying to send national updates with the changes that happen.

CPRS Vista is an old program and is terrible to try to program in. As a result, many of those customized solutions that worked around the problems don’t work anymore, they don’t exist. So those challenges will be lesser. There will be new challenges with this new system to learn. There will be a career progression possible for them. It’ll take 5-10 years to make this transition. There are still these facilities that need CPRS Vista support that haven’t transitioned yet.

**Q: So they’re still going to need their workflow and problem solving skills. In addition, what do you think HCD can offer to them?**

**A:** Call Margo or someone else at HFE and ask them if this makes sense in the configuration. Technically Cerner is supposed to have their own HF group. We need to understand too though, so we ask for the right things when we need help. There is not a lot of role for the independent HF people.

**Q: So, when you think about how the CAC role will change, can you think of areas of training and skills that might be offered? What do you think would be a good fit?**

**A:** It’ll be provided automatically from us. Super user training will be required for all CACs. It should give them super user understanding of how all the Cerner stuff works. We’re going to show them some things in what the capabilities are with additional training within Cerner, but don’t know how that’s going to work yet.

My vision is that they’ll get technical fundamental training to learn how the database works. Based on the position they have they’ll get other training. Still, they’re not writing the code, but they need to know what the system capabilities are. There will be some local configuration, but it’ll be filling in the blanks, not writing the whole thing.

*Lights On* is a non-invasive surveillance system that looks at human factors. How is the provider accessing their information? How much time are they spending in the doc or on a lab app? Did they get there in an efficient matter? Use this to identify people who are struggling and direct them to an informaticist to give them more training to be more efficient. It’ll let us know if they are having trouble navigating so we can help to improve their efficiency.

Nurse Informaticists (NIs) will have the eye view and get training on how to configure it at the facility level for their users. They can set that up for the people at that particular ward. Hopefully they can make those changes so everyone can understand and work from a template.

**Q: What kinds of tools or techniques would the NI need?**

**A:**

* Experience in clinical area
* Basic human factors knowledge
* Computer Ergonomics (Informaticist know this)
* User interface design. Reducing mouse clicks, etc.
* Knowing how the data and packages work.

**Q: Would informaticists be responsible for building business cases?**

**A:** Absolutely. If they see our workflow and think there is a better way to do it, we want to see it and get it nationally distributed. We are all for people showing us better workflows. We want to see those recommendations. It involves a change through the enterprise recommendation.

**Q: When you think about the form that the grassroot input might take, can you think of the skills people might need?**

**A:**

* Visio\*\*\*
* They should be good in Office suites
* Do TMS training in teams.
* All basic things the informaticists use.
* How to do flowcharts is good to know. What the symbols mean. Why you always have to have a start and end. Understanding that is helpful.

These basic things are important

**Q: How might they develop that information before they develop it in a flowchart? Is there value to teaching them about structured interviews, etc.?**

**A:** Most of the observations stuff will be received through *Lights On*. Then they really need to do structured interviews when they identify users that need help. So yes.

Informaticists will be trained at super user level or higher.

When Cerner does the triage, if there is no super user nearby, they will act as the super user, but the provider might get quicker responses if they go to their local super users. There are a lot of different levels of super users. Every area will have a super user for each environment. Then the informaticist will have the overall super user to form the core of the informatics committee. It’ll be dynamic, because it’ll determine if it’s a user issue or configuration issue. Then the solution will call the help desk and send the solution to the National team.

Informaticists need structured interviewing skills to figure out where the problem really exists.\*\*\*

**Q: I’m looking for places in this changed environment where HCD methods can be of value.**

**A:** May find a resource in Simmler (?) in terms of being able to exercise the change. It’ll be a year until we have it. Simmler is an emersion clinical environment. Use devices, high-end mannequins. Real providers can come in to practice skills or learn a new one. Implement Cerner with them also. Could be an opportunity there in the future.

There is talk of mobile devices in the future to run all systems they’d need to use. Not much to do with human factors there. Maybe in infection control requirements.

**Q: Thinking about the environment in the medical center and other skills informaticists might need to be more productive and efficient with the change to Cerner, can you think of other things you wish they would provide?**

**A:** Education for the users. Many of our CACs have become specialized. They are given the role of a specific application (templates, orders, order menus, etc.). Understanding software organization structure and potential pitfalls. If you only know 1 package, then you don’t know other solutions. If you only follow 1 service, you may not know that solution exists in another service. Need an understanding of organization structure and caveats to that structure.

Spanic control. (?) They need to understand service structure. There needs to be single source leadership. So leadership training would benefit the CACs. Learning how to be a leader would be good to teach them. Different from learning to be a supervisor.

They should not exceed 7 +/- 2 roles. Can’t handle more than that. Get directors to understand how many informaticists they need. Which only happens when you have a good leader who can say who you need.

Typically. I’d say there is 1 CAC for every 10,000 in the pop. (?)

**Q: When you think about the need for leadership training…do you have in mind that the CACs and informaticists will be one pool of people?**

**A:** Yes. NIs, Lab ADPACs, CACs, pharmacy, radiology, medical, dental, surgery, etc. All these people need to understand the workflow and supply chain that pertains to their area.

We brought medical pacs and radiology into informatics. When they had issues they could play into each other. They knew who to go to for the service if something needed to be changed.

This is something you learn from leadership. Spanic control, unity of command, and diversity.

**Q: Individual medical centers…what would you have valued to learn when you were working as an informaticist? What do you think informaticists could benefit from learning?**

**A:** I was blessed that I had really capable people. There was also really great staff. You need to enable your informatics folks to make decisions without fear of reprisal. I just want the decision and justification, even if it’s wrong because we’ll fix it. There is nothing in informatics that could kill a patient so making mistakes is okay.

I need/want logistical support. The VHA has a really convoluted way of going through inventory. Most of the assigned services don’t have the manpower to do that at all. Those devices can be monitored electronically but the VHA doesn’t allow that.

I didn’t really have anything we couldn’t get.

Informaticists need to “walk the hospital” and understand. Just walk downstairs to the other environment. That gives a lot of information into what the workflow is

**Q: If you’re investing in training for informaticists, what would be top of mind?**

**A:**

Basic:

* Understand tools and use them. Visn 8 had a class teaching all the tools. Its very effective. National will provide face to face teaching of Cerner.
* Ethics, leadership to understand, grammar and spelling.

Medium:

* Configuration human factors workflows. They’ll get to see it but they’ll never get to use it. Only a handful of national people were trained and certified to use it.

Advanced:

* Problem solving
* Local changes
* Building workflows into service tickets that become a national change.

This is pretty fresh and new stuff.