AMS-CM- Ep 9 - Chandi Chandrasena

Helen 0:00
Well, welcome, hello. I'm here with Dr Chandi Chandrasena. You are Ontario MDS Chief Medical Officer. (I am.) You are. So why don't you tell me a little bit about what a Chief Medical Officer actually does and how you work with Ontario's primary care practitioners?

Chandi 0:20
Yeah, perfect. I'm glad you're asking me that now that I'm almost four years into the job, because I think I'm starting to understand what it is I'm supposed to do. Thanks. So I'm going to back up a little bit like so Ontario MD is a wholly owned subsidiary of the Ontario Medical Association, but we're unique in that all, almost all our funding actually comes from ministry and, OH - Ontario Health, we're actually funded to be a delivery partner for the government in Ontario health. It's interesting, because we're part of a medical association, but also part of government. We kind of straddled the two. And so I kind of say we actually have three bosses. So we have the OMA, we have OH, which is Ontario Health, and then we have physicians, right? Because they're the members of the Ontario Medical Association. But yet, you know, no one wants to pay us, except the government. So it's kind of like, how do we manage that? So part of my role as Chief Medical Officer is, I'm kind of the physician facing face of Ontario. MD, so I'm responsible. I'm actually the only physician that's full time hired there, and I'm actually responsible for a number of kind of portfolios. So one is obviously physician and clinician engagement, because it's everyone in the community. So it would actually be family docs, specialists, nurse practitioners, the clinics, the staff, it's anything that touches community or primary care, but also specialists.

So specialists aren't traditionally considered primary care, but in the community, they're part of our mandate. And then the second thing I'm responsible for is the education curriculum is really digital health onboarding tools, kind of, you know, there's this new, shiny technology that we want you to use. It requires a little bit of help to get that done properly. And so I help with that. And then the last piece is advocacy is that's kind of the part that's like dearest to my heart, right? It's kind of looking at wellness and motivation, and how do we get this technology into community so that, you know, people are happy with it and it's not burning them out, and we've done it in a kind of a thoughtful manner. So those are the big three things

that I kind of do. There any project that OMD touches has to have that physician clinician lens on it. So I end up actually being part of every single project that comes our way, which is such a privilege, because I get to kind of see everything and sit on these really amazing tables and really learn new things.

Helen 2:55
So can you tell me a little bit more about some of the projects that you might interact with? And yeah, as you're talking about, how do you, as one person get all that done, and do you have a team and other things? But let's first things first. Let's talk about an example of a project.

Chandi 3:10
So, you know, the projects are so varied, right? So originally, we were actually created for EMRs - Electronic Medical Records. So that was 2008, I'm probably getting the date wrong, but sounds about right down there. Yeah, there was a lot of funding, and the push was to get electronic medical records or EMRs into clinicians in the community, get them start using it. And that actually required a lot of change management and onboarding and teaching and developing. That's how we started, and then we pivoted to anything that touches an EMR. So different tools like online appointment booking, right? So that you can book your appointment online instead of having to call and wait forever, you know, for a receptionist, secure messaging portals and then workflows like consults, referrals, all the stuff that clinicians touch all the time. There's these digital processes and technology. So each one of those are kind of a project that would in some form end up on my desk or in our organization that we would be involved with. And then the other parts are, like the HRM - hospital report manager. I'm going to digress a bit, because I'm going to tell you it's an incredible technology at the time when it was developed, because it bypassed the facts, and it went directly from hospitals into your electronic medical record, into the patient chart, seamlessly, without any intervention. And it was kind of like, this is amazing, but then, like a lot of technology, when it's not completely thought through, ends up becoming a burden. So a lot of the work I do is actually around the HRM and the issues it's causing, or the reports that come through our HRM technology that hasn't been standardized. You're kind of saying, Wait, you can't send me 50 pages because it's really easy to do. And so we work a lot on that. And. Then AI Scribe is like, AI is kind of like the “new kid on the block”, so we touch those projects also.

Helen 5:07
Yeah, it's a pretty exciting time for AI scribe, because we're in the middle of a big provincial procurement, right?

Chandi 5:13
We are, we are, so we're involved with that also. So it's kind of incredible all the amazing stuff that we potentially can be part of.

Helen 5:23
So how do you how do you get it all done?

Chandi 5:25
I know, yeah, I don't think I do the beauty of this organization. I have to say I really like Ontario MD as an organization, because at the core is the belief that everything we're doing is for patients and clinicians in the community, and that belief actually trickles down to every single staff member in the whole organization. So even if you're doing something that you think is insignificant or you think it's not like part of a bigger project, it links somehow to a patient or a clinician or a clinic or something like that. So I think when you work for an organization that has that core value, it's kind of everyone pitches in, and everyone really, works really hard. So when we have these projects, I kind of just pull from whoever's around, and we do a lot of stuff off the side of our plates actually.

Helen 6:22
Amazing, because sometimes it's hard when you split it like you've got three different it is accountabilities, or, you know, drivers, yeah, and trying to sort of navigate that. It's like spinning plates.

Chandi 6:34
Sometimes, I'm sure there's a lot of management relationships, for sure.

Helen 6:39
So you've gone from being a practicing primary care physician to, you know, a leader in a provincial organization that's trying to do good work, particularly at a time when primary care is challenged. Yeah, so interested in your alert leadership journey, like, how did you get here? Yeah, from there,

Chandi 7:00
I wonder that many times, you know, I kind of sit down and go, How did I get here? And I call myself like an accidental leader, right? Because I actually, it's funny, because you're using the term leadership, and I don't even know if I qualify as a leader, because I'm thinking, well, wouldn't everyone do this? So I think it's kind of the experiences you have and then the doors that open for you. So yes, family doctor. So I actually am a daughter of immigrants, so no doctors in my family. My family came from Sri Lanka, so we, we didn't have a lot, but education was like a big piece, and what was instilled was kind of, like a social responsibility and accountability. So it's really, you know, no matter what you do, do your best. It's kind of, I think that your typical new immigrant mentality like, do everything you can, do the best, and then make sure you leave it better than when you came. And that was kind of the way that I was raised. And also I, obviously, we're on a podcast, but I have a brace. I had polio when I was younger, so I'm differently abled, right? But that had never, ever been a factor. But I grew up in the healthcare system as a recipient, and so then when I luckily got into med school, and I was so privileged to be a family doctor, I already had, like, a lot of experiences and kind of an idea of where I wanted to go. And then I started off in rural medicine, actually. So I did the rural Ontario Family Medicine program, NOFM / Northern Ontario Family Medicine before NOSM. Right, which is the med schools opened. And I actually worked up there for a couple of years, and then finally settled in Ottawa, and I did 20 years of comprehensive, longitudinal Family Medicine, like birth to grave, as we say.

And I think you really need to get that practical clinical experience in order to really translate that in other roles, and then along the way, I've always been involved with the Ontario Medical Association elected delegate positions. I was district chair, which is kind of like their mini government that they had for Ottawa. I was a peer leader. The OMD has this peer leader program where they it's like a consultancy for family docs, nurse practitioners and clinic managers to kind of help them teach. And it's a lot of knowledge translation. So I think I know it's a long answer I'm giving you, but it started with kind of a family medicine piece to taking on everything I liked, to actually being more involved in kind of leadership that way.

Helen 9:48

Why technology? Is it just because that's where the opportunity is? Or do you have a particular affinity for technology and the change? That it is bringing about in family practice and in the healthcare system generally.

Chandi 10:04
Yeah. So I think that was it, because I went from being a paper family doc, so you know, you kind of have your wall or charts, and then you're kind of curing and everything's written down. So I went from that to actually transitioning to an electronic medical record, where all of a sudden everything was in this box, this computer, and it really helped quite a bit. So I found that it was better patient care. I could keep track of my patients better. I could kind of pull out all my diabetics. I can make sure that I've done their preventive care. I can make sure they've had their PAPs and their mammograms. Like it really helped me do a better job, and initially it's saved me time, like it was actually quite wonderful. And so that's when I started kind of thinking, you know, we need to be able to get this out there better. At that time, I was kind of like that self-expert. Everyone would kind of call you up and because you actually knew how to use it, and no one else did, and then you would help them. And then Ontario MD had this peer leader program where this was, like a formal program. And so I joined that, and it's, you know, I really like helping people understand, like the art of the possible and how to get that efficiency going. So it started there.

Helen 11:17
So it's interesting. When you're talking about it, you talk about the, I guess, the benefits of technology. And do you have any thoughts on how tech is changing family practice? Because we're also hearing, you know, that's one side of the story, but we're also hearing about the burden of technology and time, and in some ways, that's where digital scribes are supposed to be part of the solution, and we met when we were starting to look at physician Burnet. So talk to me about how you think technology is being used and is shaping kind of the next phase of what family practice looks like.

Chandi 11:55
So I got into this kind of landscape because of technology, because it seem like it was really helpful and at that time? I think it was then over, over that time. So, EMR, let's say, like 12 years now, 12 to 15 years that you've been on this it's actually kind of taken a turn for the worse for family practice. So as you know, primary care is suffering right now. Right like clinics are

closing, there's no access to family docs. Students don't want to go into family medicine anymore, and so some of that blame has been placed on the technology that have to be used, because it's created such an administrative burden, and it's turned clinicians into data entry clerks, and they just want to spend that time with their patients. That's why we all went into this world, right? And so the technology acts as a barrier in many ways, and I think, I think I'm hoping we're able to kind of pull ourselves out of that. But a lot of that happened because we didn't really realize, you know, hindsight is 2020 you didn't know he was coming. Otherwise, you probably would have set up some strict programs in the beginning to prevent all this from happening. Right? And a lot of that didn't happen because you kind of kind of pivoted as you went along. So I think now that there is a lot of burnout, we have to step back and kind of figure out which technology is causing that, and then maybe change the way we're doing it. So I think there's a lot of room there still to learn.

Helen 13:36
I think about the family doctor that lives in my house. Yes, not me. I think he's on his third EMR, right? Yeah. You know, I think they started with Oscar, yeah, and then moved to something else, and now they're migrating to something else. So in the course of 12 years to do three migrations, you know, in and of itself, that's a lot of change in practice, right?

Chandi 13:57
Yeah. It's a lot of change and migration, especially because you lose data and then you lose time, and then you have to relearn a whole new system. So I think in retrospect, there's a lot of things that should have been standardized or regulated better. But going forward, I think we need to learn from that and make sure that we have our eyes wide open when we're looking at these new technologies.

Helen 14:22
Do you have any examples of when it works well, or some context where the introduction of technology has, you know, gone pretty smoothly, and where you know, there's a patient benefit and the physicians are happy? And are there any lessons learned from those because, you know, it's a challenging time, and we might as well take the best of what we've got if possible, right?

Chandi 14:48

So I think you have to, I know, for it to be successful, everyone needs to buy in, right? And that's part of it. So I can give you an example, from a clinic level. And I think you can take those lessons learned and you can expand that to really any level. So in our clinic, when we went from EMR and then we wanted to start adding on extra tools, you needed everyone to buy in, right? So if we're going to do online appointment booking, or if we're going to do a patient portal, or we're going to do e forms, like forms that are sent electronically to patients, that they can fill out, and then it comes back into your EMR, like, there's a place where all this creates efficiency, but then there's a place where there's a lot of retraining, relearning and kind of workflow management. So at one point, what we did is we kind of mapped out the pain points of our clinic. So instead of saying, Oh, look at this cool technology, you work the other way around, right? So you look and you say, Okay, where are the bottlenecks in this clinic, right? Like, is it online booking? Like, I know that's the coolest new thing, but is that where our problem is? And then you figure out also from different lenses. So we kind of look a little bit about the patient lens, like, how do they flow through our clinic? Then you look at the staff lens, and you look at the management of the office manager, and then the physicians and the nurses, and you map it out. So then if you're able to find places where everyone has buy in, like, Oh, if it's actually going to make it easier for me here, then it's kind of nicer when you introduce it, because everyone's kind of got a little kind of stake in the game a bit. And then I think it's a matter of not doing it for everyone at the same time, right, but just kind of little bit at a time, and then tweaking it, and then being ready to walk away if it doesn't work. So there are examples where it works really well. So we implemented E forms, and it's amazing, because before patients would come in, they would tell the reason they were coming in, and then they would have to repeat their story, and then they would come see me, and I would ask them again, why are you here? And then I would ask all these questions, which were just part of a form. But this way, if you knew why they were coming in, you can send all the forms. They could do it off their phone and the comfort of their home, all those answers get put into my electronic medical record, so when they come in, I've already got the story, and it's just a matter of a dialog to clarify, and it just makes everyone's a lot happier.

Helen 17:26
That must feel pretty good from a patient perspective as well, right? Yeah, one would think that, you know, there's sort of, you're walking into a room and somebody already knows something about you. Obviously, these are

hopefully long-term patients, but still knows the problem, and you have a chance to tell your story, and you feel probably less rushed in putting it down. Do you have any sort of experience in understanding it more from the patient perspective?

Chandi 17:52
So I think so, nothing formal. Okay, so I think Family Medicine gives us this privilege where we are very entwined in the lives of our patients. We really can understand what they're coming from, because they're they tell us, right? So I think a lot of it is just kind of asking what their issues are, or they'll just tell us without, kind of without kind of asking them, I get a lot of feedback. So from that perspective, I think we're able to kind of understand where the gaps are. Then if you kind of go a little bit like you pull the lens back a bit, and you look at it more from a health system, and where do patients fit in from that I think it's more some of the work we do with Ontario MD is around surveys. When we do studies, we try and understand also what patients feel about the technology. We have a patient Leader Program, which is very early days, where we get input, and it's kind of like, okay, kind of bringing them from different sources, and then understanding where the pain points are.

Helen 18:59
That's great. I'm interested in your leadership roles. Having had a few myself, I find that, you know, sometimes you tap into different capabilities depending on whether you're, you know, functioning as an executive, you're functioning as an expert, you're an advisor, you've been a governor, you're an educator. How do you approach leading in all these different contexts? Do you have a core set of skills, or how does context matter in terms of what you're trying to achieve in those various roles?

Chandi 19:33
I think context does matter. I'm a people and process person

Helen 19:38
I do know that.

Chandi 19:40
Yes, I'm more about the relationships, and I'm more about kind of leadership through kind of understanding and bringing people to where you think they should be, or and sometimes kind of bringing yourself to where

they are. And I think that's it doesn't matter where you are. I think. What it is, I think it's people and process and trust is the first thing in leadership. So I approach everything the same way. I think where my hats change is really the context, right? Its like, which hat am I speaking with at that point.

Helen 20:14
Right. And a lot of the work that you do, you're not actually in a position of administrative authority, not holding the purse strings. You don't make the regulations. You're not necessarily the governor asking challenging questions, and yet you're able to implement change. So you've been pretty and you've been pretty successful at it. So what's the secret sauce to getting people to go along in a journey when you actually don't have many levers? You might have a couple, but not many.

Chandi 20:51
I know you make it sound like so dire. No, you're absolutely right. You're absolutely right. You know, I draw my skills in family medicine, right? Like you're a patient, and you come see me, and you've got a problem, and we work together and we figure out the solution, but you don't actually want to take the medication, or you don't, you're not sure about the medication, you're not sure about we came to the right solution. So it's really about kind of listening to each other and kind of figuring out, okay, where can we meet, and how do I get you to where I need to get you to, because that's what's good for you, and it's kind of that journey. And so a lot of what I do is kind of, it's understanding where you're at, and then a little bit of knowledge translation and a lot of education, right? A lot of education, and then a lot of Okay, where can we go the next step? And that, I mean, doesn't always work, but I find when people understand where each other is coming from, and they kind of know that you're coming like you're speaking from a community voice, and that's your bias. And this is the education of where I come from, and they understand that I feel like there's better dialog than if you just come in and say, No, that's not going to work.

Helen 22:11
And before we started recording, we were talking a bit about some work that you were doing on data standards. Yeah, yeah. So how are you using these skills to get to the holy grail of, you know, Pan Canadian data standards,

Chandi 22:24
I know. So I've been really lucky in this job that it's opened up a lot of new experiences for me. So I've worked with the Canada Health Infoway and CMA Canadian Medical Association, and now CHI, and we're looking for data standards, and we're looking at interoperability, right? Because that's, that's what everybody wants, is interoperability. And so in order to have that, you have to have data standards. And I know you're nodding your head, but to me, I was like, Oh, of course that that makes sense. But you know, the reason I really enjoy working with chi high right now is that they're looking at the data standards, and their advisory group has diversity, there's clinicians, there's non clinicians, there's patients, and everyone has input into these standards. And they're not only just looking at standards, or they're not saying you need to have all these data, and I want you to be entering this at source. And it doesn't matter where you are, we need to collect, collect, collect. It's more the Why are you asking for this, and who are you expecting to enter this? Because if you're asking for these standards, and you're expecting me, as the physician, to be entering it, this is not clinically relevant for me. I'm not going to do it, like, it's just not going to work with my workflow, so therefore, I probably wouldn't support them. So there's a lot of that, okay, would you support it if it came from another source? And I'm like, yes, that I might support so I'm finding it really interesting that they're starting from the bottom up, like, what's the problem you're solving in the community? And we can solve that problem with these standards, but we're not going to create more burden, because we're going to try and figure out not to put this on you, but on ever, like on kind of spread it evenly.

Helen 24:14
So well, good luck. I know, because we need it, right?

Chandi 24:19
We need it. We need it. But you know, the thing is, you develop data standards, so now you have to implement them. So you have to change legislation, regulation, the vendors have to implement it, okay, but as the vendors implement it, they're going to implement it all different ways, and some are going to implement it very easily, and some will just put that in there and cause more burden, because you're now clicking all over the place. So the standards is just the first part, right? But it has to link to how it's actually going to get put into the EMR.

Helen 24:54
Great. So I'm going to finish off asking a bit going back on digital scribes, just because it's so. More topical. What's your hope for the work? Because it's really, you know, there was a nice study that was done. You were involved in it, as was good colleagues at Women's College, right? Looks pretty promising. Where do you think it's gonna go? Or at least, what do you hope is gonna happen?

Chandi 25:16
Well, I hope it's just the start of many, right? So, yes, we did our study. It was with weave and E Health Center of Excellence, and that was published in September, and then since then, we've been working on a vendor of record to vet AI so that it's available and the contracts. Because when you talk about AI, it's really the privacy and the legal bits and the liability pieces that you have to kind of be sure about. But you know, AI is low hanging fruit. It's just about documenting your work, and that's not it's a pain point. It gives us some capacity. It helps us. But that's not where we need the help. Where we need the help is really the other pieces of administration. So AI inbox, where the forms come in, the lab management comes in, AI clinical decision tools so that I don't have to remember all these guidelines in my head. I can kind of depend on an AI as an external brain, right, to guide me through that. You know, AI triage and AI scribe can be so much better, right? So right now it's a conversation, but what if they took the diagnoses or the conditions in the conversation and they were able to put those into data fields in your EMR, or code it and clean up your data so that you would actually take that conversation and that becomes this data mine that's like coded lovely and nicely, that could then be used for one patient, one record that's accurate. So I think there's more to it than just what's happening now, but the vendors have to build to that, and we have to kind of guide that, and there has to be a clinician voice that's pushing that there.

Helen 26:56
Sounds like that's you.

Chandi 26:58
Me and everyone else calling who's listening to this podcast, saying, you know, if you're a clinician, I think there's a professional accountability there that you need to lift our profession up, and this might be the way to do it.

Helen 27:10
I think, well, from my experience, I think you're right. Certainly, we talked a bit about the work that that I did at the renal network, and I think at every fork in the road. It was big tent, right? Build a big tent. Get people engaged, make it. Make your mission their mission. And, you know, basically, take all comers and let's kind of move this in a positive direction.

Chandi 27:34
Absolutely. I think that's the only way it's going to work. It cannot be top down.

Helen 27:39
Well, I can say is Godspeed. We're happy to go on that journey with you and wish you every success.

Chandi 27:45
Ah, thank you. And you're doing such amazing work in AI that I'm kind of, I'm looking towards you to actually lead some of that way.

Helen 27:53
Absolutely, we'll be partners in. Yes, absolutely. Thank you.

Chandi 27:56
Thank you.