

# **Deborah A. Houston, MSN**

Interview #20

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# Deborah A. Houston, MSN

Interview #20

## Interview Profile

### Interview Information:

Two interview sessions: 26 July 2012, 27 July 2012  
Total approximate duration: 3 hours 40 minutes  
Interviewer: Tacey A. Rosolowski, Ph.D.

For a CV, biosketch, and other support materials, contact:

Javier Garza, Archivist, Research Medical Library  
jgarza@mdanderson.org; 713.792.2285

### About the Interview Subject:

Deborah A. Houston (b. 1950, Honolulu, Hawaii) joined MD Anderson as a staff nurse in 1972. Between 1986 and 1995 she served as Director of Nursing and in 1995 assumed the role of Center Administrative Director for Hematology (until '97). From 1986 to 2008 she was a Clinical Assistant Professor in the University of Texas Health Science Center School of Nursing. In 1982, Ms. Houston was the first nurse to receive the Brown Foundation Outstanding Nurse Oncologist Award.

Ms. Houston shifted career paths in 1997, when she became Coordinator of Clinical Systems – Patient Care Information Systems. Her administrative roles in Information Systems expanded to Director, Enterprise Applications, Management Info Systems ('99 – '05), then Director of Perioperative and Critical Care Informatics ('06 – '09), then to her present role of Director of Information Systems Clinical Operations and Projects ('05 – present). She has written numerous articles on oncology nursing and on the role that Information Technology can serve in patient care.

### Major Topics Covered:

Personal and educational background

Oncology Nursing: overview, evolution of, practice of at MD Anderson; nurses and multi-disciplinary teams

Nursing management at MD Anderson

Career change from nursing to information systems

Information systems as a service provider; information systems for team care delivery

Electronic medical records

MD Anderson culture

**University of Texas MD Anderson Cancer Center  
Making Cancer History Voices® Oral History Project**

**Research Medical Library: Historical Resources Center**

Original Interview Profile: Deborah A. Houston, MSN  
Submitted by: Tacey A. Rosolowski, Ph.D.  
Date: Revised, 9 June 2014

Deborah A. Houston (b. 1950, Honolulu, Hawaii) has worked at MD Anderson for 33 years and has served as Director of Information Systems Clinical Operations and Projects since 2005. In this two-session interview (total duration, approximately 3:40) conducted on July 25 and 25, 2012, she traces her career path from Oncology Nursing and to Information Technology. The sessions take place on the Main Campus of MD Anderson in Ms. Houston's offices in Pickens Tower and the Fannin Bank Building). Tacey A. Rosolowski, Ph.D. is the interviewer.

Ms Houston received her BS in Nursing in 1972 from Texas Woman's University, Denton, Texas and her MS in Nursing from the Houston campus of that same institution. She began to work at MD Anderson while still a nursing student and began full-time as a staff nurse in 1972. She rose to Head Nurse '75 – '78), Clinical Supervisor in Thoracic, Neuro, and Orthopedic Surgery ('78 – '79) , and Clinical Nurse Specialist in Thoracic Oncology ('79 – '86). Between 1986 and 1995 she served as Director of Nursing and in 1995 assumed the role of Center Administrative Director for Hematology (until '97). From 1986 to 2008 she was a Clinical Assistant Professor in the University of Texas Health Science Center School of Nursing. In 1982, Ms. Houston was the first nurse to receive the Brown Foundation Outstanding Nurse Oncologist Award.

Ms. Houston's career shift occurred in 1997, when she became Coordinator of Clinical Systems –Patient Care Information Systems. Her administrative roles in Information Systems expanded to Director, Enterprise Applications, Management Info Systems ('99 – '05), then Director of Perioperative and Critical Care Informatics ('06 – '09), then to her present role of Director of Information Systems Clinical Operations and Projects ('05 – present). She has written numerous articles on oncology nursing and on the role that Information Technology can serve in patient care. In 2007 she received the Association for Women in Computing Award for Leadership in Technology, awarded by Top Houston Women in Technology.

In this interview, Ms. Houston gives a vivid portrait of Oncology Nursing and the key role the Oncology Nurse serves for patients. She also provides an insider's perspective on the organization of clinical structures that facilitate patient care and talks about her many initiatives to improve its delivery as she rose through Nursing's administrative ranks at MD Anderson. As she traces her career in Information Systems, she traces the process of an institution adopting complex new technology. She also explains how challenging it is to create electronic applications that suit the unique requirements of MD Anderson's patients and care providers.

## **Deborah A. Houston, MSN**

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Interview Session Two: 27 July 2012

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Segment 00B

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## Deborah A. Houston, MSN

Interview #20

### Segment Summaries

Session One: 26 July 2012

Segment 00A  
*Interview Identifier*

Segment 01  
*A Nursing Student Discovers MD Anderson and Oncology Nursing*  
A: Educational Path

Story Codes  
A: Personal Background  
A: Inspirations to Practice Science/Medicine  
A: Influences from People and Life Experiences  
A: Joining MD Anderson  
B: MD Anderson History  
B: MD Anderson Snapshot

In this segment, Ms. Houston talks about her family background and the path that led her to oncology nursing. Born into a military family, she moved a great deal as a youngster. As her mother and aunts were nurses, she followed in their path, attended Texas Woman's University in Denton, Texas. She began to work at MD Anderson while still in nursing school (in '68 or '69), choosing Anderson over Methodist Hospital, because of the higher wage (\$18/8 hour shift). She describes her responsibilities at this time (dressing changes, for example). When she did her clinical rotation at MD Anderson, she was so impressed with the culture of work and care for the patients that she decided to become an oncology nurse.

Segment 02  
*Why Oncology Nursing is Unique*  
A: Overview

Story Codes  
A: Overview  
C: Professional Practice  
C: The Professional at Work  
C: Human Stories  
C: Offering Care, Compassion, Help  
C: Patients  
B: MD Anderson Culture

Ms. Houston describes how important a nurse is during the frequent “life ending” situations of cancer. She explains how a nurse gets to know patients and helps them confront all dimensions of their disease, though she also describes how uplifting it is to see patients beat cancer, as she was able to see when working with many lung cancer patients. She gives an example of a life-ending situation with a patient she particularly admired, and who spoke with her about how he could help his family during the rapid progression of his small-cell cancer.

#### Segment 03

##### *Nursing and Nursing Management at MD Anderson in the Seventies*

A: The Clinical Provider

#### Story Codes

B: Multi-disciplinary Approaches

B: Institutional Processes

C: Professional Practice

C: The Professional at Work

A: Professional Path

In this segment, Ms. Houston talks about the progression of her nursing career. She first summarizes her experiences as Staff Nurse ('72 – '76), when she worked with a number of units: Surgical, Thoracic, General, and Head and Neck. The separation of these units causes her to observe that although multi-disciplinary treatment was a goal from MD Anderson's inception, it became a reality in the 90s with centralization of patient services. She also comments on the role of nurses in the team of care providers, noting that before the hiring of physicians assistants, nurses helped physicians manage their patients. Next she talks about her role as a teacher and mentor once she became a Nurse Manager (Head Nurse) in 1976, and she helped nurses under her to learn how to care for lung and esophageal patients. At the time, there were only three people in nursing staff development (now there are over thirty).

#### Segment 04

##### *Nursing Administration and a New Setting of Multi-Disciplinary Teams*

A: The Administrator

#### Story Codes

B: MD Anderson History

B: Institutional Processes

A: Professional Path

A: The Administrator

B: Multi-disciplinary Approaches

B: Growth and/or Change

A: The Clinician

B: Critical Perspectives on MD Anderson

A: Career and Accomplishments

A: Overview

Ms. Houston sketches the next phase in her career ('79 – '97): her move from Associate Director of Nursing, to Director of Nursing, and then into the position of Center Administrative Director of Hematology. (She was the first Center Administrative Director.” She summarizes the scope of her responsibilities in each role and then focuses on the restructuring MD



Anderson was going through at the time to create “centers” for Radiation Therapy, Hematology, and other services in order to create continuity of care as patients shifted from being in-patients to out-patients or vice versa. This was part of a general institutional push to create “multi-disciplinary care environments.” Ms. Houston describes the reporting chains in these centers and the teams –made up of a surgeon, a medical oncologist, a radiation oncologist and a nurse, among other service providers. She confirms that giving clinics autonomy in this manner represented a cultural shift in MD Anderson, and its goal was greater cost effectiveness. She explains why this goal was not achieved. She then describes the roles that nurses served within the new structure. At the time, leaders in the field of nursing were becoming more vocal about the importance of nurses. At MD Anderson, however, she feels that nurses were involved as an afterthought and because individual physicians understood the role nurses play in organizing patient care, helping the physician to assess the patient, and supporting the patient who must ask the physician about his/her care. At the end of this segment, Ms. Houston talks about her role on the selection committee for the Ethel Fleming Arceneaux Outstanding Oncology Nurse Award, which recognizes the central role nurses play in patient care.

#### Segment 05

*Director of Nursing and Center Administrative Director*

A: The Administrator

#### Story Codes

A: The Administrator

A: Professional Path

B: Institutional Processes

B: Building/Transforming the Institution

B: Multi-disciplinary Approaches

D: On Research and Researchers

Here Ms. Houston goes into detail about the operation of the different units she administered during the nursing phase of her career. She begins by speaking about the stresses associated with serving as a Director of Nursing ('86 – '95) in a “very physician-driven environment.” She notes some of the initiatives she took on: adding services for patients and a mentoring program for nurses, as well as setting up a satellite laboratory on the eighth floor of the Ambulatory Care Clinic. (In-patient nurses would work a week in the Clinic so they could see patients who had gotten better.) She then talks about her role as Center Administrative Director of Hematology responsible for four inpatient units. Most patients, she observes, were involved in research studies, and she describes the difference between nurses focused on patient care and research nurses, but goes on to explain the research element of all nursing at MD Anderson, as clinical nurses help the patient understand the investigational protocol.

#### Segment 06

*Inspirations and Observations About Changes in Nursing*

A: The Clinical Provider

#### Story Codes

A: Influences from People and Life Experiences

C: Portraits

B: MD Anderson History

B: MD Anderson Culture

B: Growth and/or Change  
B: Obstacles, Challenges

In this segment Ms. Houston talks about people who inspired her. Renilda Hilkemeyer, “a phenomenal nurse and pioneer,” and the first Director of Nursing at MD Anderson, inspired Ms. Houston to be progressive. She learned how to conduct project and test out new work flows from Joyce Alt, the second Director of Nursing. And her late husband, Gary Houston, the first male nurse hired at MD Anderson and a Nurse Manager, involved her in many programs. This segment also includes Ms. Houston’s observations on how technology has increased the pace of care delivered, creating a rush in the work place and altering nurses’ relationship to patients and each other.

#### Segment 07

##### *A Career Change to Information Systems and the Challenges of New Technology*

B: Building the Institution

#### Story Codes

A: The Administrator  
A: Professional Path  
B: Institutional Processes  
B: Building/Transforming the Institution  
B: Multi-disciplinary Approaches  
B: Building/Transforming the Institution  
B: Institutional Processes

Ms. Houston talks about how MD Anderson did not offer much leadership development support in the seventies. In the mid-seventies, she became involved in the Oncology Nursing Society (at both the local and national level) to build her leadership skills, and also absorbed a great deal via on-the-job training. Summarizing the qualities of a good leader, she says, “A good leader can go on vacation and no one knows you’re gone.”

She then describes her shift in career from nursing to Information Systems: despite the fact that she knew nothing about computers, Dr. Mitchell Morris invited her to come to work on the Electronic Records Committee in 1997 because of her experience with both in-patient and out-patient care and her knowledge of forms and documentation (and because she was a fun person). Next, Ms. Houston describes the first project she worked on as Coordinator of Clinical Systems –Patient Care Information Systems ('97 –'99). She was part of a group comprised of two others from MD Anderson and 4-5 consultants from a software company, and strategized adoption of the Computer Based Patient Records. One of the first tasks, as she said, was to involve more MD Anderson staff and phase out the consultants. MD Anderson was an “early adopter” for technology and worked with software for dictation, pharmacy orders, and records. She stresses that they were looking for software that could assign a patient a single record number that would follow him/her across in-patient and out-patient care. She explains why this is important for patient safety, particularly those receiving chemotherapy whose total dosages must be closely monitored.

Next Ms. Houston explains that Clinical Systems purchased a brand new product from Cerner Millennium [Health Information Technology] (though they stopped implementation a couple of years later). They adopted the Cerner Millennium product to speed requests for records and processing pharmacy orders, as well as to coordinate and consolidate patient care by reducing

repeated work. She stresses that the MD Anderson record systems provides data in the form that MD Anderson users need. She is particularly pleased with the electronic reporting of laboratory data and vital signs. In contrast, she outlines the continuing challenges with regularizing data entry for physician dictation. Information Systems has adopted a system form M\*Modal that processes natural language. The aim is to move physicians away from their habitual way of dictating to a structured output that can be electronically reported and searched.

## Session Two: 27 July 2012

### Segment 00B

#### *Interview Identifier*

### Segment 08

#### *Recognizing Nurses and Nursing: The Brown Foundation Outstanding Nurse Oncologist Award*

#### B: Institutional Processes

#### Story Codes

A: Career and Accomplishments

B: MD Anderson History

B: Institutional Processes

B: MD Anderson Culture

C: Giving Recognition

In this segment, Ms. Houston talks about winning MD Anderson's first award for an Outstanding Nurse Oncologist (1982). (She has also served on the section committee.) She briefly recounts the history of the award then describes some of the peculiarities: it carried a \$10,000 cash award (now \$15,000), given at a Board of Visitor's dinner, but awardees had to keep the honor secret (no longer the case). She describes the criteria used to select the Outstanding Nurse from among the names presented by nomination: going beyond MD Anderson's very high standards for patient care and also making an impact developing programs and materials.

### Segment 09

#### *Information Systems at MD Anderson*

#### B: Building the Institution

#### Story Codes

B: Institutional Processes

A: The Administrator

A: Professional Path

C: Professional Practice

C: The Professional at Work

B: The Business of MD Anderson

Ms. Houston begins this segment by briefly describing what led her 1997 decision to shift from nursing into Information Systems after agreeing to serve on MD Anderson's Computer Based Records Project. She then talks about how Information Systems has fit into (and driven) the

2005 restructuring and combining of Departments. She notes that much of her role involves serving as a liaison between Information Services and Clinical Operations and gives the example of working with critical care providers while implementing the Picis system to do preoperative evaluations and various kinds of documentation. She also notes that Information Systems was first perceived as a “top down” initiative, but after the 2005 restructuring, this shifted as “clients” within the institution requested services and support. She explains how IS is funded and how she helps Dr. Thomas Burke, M.D., Executive Vice President and Physician in Chief, prioritize the IS projects funded. She describes some of the challenges of satisfying the requests for IS support. They have funds, but a great deal is already committed to ongoing projects. With the case of Infection Control, for example, they have funds, but not enough people to implement and support a new IS initiative, and contracting this support would increase the price.

Next, Ms. Houston describes the challenges that come from MD Anderson’s desire to always have the newest, most cutting-edge products. In Information Systems, this can mean purchasing newly developed software that may not be ready for full-blown use. The challenge of working with MD Anderson: patients have one record that follows them across inpatient and outpatient care, so providers can keep track of all procedures and drugs given. Chemotherapy administered in the hospital must be added to treatment given in the Ambulatory Care Clinic to avoid exceeding safe dosages. Ms. Houston then talks about how unique the laboratory systems are at MD Anderson and the high volumes of tests they perform, all of which have to be tracked by computer-based patient records.

#### Segment 10

##### *A Reality Check for Information Systems: Building Systems for Teams*

##### B: Building the Institution

##### Story Codes

A: Character, Values, Beliefs, Talents

A: The Administrator

A: The Leader

B: Institutional Processes

B: Devices, Drugs, Procedures

B: Building/Transforming the Institution

C: Portraits

C: Professional Practice

C: The Professional at Work

C: Diversity at MD Anderson

In this segment, Ms. Houston talks about the role she has served “an interpreter” in building information systems at MD Anderson. She explains that her 27 years of experience in patient care have enabled her to represent users’ needs in Information Systems. When information services are planned, she understands how work flows in clinical situations, how providers integrate record-keeping and data entry into their work day, and how they relate to screens and the organization of applications. While Director of Enterprise Applications in Management Information Systems (’99 – ’05), she also set up a class for technical staff about cancer, so they would have some idea of the real life situations that Information Technology users at MD Anderson deal with. Ms. Houston also notes that on first joining IT she sometimes heard, “What’s that little nurse doing here,” and won respect by performing well also noting the increase in numbers of women in the field and change in attitude. She then expresses concern

about how her skill set will be replaced after her retirement, given her unique view and the respect and collaborative networks she has built over the years. In a discussion of ClinicStation software, she gives an example of her ability to facilitate users' understanding that technology may not be the solution to their problems if what is needed is a change in work process.

#### Segment 11

##### *Medical Records and System Design for Faster Work and Better Patient Care*

B: Building the Institution

#### Story Codes

A: The Administrator

B: Institutional Processes

B: Devices, Drugs, Procedures

B: Building/Transforming the Institution

C: Professional Practice

C: The Professional at Work

C: Diversity at MD Anderson

In this segment, Ms. Houston explains a number of devices and services that IS has implemented to facilitate work at MD Anderson. She first talks about the Alkek Hospital Bed Expansion, and how the building's design made it necessary to give nurses the VOCERA hands-free communication device. She explains why the attempt to install tablet computers in patient rooms to document vital signs and other information was unsuccessful (and how other computers are being installed) and explains the electronic white boards installed to monitor patient status. Next, Ms. Houston explains the decision made in 2005 to adopt ClinicStation. She talks about the assessment strategy and what this software allows. She explains that Information Systems has developed ClinicStation into a certified Electronic Medical Records system that meets government standards. The government takes an interest, she says, because electronic records should bring down the cost of healthcare. At the end of this segment, Ms. Houston talks about how Information Systems customized ClinicStation to suit MD Anderson needs.

#### Segment 12

##### *Information Systems as a Service Provider*

B: An Institutional Unit, Program

#### Story Codes

A: The Administrator

B: Institutional Processes

B: Devices, Drugs, Procedures

B: Building/Transforming the Institution

C: Professional Practice

C: The Professional at Work

Ms. Houston explains that while she was Director of Perioperative and Critical Care Informatics ('06 – '09), she began to work with areas in MD Anderson that still had their own IT support (surgery, and radiology, for example) while Diagnostic Imaging, laboratories, and Physical Plant had consolidated within the central Information Systems service. She explains that these departments had remained independent because IS could not provide them with adequate

support, and also notes the advantages of consolidation (e.g. economies of scale, standards, protection from viruses). She emphasizes that Information Systems must be able to provide support for specialized IT needs. Ms. Houston then talks about current her role as Director for Information Systems Clinical Operations and Projects ('05 – present). She explains several projects: the further development of Electronic Medical Records and the Diagnostic Imaging Information Technology Group (upgrade to Radiology), and speaks in detail about the project, “Institutional Bar Code for Patient Safety.”

Next Ms. Houston notes that she plans to retire in three to four years, and by that time she would like to see efficient data entry for nurses and computerized systems for physician documentation, as well as completion of the project, Institutional Bar Code for Patient Safety. All of these initiatives, she says are key to safety and productivity. They are also tangible and achievable goals. As she looks back on goals already accomplished, she pleased to have started the hematology laboratory for patients and also gratified with the success of the Perioperative and Critical Care Informatics group that she directed from '06 to '09. MD Anderson faculty and staff are quick to ask for new technology, but the challenge is getting them to actually use it, Ms. Houston says.

### Segment 13

#### *Perspectives on Changes at MD Anderson Culture and Contributions to the Institution*

B: Institutional Change;

#### Story Codes

B: Growth and/or Change

B: MD Anderson Culture

A: Career and Accomplishments

A: Personal Background

A: The Administrator

Ms. Houston begins this segment by observing that since the seventies, MD Anderson has grown so much that it is impossible to know everyone, and interactions have become more impersonal. Technology has contributed this, as people email and text one another instead of communicating by phone or fact-to-face. Reflecting on whether the Institution can become too large, Ms. Houston observes that the Regional Care Centers return in a sense to the more personal feel of the old, smaller MD Anderson. In the case of Information Systems, she says, there is no quality compromise as the institution expands into remote units. In the case of overseas units (Global Oncology), she notes there is always a question about whether patient care is delivered in the same way as in Houston.

Next Ms. Houston says that her greatest concern is to find her replacement. She hopes that people in Information Systems will continue to foster a culture in which “everybody has worth” and can feel successful in what they do. MD Anderson has given her tremendous opportunities for success and to make friends. Once she retires, she intends to indulge her love of travel (especially taking cruises), her dogs who are like her children, and her various hobbies such as needlework.

## **Deborah Houston**

Interview Session 1— July 26, 2012

### **About transcription and the transcript**

This interview had been transcribed according to oral history best practices to preserve the conversational quality of spoken language (rather than editing it to written standards).

The interview subject has been given the opportunity to review the transcript and make changes: any substantial departures from the audio file are indicated with brackets [ ].

In addition, the Archives may have redacted portions of the transcript and audio file in compliance with HIPAA and/or interview subject requests.

### **Chapter 00A** **Interview Identifier**

*Tacey Ann Rosolowski, PhD*

**00:00:01**

All right. I always make sure we are recording, and we are.

*Deborah Houston*

**00:00:03**

Okay, great.

*Tacey Ann Rosolowski, PhD*

**00:00:05**

I am Tacey Ann Rosolowski, interviewing Deborah A. Houston, Director of Information Services Clinical Operations and Projects. That's correct?

*Deborah Houston*

**00:00:14**

Correct.

*Tacey Ann Rosolowski, PhD*

**00:00:17**

Okay. At the University of Texas MD Anderson Cancer in Houston Texas. This interview is being conducted for the Making Cancer History Voices Oral History Project run by the Historical Resources Center at MD Anderson. Ms. Houston, and is that title correct?

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***Deborah Houston***

**00:00:30**

Uh-hunh (affirmative).

***Tacey Ann Rosolowski, PhD***

**00:00:31**

Okay. Ms. Houston has worked at MD Anderson since 1969. Her first career was in oncology nursing. Then, she made a career shift into information systems. This session is taking place in Ms. Houston's office in the Pickens Academic Tower on the main campus of MD Anderson. This is the first of two planned interview sessions, and today is July 26, 2012. The time is eight minutes after 3:00. Thank you very much for taking part in this interview.

***Deborah Houston***

**00:00:59**

You're welcome.

## **Segment 1**

**00:01:00 to 00:07:38**

### **A: Educational Path**

#### ***A Nursing Student Discovers MD Anderson and Oncology Nursing***

#### Story Codes

A: Personal Background

A: Inspirations to Practice Science/Medicine

A: Influences from People and Life Experiences

A: Joining MD Anderson

B: MD Anderson History

B: MD Anderson Snapshot

***Tacey Ann Rosolowski, PhD***

**00:01:00**

So, I wanted to just start with some personal background—just general background. If you could tell me where you were born and when—where you grew up.

***Deborah Houston***

**00:01:10**

Well, I was born in Honolulu, Hawaii, actually, on November 7, 1950. My father was—both my parents, at that point, were in the military, so we moved around a lot. When my father retired from the military in 1960, we moved to California. About 1963, we moved to Houston, when he was working for a subcontractor for NASA. Well, it wasn't NASA then. I don't know what it



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was called back then. Then it became NASA, and they were going to build the Johnson Space Center.

*Tacey Ann Rosolowski, PhD*

**00:01:48**

Oh, I see.

*Deborah Houston*

**00:01:50**

So we moved to Houston, so I consider Texas my home. My mother is from Texas.

*Tacey Ann Rosolowski, PhD*

**00:01:54**

Now was anyone else in your family involved in the sciences? Was your father?

*Deborah Houston*

**00:01:59**

No, my father—no. He was actually a business graduate. My mother was a nurse.

*Tacey Ann Rosolowski, PhD*

**00:02:05**

Okay.

*Deborah Houston*

**00:02:06**

Is a nurse. Well, she is retired, but she is still alive. My father was not in the sciences. He worked in kind of procurement work with the company he worked in. His company provided supplies and things like that for NASA.

*Tacey Ann Rosolowski, PhD*

**00:02:24**

So what made you decide to go into the sciences and, ultimately, to go into nursing?

*Deborah Houston*

**00:02:31**

I think it was probably my mother. There was a lot of—she had other sisters that were nurses. I liked science in high school. I guess I made decent grades in science, and it was interesting. Originally, I thought about going into medical school, then I decided I didn't have good enough grades, and it was going to take too long, so I decided to go to nursing school and don't regret it at all.

Interview Session: 01  
Interview Date: July 26, 2012

***Tacey Ann Rosolowski, PhD***

**00:02:59**

So tell me about your educational background.

***Deborah Houston***

**00:03:02**

I got my bachelor's degree from Texas Woman's University in Denton in 1972 and also got my Master's in Nursing from Texas Woman's University, as well, in 1984.

***Tacey Ann Rosolowski, PhD***

**00:03:16**

In the same institution

***Deborah Houston***

**00:03:17**

Same institution

***Tacey Ann Rosolowski, PhD***

**00:03:18**

Uh-hunh (affirmative).

***Deborah Houston***

**00:03:19**

And did my clinical for school at the Houston Center. TWU has a campus here.

***Tacey Ann Rosolowski, PhD***

**00:03:28**

Did you find yourself gravitating toward any specialty at that point?

***Deborah Houston***

**00:03:32**

When I was in school, I got really excited about neuro, so I thought about going into neurosurgical nursing. There was a program that Methodist Hospital had with neurointensive care. I had a friend in school that was really interested in that. So, I thought about that and thought that's what I wanted to do. I took some extra science courses in college in neurophysiology and things like that. But when we came to Houston and found that we could work as students at the various hospitals in the Medical Center, and I came to Anderson and worked on-and-off. By the time I was a senior in nursing school, realized that oncology was really what I wanted to do.

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***Tacey Ann Rosolowski, PhD***

**00:04:21**

Now tell me about how you ended up working at MD Anderson as a student and what exactly you did.

***Deborah Houston***

**00:04:28**

Well, all of the hospitals in the Medical Center at that time, so this is in like 1968, 1969—'69 when I came here—would hire students to work on weekends or at night or whatever. A lot of people went to work at Methodist, because Methodist was a general hospital, and everybody thought that was a great place to work. A lot of clinical rotations were at Methodist Hospital, but MD Anderson, we discovered, paid more than Methodist Hospital. A friend of mine and I came to MD Anderson to work, because we were paid the tidy sum of eighteen dollars a shift for eight hours of work. That was working the night shift, actually.

***Tacey Ann Rosolowski, PhD***

**00:05:20**

Wow.

***Deborah Houston***

**00:05:22**

So we came in the first year. It was a Nursing Assistant One position. It was sort of like a hospital aid or nursing aid. We helped patients bathe and get up and ambulate and empty bed pans—that kind of thing—take vital signs, turn patients, comfort care—those kind of things—things that a hospital aid would do—feed them. Then the next year, I was a Nursing Assistant Two. That year, I was able to do procedures—dressing changes, things like that. I worked a lot of times with the LVNs, who would teach you how to do things.

***Tacey Ann Rosolowski, PhD***

**00:06:11**

LVN?

***Deborah Houston***

**00:06:12**

Licensed Vocational Nurse.

***Tacey Ann Rosolowski, PhD***

**00:06:14**

Okay. Uh-hunh (affirmative).

Interview Session: 01

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***Deborah Houston***

**00:06:15**

They would—you could learn to do dressing changes, suction patients, do things like that—do a little more complex care.

***Tacey Ann Rosolowski, PhD***

**00:06:24**

So at what point did you decide that it was oncology nursing you wanted to do, and why did you make that decision?

***Deborah Houston***

**00:06:30**

When I was a senior in nursing school, and I worked here like two weekends a month. It wasn't like I was working here hundreds of hours a month. We had to go one semester back to Denton, to the main campus of TWU, so I did that in my fall semester. At that point, I was still toying with I wanted to go into neurosurgery nursing. When I came back to Houston for the spring semester for my final semester—that was in 1972—and I came to Anderson and did my clinical rotation at Anderson. I realized it was sort of like an epiphany of why would I want to work anywhere else? Just the skill of the nurses that I was working with; it was like that's what I wanted to do. The people that I had worked—I was still working on the weekends occasionally, and the nursing staff that I worked with was like, "You just need to come work here. You need to just continue working and come be a nurse with us."

***Tacey Ann Rosolowski, PhD***

**00:07:34**

What was it that really—can you give me an example of what just really drew you?

***Deborah Houston***

**00:07:38**

I think the working relationship of the staff with each other, and then the caring that they gave the patients. I mean, the patients really needed nursing care. To me, it was very different than going to a general hospital or an OB hospital or something like that. The patients really needed a nurse. Yes, you need a nurse when you have a baby, I guess, but you had a baby. It's a wonderful, great experience, and you go home. Here, we were—back in those days, in the old days—patients were here for long hospital stays. We didn't do as much outpatient chemotherapy as we do now, so patients were in the hospital for a long time. The types of wounds that we saw—their cancers were well-advanced, and it was just a lot of physical care that you provided and comfort and that really was something I felt I was good at and wanted to do.

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## **Chapter 2**

**00:08:43**

### **A: Overview**

#### ***Why Oncology Nursing is Unique***

### **Story Codes**

- A: Overview
- A: The Clinician
- C: Professional Practice
- C: The Professional at Work
- C: Human Stories
- C: Offering Care, Compassion, Help
- C: Patients
- B: MD Anderson Culture

### ***Tacey Ann Rosolowski, PhD***

**00:08:43**

That kind of leads to my next question, which is how and why is oncology nursing different from other kinds? I've started to get a sense of that, but I'm sure you've thought a lot about that.

### ***Deborah Houston***

**00:08:59**

From my perspective, I think, one of the things is oncology nursing is about the patient and their entire family. I'm sure pediatric nursing tells you that and other people will tell you that, as well. This is a life-ending situation for many, many, many of the patients that you will care for, so you have to get to know your patients and really understand what they need. When I first started working and really got to—had time to really start understanding what I was doing and learning, I worked on a surgical unit here. The patient's would come in. They would have surgery. They would go home. We wouldn't see them again. It's like, oh, well, that's not too bad. Well, then we kind of reorganized the care model, and I was over a unit that had medical and surgical patients with the same disease—with lung cancer patients, thoracic patients. It's like they don't do well. They come back fairly soon with metastatic disease or they need chemotherapy, and they don't do well. It really made me realize that they're coming in here, and this is something that may or may not go well for them. So how do you help them and their families prepare for that? When they do well and are cured and have long survivals, it's fabulous, and when they don't, how do you help them make that transition and make them as comfortable? It's more about the quality of their life than the quantity of their life.

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***Tacey Ann Rosolowski, PhD***

**00:10:42**

Is there a particularly memorable case where you helped someone navigate through that—the difficult life-ending situation?

***Deborah Houston***

**00:10:52**

I remember a patient that was a—I think he was a judge from Georgia. I just remember he was a Georgia Bulldog fan. He was here during the fall, so it was football season. We would talk about football. He had small cell cancer of the lung, which is a disease that responds well to therapy, but if the disease doesn't continue responding, it usually progresses pretty rapidly. He was a very, very intelligent man. His wife was very intelligent. They were a very loving family. He had children in Georgia. He was at the—he had his diagnosis. He knew he wasn't going to be cured but took treatment, radiation, chemotherapy, but progressed pretty quickly and would come back in every month or so. After several months, he was back, and it was obvious he was not going to survive. He was someone that was like—he was just very open about it, and he wanted to make the right decision and wanted to talk about, "What's going to happen if I stop treatment? How do I tell my family? How do I help my wife?" Those kind of things. Trying to make him comfortable, help him breathe as best as he could, positioning him so that he was comfortable, then at the end, making him comfortable so that he had a peaceful death with his family with him. It's one of those—I think I related to the man, because he was from the south. My father was from the south. You know, he had an accent that just really drew you in and was one of the patients that I will always remember. There's been lots of patients like that over the years of various ages from all kinds of places.

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### **Chapter 3**

#### **A: The Clinical Provider**

#### *Nursing at MD Anderson in the Seventies*

#### **Story Codes**

B: Multi-disciplinary Approaches  
B: Institutional Processes  
C: Professional Practice  
C: The Professional at Work  
A: Professional Path

*Tacey Ann Rosolowski, PhD*

**00:13:00**

Now, when you came, you said you were particular impressed with the working relationships among the staff. I was curious about how—since MD Anderson was always about multidisciplinary and kind of a team approach to care—okay. It sounds like maybe you have an observation to make on that.

*Deborah Houston*

**00:13:22**

I just need to see real quick who texted me.

*Tacey Ann Rosolowski, PhD*

**00:13:24**

Sure.

*Deborah Houston*

**00:13:30**

When I first started working here, we had a—the unit that I worked on when I was a student and right after I graduated from high school was a medical—general medical—well, it was kind of an overflow unit of a little bit of everything, then it became a medical unit. Then I transferred to a surgical unit. So we had thoracic surgery, general surgery, head and neck surgery. Then there was a unit that had medical oncology, and there was a unit that had hematology patients, so it was very—then, there as a pediatric unit. There was a GYN unit. It was pretty much specialty oriented. On the medical unit, you would have breast cancer patients and bladder cancer patients and lung cancer patients and sarcoma patients—all those patients getting chemotherapy. In the clinic, we had a surgical—general surgery clinic, a thoracic surgery clinic. Then there was a breast medical clinic, so if the patient had breast cancer, she went to the general surgery clinic to see the surgeon and then went to another clinic to see the medical oncologist. So the multidisciplinary concept that came in and our multidisciplinary clinic concept that came in in the '80s was more of the—or really '90s—was more of the—we have the Breast Center where

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we have medical, surgical, radiation doctors all—the patient goes to one place, and we come to the patient, which originally it wasn't like that. The patient went various places.

***Tacey Ann Rosolowski, PhD***

**00:15:12**

Okay. At another level of organization, I was curious on how you, as a nurse, were integrated into the team of people taking care of this patient or were you pretty much separate, because the patient was going here, there, and everywhere?

***Deborah Houston***

**00:15:29**

Well, up until the late '80s, I worked inpatient.

***Tacey Ann Rosolowski, PhD***

**00:15:32**

Oh, okay.

***Deborah Houston***

**00:15:33**

I didn't work in the clinic at all. I didn't have any clinic responsibility, so I was—I came and I worked my eight-hour shift or twelve-hour shift, whatever many hour shift I did or I managed—I became a manager. So I was the head nurse, at the time, was the title we had of the Thoracic Surgery Unit. Then, we moved to the—what was called the Lutheran Pavilion—the new building, which is the Purple Zone now. That was a thoracic surgery/thoracic medical unit. It was a combined unit. I was part of a team and, then, I helped provide the inpatient care and supervise the staff that provided the inpatient care for all of those patients. I worked with the physicians, made rounds with the physicians, you know, so I knew what they wanted and what their expectation was.

***Tacey Ann Rosolowski, PhD***

**00:16:32**

How did they—how were you treated, basically? I mean, was there a good sense of collegiality and quality?

***Deborah Houston***

**00:16:39**

Oh, I think so. Oh, yeah. I think so.

***Tacey Ann Rosolowski, PhD***

**00:16:40**

Okay. So there was a sense that—



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***Deborah Houston***

**00:16:42**

Oh yeah. I think—there was always a good relationship with the staff. I mean, the physicians, I think—back in the day—they didn't have the physician assistant mid-level nurse practitioners like they have today. There weren't any of those people, so they were relying on the nurse on the floor to help them manage their patients, so they knew when you called the physician you needed to have all your information together. You called him about several people. You didn't just call him about one at a time. The better that you communicated and helped give the right information to the physician, the more they respected you and the more they treated you like you wanted to be treated.

***Tacey Ann Rosolowski, PhD***

**00:17:33**

So tell me about your own career arc. So you were director of nursing for nine years, and what—when did you take on that role and what were your responsibilities.

***Deborah Houston***

**00:17:49**

Well, I was a staff—I guess I became a nurse manager—head nurse, whatever—I think back in like 1976. I did that for several years and then went into sort of clinical supervisory type roles and became a clinical nurse specialist then in 1984.

***Tacey Ann Rosolowski, PhD***

**00:18:09**

What does that mean?

***Deborah Houston***

**00:18:10**

Okay. That role, at the time, was kind of what they are now introducing as a clinical nurse leader on the unit. There would be a manager to take care of the management of the nurses, but I was there to help the nurses learn to care for the patients and sort of be there to help them with the more acutely ill patients.

***Tacey Ann Rosolowski, PhD***

**00:18:34**

What were some of the skills that needed to be learned in that situation?

***Deborah Houston***

**00:18:38**

By the staff or by me?

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*Tacey Ann Rosolowski, PhD*

**00:18:41**

Well, you said you were helping other nurses—

*Deborah Houston*

**00:18:44**

Well, that role was with the thoracic patients, so it was lung and esophageal cancer patients. They would not know—a new nurse coming in would be frequently challenged or didn't feel comfortable taking care of patients that had chest tubes in after surgery, or they didn't know how to do tube feedings on an esophageal cancer patient, or they didn't know how to manage patients with large wounds or fistulas or things like that. I would work with the staff to help them learn to care for the patients—teach them how to start IVs. There were nursing instructors, but if you were around, I would help them do that or help them with more difficult patients and things like that.

*Tacey Ann Rosolowski, PhD*

**00:19:32**

How well do you feel—was that an issue of nursing training at the time—really not preparing people for the oncology specialty itself or was—how did your training prepare you?

*Deborah Houston*

**00:19:45**

Well, I think in nursing school itself, I may have had an hour or two of lecture about cancer. I think now maybe they teach more of that. I mean, I went to a bachelor's degree program, and the philosophy of the school is they're training people to be leaders. I used to tell people this—I learned to be a nurse and how to take care—do physical care and take care of patients by working at MD Anderson on the weekends. In school, I knew how to write nursing care plans, and I knew how to do all those kinds of things, but you don't really learn how to take patients, I don't think. When you get out of school and you come to work, you may not have ever taken care of a patient with a chest tube or had their lung removed or something like that—to know how to position them or what to do. When you come to work, you have to learn those things from somebody. You learn that from the nurses that have worked there that have learned things from other nurses or from the physicians or things—people like that. At the time, we had nursing instructors, and there were staff development instructors at MD Anderson, but there weren't the volume that we have today. There might have been—when I came to work here there were two people—three people in nursing staff development. Now there's probably thirty; I don't know how many are in there.

*Tacey Ann Rosolowski, PhD*

**00:21:13**

Wow.

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*Deborah Houston*

**00:21:15**

It was just—it was different. The staff on the floor helped the nurses—you kind of had a buddy that taught you how to do things.

*Tacey Ann Rosolowski, PhD*

**00:21:23**

Was there an attrition rate—where nurses might come but then realize they couldn't handle oncology nursing?

*Deborah Houston*

**00:21:28**

I think—there is. I don't know what the rate was. It seemed like nurses came and either really liked it or they left usually within a year or less. Frequently, if people stayed, it seemed to be—the people that I knew about—they stayed until—if they had children or something, they didn't want to commute into the medical center or something like that. People came and liked it or they left.

*Tacey Ann Rosolowski, PhD*

**00:22:00**

I was reading in some source that at the time there was a real difficulty in attracting people to oncology nursing because of the presumption that it was depressing, death, and—

*Deborah Houston*

**00:22:12**

Oh, yeah, yeah. How do you work with those patients all the time? Right.

*Tacey Ann Rosolowski, PhD*

**00:22:16**

Uh-hunh (affirmative). How did you work with those patients all the time?

*Deborah Houston*

**00:22:19**

Again, I think I looked at the quality of their life and not at the fact that they were dying. They could have a terrible prognosis, but you could still laugh with them and make them comfortable and joke around. I mean, it's okay. I don't know. It's one of those things that you just—I never even thought about.

*Tacey Ann Rosolowski, PhD*

**00:22:43**

Yeah. I think people have different kinds of interpersonal gifts.

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*Deborah Houston*

**00:22:45**

Yeah. I never even thought about it.

*Tacey Ann Rosolowski, PhD*

**00:22:47**

There are some people who can handle that situation.

*Deborah Houston*

**00:22:48**

I can't remember that I had—I don't ever remember—a lot of people say, "Well, I took care of my grandmother that had breast cancer" or "my grandfather who had prostate cancer." I don't remember that in my background. I had a grandfather that had a chronic leukemia, but that was diagnosed right at the end of his life when he had complications of a bunch of other things, and he didn't die from that. I don't remember that there was some cancer thing that made me want to go into oncology. It's just—I don't know.

*Tacey Ann Rosolowski, PhD*

**00:23:25**

It was discovering a particular gift, really, kind of by accident, yeah.

*Deborah Houston*

**00:23:31**

I guess, because I've stayed here forever.

*Tacey Ann Rosolowski, PhD*

**00:23:33**

It sounds like it—well, not forever but—

*Deborah Houston*

**00:23:36**

Close.

*Tacey Ann Rosolowski, PhD*

**00:23:36**

Enough to demonstrate a real devotion.

*Deborah Houston*

**00:23:38**

Yeah. Yeah.

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## **Chapter 4**

### **A: The Administrator**

#### ***Nursing Administration and a New Setting of Multi-Disciplinary Teams***

#### **Story Codes**

B: MD Anderson History  
B: Institutional Processes  
A: Professional Path  
A: The Administrator  
B: Multi-disciplinary Approaches  
B: Growth and/or Change  
A: The Clinician  
B: Critical Perspectives on MD Anderson  
A: Career and Accomplishments  
A: Overview

***Tacey Ann Rosolowski, PhD***

**00:23:40**

So as you moved into the Director of Nursing role—that was in 1986.

***Deborah Houston***

**00:23:47**

Right. I had been a clinical nurse specialist for several years, and it was kind of like, what did I want to do next? A director position became available in the outpatient area, so one of the other directors said, “You know, you ought to consider it.”

***Tacey Ann Rosolowski, PhD***

**00:24:15**

Who was the person who encouraged you?

***Deborah Houston***

**00:24:20**

A friend of mine, Virginia Ramsdell and the man that turned out to eventually be my husband, Gary Houston. I applied, and I became the director for the outpatient medical clinics. I don’t remember what I said last.

***Tacey Ann Rosolowski, PhD***

**00:24:39**

Okay. You were talking about how you moved into the role of the director of nursing. Now just let me say, was that—were you looking for a new challenge or feeling like you had leadership skill? What was probably the motive?

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***Deborah Houston***

**00:24:56**

I would say I had leadership skills because I was—I guess, yes, to answer the question. I had—it wasn't that I didn't enjoy what I did because I did. It was like an opportunity to do something a little different but still be involved with patients and still be involved with clinical care.

***Tacey Ann Rosolowski, PhD***

**00:25:21**

So what was your role?

***Deborah Houston***

**00:25:22**

I was—I think the title then was actually associated director and then I became director for medical—for the medical clinics. So, I was over—there was probably ten different medical clinics. At the time, what is now our Ambulatory Treatment Center and Emergency Center, but that wasn't what it was called back then.

***Tacey Ann Rosolowski, PhD***

**00:25:49**

What was it called back then?

***Deborah Houston***

**00:25:50**

Station nineteen.

***Tacey Ann Rosolowski, PhD***

**00:25:52**

Oh, yes.

***Deborah Houston***

**00:25:56**

We had a relatively small Infusion Center, compared to what it is today, and an area—we had Station nineteen, A, B, and C. A was for ambulance. That was sort of a stretcher area. B was some other beds, and C was a chair area. There were maybe eight beds and six chairs or something like that. Then we had medical clinics that were down a hallway, which now is full of—I think it's full of radiation therapy offices or something—down in the Anderson Building—part of the hospital. There was the GI center and the leukemia center and the lymphoma—they weren't centers—clinics. The Breast Clinic. They were all in kind of a hallway. Activity was much, much less than it is today.

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***Tacey Ann Rosolowski, PhD***

**00:25:56**

Oh, I bet. I bet.

***Deborah Houston***

**00:27:03**

So I had nurse managers reporting to me—head nurse—whatever we call them and staff. Then, during that process is when we sort of began to divvy up and do the more multidisciplinary in- and outpatient kind of things. We consolidated inpatient units and outpatient clinics together in our organization with nursing.

***Tacey Ann Rosolowski, PhD***

**00:27:32**

Help me understand that a little bit better. It sounds like—really important.

***Deborah Houston***

**00:27:38**

We had inpatient nursing directors, and we had two outpatient nursing directors. We were going to go with this new multidisciplinary idea. At the time, I had all the medical clinics, so what we did was we switched. We would have somebody that would just have the head and neck inpatient unit and the surgery inpatient unit and the associated outpatient clinics or we had—that's what we did. We had the inpatient hematology units and the outpatient hematology clinics.

***Tacey Ann Rosolowski, PhD***

**00:28:22**

What was the advantage of doing it that way? The idea was that we were going to be able to—well, which we did—promote care across and communication across the in- and outpatient continuum. At the time, I went and I was over the infusion therapy team and then ambulatory treatment center—was my assignment, at that point. That was when we first expanded the old Station nineteen in to the area that is in the Rose Zone today.

***Tacey Ann Rosolowski, PhD***

**00:29:02**

I'm sorry. I missed that. You expanded Station nineteen into what?

***Deborah Houston***

**00:29:07**

The area that is now on the second floor of the Rose Zone—the Ambulatory Treatment Center that is on the second floor of the Rose Zone and the Emergency Center was there, as well. It's all expanded since then, as well. I had that for several years. Then we had other directors—other directors of nursing had other areas, and then we switched around. From that, I went over and I had another assignment, which was thoracic inpatient and outpatient, which I was very, very

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familiar with, and the Radiation Oncology Clinic. Then someone retired, and I got added to that—the hematology inpatient and outpatient areas. About that time, which was probably early '90s, probably by then, mid-'90s—I don't remember the dates exactly—was when we had the whole push to develop multidisciplinary clinics—the outpatient environment reinvented itself. That's when I—up until this time I had been in the Division of Nursing. At that point, I became the first Center Administrative Director. I was over the Hematology Center.

*Tacey Ann Rosolowski, PhD*

**00:30:38**

What is the significance of that—the first center division director? Educate me on that.

*Deborah Houston*

**00:30:41**

I don't know that there's any significance to it, other than we had—the previous way we were organized was the clinic administration—the nurse manager of the clinic or the director of the clinic reported to nursing. When we went to the multidisciplinary clinic, and we developed the center administrative director, the center business manager, the center medical director concept, that person no longer reported solely to the division of nursing. You reported to clinic operations, as well, hospital and clinic operations, which was a different reporting mechanism. You were then charged with the overall, which technically you were as the manager or director, as well, but you were then responsible for the business operation of the clinic, as well.

*Tacey Ann Rosolowski, PhD*

**00:31:34**

What was the advantage of that and maybe what were some of the disadvantages that showed themselves?

*Deborah Houston*

**00:31:39**

I think the goal was that you had a team—the medical director of the clinic and the clinic administrative director, which was a nurse, and they all still are nurses—were a team and were responsible for the collaboration and the cohesiveness and the output of the work of that clinic. You made it work. You worked very, very closely with that person. There was a team of three—usually three physicians: a surgeon, depending on the clinic you were in, a medical oncologist, and a radiation oncologist. All three disciplines within the multidisciplinary care center were represented. One of those positions was the director. Then you had a nurse person, as well, so you were the leadership team of the clinic.

*Tacey Ann Rosolowski, PhD*

**00:32:39**

In your experience, how did that work?



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***Deborah Houston***

**00:32:43**

I think it worked—and it works well today—it worked well. It was a culture shift for the institution. There was a lot of restructuring, reorganizing, people re-interviewing for jobs. Some people lost jobs. Some people got promoted into jobs. Some people were moved to other areas. It was a—people were influx. It was one of those unsettling times for the institution, I think. I think in the end it was good. They changed the whole way the clinics were operated, and they were given a lot of autonomy to be successful, which has been good. However, that meant that lots of people did things different ways. We still struggle with that today—trying to get things consistent across clinics or centers continues to be a struggle today in some areas.

***Tacey Ann Rosolowski, PhD***

**00:33:48**

Now this period that you are referring to in the '90s was really that period when MD Anderson was trying to survive with managed care?

***Deborah Houston***

**00:33:58**

Correct.

***Tacey Ann Rosolowski, PhD***

**00:33:59**

So what was the goal for—there was this restructuring, and one goal is certainly to create more collaboration to deliver patient care?

***Deborah Houston***

**00:34:07**

The other goal was to be more cost effective.

***Tacey Ann Rosolowski, PhD***

**00:34:10**

How did that work?

***Deborah Houston***

**00:34:12**

I don't think it worked at all. That was when we had—well, I shouldn't say that probably—that was when we did have a lay-off of staff. In the clinics that I was over—the areas I was over—we did have to lay people off. Luckily, they all came back in other jobs and probably are better off in the end. It was frustrating because they wanted every—and this has been struggle and is still a struggle today—they wanted everybody to use the same staffing model. Clinics work differently. It is very different to—physicians all work differently. Depending on the kind of patient that you're taking care of, if you're taking care of a quick post-op visit followup, you turn patients

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over pretty quickly. If you're in another clinic where you're doing lots of complex chemotherapy planning or whatever, patients take longer to be seen. There are more issues. There are more complications for those patients. They have to be scheduled for additional tests—it's like, does that need more or less staff? Are you staffing based on number of patients, are you staffing on level of care needed? There is no real good outpatient ambulatory staffing model. They are working on and are about to roll one of those out now, which I haven't seen, but it will be interesting to see if that makes a difference.

*Tacey Ann Rosolowski, PhD*

**00:35:37**

Now, when you said, "They want everyone to use the same." Who is "they?"

*Deborah Houston*

**00:35:39**

They—well, the big "they"—administration.

*Tacey Ann Rosolowski, PhD*

**00:35:43**

Okay, this administration in general.

*Deborah Houston*

**00:35:45**

Yeah.

*Tacey Ann Rosolowski, PhD*

**00:35:49**

So that problem has really been ongoing since the '90s. It is just a continuing challenge?

*Deborah Houston*

**00:35:54**

Oh, I think so. Again, we downsized, in theory. We did. We cut a bunch of positions. You look back now. We are way over that—we've come back. We added positions—added back more than what was originally eliminated, and it continues. I think we have managed it—not being part of operations officially—it seems like we've managed it. It's a struggle, I think, for people to get the resources they need in some instances—to convince people of the resources they need because there is no real easy way to justify it.

*Tacey Ann Rosolowski, PhD*

**00:36:45**

When you were part of the—sort of the process at the moment in the '90s—of trying to re-structure all this, who did you work with and how—were your part of kind of coming up with ideas for how to resolve these problems?

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***Deborah Houston***

**00:37:01**

Well, when we first had the—well, I don't know that I was part of the idea of coming up with part. There were the people that were over—the physician in chief and the person that was over the main hospital operations and clinic operations people were primarily doing that. When we got involved in interviewing for jobs, and I was one of the first CADs and Wenonah Ecung was one of the first CADs. The medical directors were all appointed because they were physicians that were already working in those clinics. Now, we had to identify the nurse leaders, so we were involved in a lot of the discussions in the beginning because we're having meetings as a group with these medical directors and CADs.

***Tacey Ann Rosolowski, PhD***

**00:38:00**

What's a CAD?

***Deborah Houston***

**00:38:01**

Center Administrative Director, I'm sorry.

***Tacey Ann Rosolowski, PhD***

**00:38:02**

That's right, yeah.

***Deborah Houston***

**00:38:08**

We had educational sessions and all that, and we were part of that. It has been good because that role has been considered as key as the medical director role for the success of these clinics, and that continues today. They're involved in the education planning and activities and things like that—so that's been good.

***Tacey Ann Rosolowski, PhD***

**00:38:27**

Where does MD Anderson sit vis-à-vis other institutions—if you can comment on it—with involving nurses in those processes? Did you feel like you had more of a voice than your colleagues at other institutions in those kinds of upheavals?

***Deborah Houston***

**00:38:48**

During that time, nursing was going through transition, as well. We had—Ms. [Renilda] Hilkemeyer [Oral History Interview], who was the original director of nursing, had retired. We had a second director of nursing, Joyce Alt. We were going through a transition period where we

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got another director of nursing, John Crosley, in there. There was some—I wouldn't say upheaval, but kind of upheaval—in that, at the time. I would say originally there probably wasn't a lot of nursing—nursing got involved—we got involved because we got in the middle of it, but was our leadership at the table? I don't know. I think now that's much more they are—definitely at the table and definitely there. I think nursing, in some instances, was an afterthought back in the early '90s, but now not so much.

*Tacey Ann Rosolowski, PhD*

**00:40:04**

To what do you attribute that change?

*Deborah Houston*

**00:40:09**

I think the people in the role, and then I just think the growth of nursing, in general. The growth of the specialty—I think physicians realizing the value of the nurse and what they can provide them and their patients.

*Tacey Ann Rosolowski, PhD*

**00:40:41**

How would you characterize what you provide to the physician? You've talked a little bit about what you provide to the patient, but what about the physician?

*Deborah Houston*

**00:40:50**

Well, I think you help him—in an outpatient setting—you help him with his organization. You help him with prioritizing what he needs to talk to the patient about. If you've assessed the patient first, you can then say, "He's got concerns about this, this, and this," and "Make sure you talk to him about that." You have prepped the patient to ask the physician the right questions, in many instances, which helps facilitate their visit. Then you also can then try to make sure at the end of the visit that that's been done.

*Tacey Ann Rosolowski, PhD*

**00:41:27**

It's really facilitating communication in a lot of ways?

*Deborah Houston*

**00:41:31**

Yeah. I think that's definitely it—facilitating what you—what they patient needs and you're facilitating the information to the physician, the physician to the patient, and the patient back to the physician and coordinating their care, coordinating everything else around it—coordinating what the physician needs. If the patient is here and you don't have the information the physician

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needs to make a decision about what he is seeing the patient for you're wasting everybody's time.

*Tacey Ann Rosolowski, PhD*

**00:42:04**

Right.

*Deborah Houston*

**00:42:05**

Trying to help make sure the patient was scheduled correctly so that when he comes back you've got the results there or that you haven't missed something.

*Tacey Ann Rosolowski, PhD*

**00:42:15** As you were talking about this, I was just thinking if you're evaluating a nurse for performance, it seems like that facilitating communication can be one of those real slippery qualitative things that's real difficult to put a metric on.

*Deborah Houston*

**00:42:34** Yeah, and when you talk about—on of the things I've been able to do the last couple of years is I have been on the selection committee for our Arceneaux Outstanding Nurse Oncologist Award. One of the things that the candidates do—is a packet of material is presented and some of that is from the people that they work with. This past year, most of the—well, actually, all of the candidates were from the ambulatory setting, so it was very, very interesting to read the letters from the physicians, even though they were blinded and we didn't know who was who. I mean, which physician was writing them, but they were from their medical director or physicians that they worked with—how they talked about how “they facilitated my ability to see patients—they were always there to answer the questions,” and that kind of thing. The physicians, I think, see that now with nurses.

*Tacey Ann Rosolowski, PhD*

**00:43:34**

Is there some mechanism to integrate that kind of information about a nurse's performance into her official record—beyond applying for a special award? I'm just curious because it does seem so key.

*Deborah Houston*

**00:43:49**

We get evaluated on things like team work, communication.

*Tacey Ann Rosolowski, PhD*

**00:43:54**

So it is there.

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*Deborah Houston*

**00:43:55**

Yeah.

*Tacey Ann Rosolowski, PhD*

**00:43:56**

That's really interesting. That's really interesting.

*Deborah Houston*

**00:43:58**

Yeah.

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## **Chapter 5**

### **A: The Administrator**

#### **Director of Nursing and Center Administrative Director**

### **Story Codes**

A: The Administrator  
A: Professional Path  
B: Institutional Processes  
B: Building/Transforming the Institution  
B: Multi-disciplinary Approaches  
D: On Research and Researchers

*Tacey Ann Rosolowski, PhD*

**00:44:00**

Now when you were Director of Nursing, did you have any particular goals—things that you wanted to achieve during that time?

*Deborah Houston*

**00:44:09**

Survive, no.

*Tacey Ann Rosolowski, PhD*

**00:44:14**

How demanding a job was it on a scale of one to ten?

*Deborah Houston*

**00:44:19**

Well, probably ten. When I was over just the medical clinics—those areas—the problem is you would get called if there wasn't enough staff. I don't know how I was supposed to create people, but people were moved around to cover in different clinics. You would get called—I would get called by physicians at night who wanted to complain about a nurse or something like that. Those are some of those special physicians that will always remain a permanent part of your history. Again, if they didn't have enough—they would call you. It's like, "Well, you know, am I going to come in and do the work?" "Sometimes you felt like you had to. You were like trying to then figure out how to move staff around to cover. It's stressful, because if the physicians—this is a very physician-driven institution. If the physicians don't like what's happening in their environment, they're going to tell you about it or they're going to tell your boss about it, so they better tell you about it. It's better for you to know about it than your boss to know it before you.

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*Tacey Ann Rosolowski, PhD*

**00:45:41**

Absolutely. Absolutely.

*Deborah Houston*

**00:45:42**

One of the things I tried to do was be visible in the areas and see what was going on.

*Tacey Ann Rosolowski, PhD*

**00:45:54**

What are you particularly gratified that you were able to achieve over that nine-year period?

*Deborah Houston*

**00:46:02**

I think some of it was organization—looking at how—trying to add some services to patients. One of the things were started when I was in Hematology was we added a satellite lab for those patients up on the 8<sup>th</sup> floor of the clinic because there's such a volume of patients coming in everyday that need lab work done. The Diagnostic Center—it's just backed up. Backed up is a bad word, but it's crowded. These are people that are immunosuppressed. We added a lab area separate from that upstairs by the clinics where they could get their labs drawn and, hopefully, get results back sooner, and that's still there today. That was nice. That's probably one of the nicest things. It was a very stressful job because I had outpatient and inpatient areas. Hematology—those are very sick patients. It was nice because I could see—the staff could—we kind of rotated staff occasionally. We had a program where the inpatient nurses could work a week in the clinic. It was easier for that to happen than take a clinic nurse and put them in the hospital setting. They could see the patients in the clinic and see when they were better—not as ill.

*Tacey Ann Rosolowski, PhD*

**00:47:40**

Why did you want to do that?

*Deborah Houston*

**00:47:41**

For staff satisfaction, staff retention. Some staff, openings would come up in the clinic and they would transfer from the floor to the clinic. At that time, there was a pay differential to work inpatient than clinic. I don't know if that still continues.

*Tacey Ann Rosolowski, PhD*

**00:48:02**

Which way did it—which was—?



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*Deborah Houston*

**00:48:03**

It was higher inpatient because in the clinic you were working Monday through Friday.

*Tacey Ann Rosolowski, PhD*

**00:48:06**

Right, right.

*Deborah Houston*

**00:48:09**

It was a little bit different opportunity for them. That program worked. We also did a kind of mentoring—not official mentoring program—but kind of a mentoring program. We also had an education program with the woman that was the clinical specialist, working with the staff on clinical experiences and clinical training that we set up formally.

*Tacey Ann Rosolowski, PhD*

**00:48:48**

What kind of things did that deal with?

*Deborah Houston*

**00:48:52**

Things like symptom management of transplant patients, for example—is a good example. She would lecture and then work with the staff and kind of mentor the staff when they would have particular patient challenges. That kind of thing.

*Tacey Ann Rosolowski, PhD*

**00:49:13**

You mentioned earlier that you thought there were some organizational things you were really happy with. Are these the things you're referring to?

*Deborah Houston*

**00:49:19**

Yeah. Yeah.

*Tacey Ann Rosolowski, PhD*

**00:49:20**

Okay. I just wanted to make sure we weren't leaving anything out.

*Deborah Houston*

**00:49:24**

We also started the—when I became a Center Administrative Director, one of the things they wanted us to do that that time was they wanted all the Center Administrative Directors to have a MBA—have that business background, and I'm like, "No." I said, "I don't want to get a MBA."

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I said, “We can hire somebody that has a business/finance background a lot easier than I can get a MBA.” At the time, it was \$40,000/\$50,000 a year job that can do it. So, we created the Center Business Manager job that has perpetuated since. I think they do encourage the CADs to have MBAs, but we also now have a business role because you can’t manage everything. The expectations of those—the outpatient managers are just really high, so we’ve got the business component, as well.

*Tacey Ann Rosolowski, PhD*

**00:50:25**

Now, when that was suggested—that was in the 90s when they were trying to—

*Deborah Houston*

**00:50:29**

Early ‘90s, yeah, yeah.

*Tacey Ann Rosolowski, PhD*

**00:50:29**

—make everybody kind of double up on all kinds of tasks.

*Deborah Houston*

**00:50:32**

Yeah.

*Tacey Ann Rosolowski, PhD*

**00:50:33**

Did you—were there instances in which you felt a lack of kind of financial background or did you always feel—?

*Deborah Houston*

**00:50:42**

Not me, personally. Even today, my philosophy is I don’t have to know everything. I just have to know where to get the information—who I can go to to get the information.

*Tacey Ann Rosolowski, PhD*

**00:50:54**

Who did you partner with at the time? Where did you go to get the financial information at the time when you were dealing with those financial issues?

*Deborah Houston*

**00:51:03**

There was someone that was in nursing that was kind of their finance person that I worked with.

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*Tacey Ann Rosolowski, PhD*

**00:51:09**

Who was that? Do you remember that person's name?

*Deborah Houston*

**00:51:11**

No.

*Tacey Ann Rosolowski, PhD*

**00:51:11**

Okay.

*Deborah Houston*

**00:51:14**

We hired someone pretty quickly.

*Tacey Ann Rosolowski, PhD*

**00:51:16**

Uh-hunh (affirmative). Did that make a big impact? Were they correct in thinking—was the administration correct in thinking—

*Deborah Houston*

**00:51:22**

I think so. I think so.

*Tacey Ann Rosolowski, PhD*

**00:51:24**

What kind of difference did you see?

*Deborah Houston*

**00:51:26**

Well, I think it let you be—let me not worry about some stuff, you know. Not only was she keeping up with was the billing for the day and that kind of thing. She was able to do—order supplies and do other things, organize some of the clerical functions that I didn't need to worry about. Then, over time, we've even added—we even added an administrative assistant kind of position. It's just more and more and more things.

*Tacey Ann Rosolowski, PhD*

**00:52:00**

Now tell me a little more about your role because—let's see. Your Director of Nursing role lasted from '86 to '95 and then from '95 to '97 you were the Center Administrative Director for Hematology.

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*Deborah Houston*

**00:52:13**

Right.

*Tacey Ann Rosolowski, PhD*

**00:52:15**

We kind of touched on it, but really what was your formal role there—in Hematology—the CAD?

*Deborah Houston*

**00:52:25**

I was over the leukemia, lymphoma, and bone marrow transplants—that is what they called it at the time—clinics. That included the Aphaeresis Unit. Then, I had four inpatient units, as well, which were the inpatient lymphoma unit, the inpatient leukemia unit, the inpatient transplant unit, and the protective environment, at the time.

*Tacey Ann Rosolowski, PhD*

**00:53:01**

Did you have—and nurses who were under your administration—did they have any role in working with physicians on research projects with patients?

*Deborah Houston*

**00:53:17**

Most of the patients were on some type of a research program because the chemotherapy they were getting was research-oriented. The staff that worked for me were not research nurse titled staff, but they worked with the patients on explaining the drugs or answering questions. The research nurse roles were the nurses that managed the protocols and did lots of patient teaching, as well, with the patients.

*Tacey Ann Rosolowski, PhD*

**00:53:51**

Now, did the non-research nurses—did they administer those drugs? I mean, I'm wondering how all these folks were integrated—

*Deborah Houston*

**00:54:01**

Yeah—no. At our—here at MD Anderson, the physician sees the patient in the clinic, and then they go to the Ambulatory Treatment Center to get their therapy. A lot of the Hematology patients are admitted to the hospital for chemotherapy. It's not given outpatient because of the illness. I mean, acute leukemia that needs induction therapy needs to be in the hospital. Transplant patients that are getting chemotherapy for that have to be in the hospital, so a lot of that is inpatient. What a lot of our staff are doing is teaching patients about what they need to do

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before and after that kind of therapy and, then, monitoring the patients during their course and watching their blood counts and that kind of thing and watching them for signs of infection and getting them in for transfusions or antibiotics or whatever—doing a lot of phone triaging with the patients. The patients get that therapy either in the hospital or in the clinic. In the Ambulatory Treatment Clinic, we have space—they had space there where patients that had already had a bone marrow transplant—after they were discharged would come back into the Ambulatory Treatment Center everyday and get fluids or be checked by the nurse practitioners or something like that. So, they could leave the hospital, but they really were still monitored very, very closely. That's still going on today.

***Tacey Ann Rosolowski, PhD***

**00:55:47**

Did you every wish that you had gotten more involved in the research part of it? I'm just curious.

***Deborah Houston***

**00:55:58**

No. It's not that I didn't want it. A lot of the nurses' role—well, I shouldn't even say, because I never did the job, but to me the research nurse role is a lot of getting patients enrolled, explaining the protocols to them, tracking and making sure they're getting labs done and whatever if they're not here in the hospital. Some do drug studies—some of that kind of stuff, then doing a lot of data collection for a particular study. Research nurses that work in like the Phase I area. They do lots of actual administration of those drugs in their clinic.

***Tacey Ann Rosolowski, PhD***

**00:56:37**

And what does—oh, Phase I means Phase I drugs.

***Deborah Houston***

**00:56:39**

Phase I drugs—early drug development. I never had an interest in that. I probably would have liked it had I don't it, but it was something that I never thought about.

***Tacey Ann Rosolowski, PhD***

**00:56:52**

Yeah. You were really attracted to the actual patient care part.

***Deborah Houston***

**00:56:56**

Yeah, yeah, yeah. But there's a huge research nurse component to what we do here and what oncology nursing does in general.

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*Tacey Ann Rosolowski, PhD*

**00:57:05**

And that is?

*Deborah Houston*

**00:57:07**

I think helping the patients understand what they're doing and making sure they're following the instructions they need for their therapy. If a patient is getting investigational drugs or any chemotherapy—put on an investigational protocol—and they're not getting the drug at the right time or getting their labs drawn at the right time, it can affect the study, as well as affect how well they do. They could get side effects. If they don't get back and get their rescue medication or start med at a certain time, they can get sicker. The drug may not be as effective as it could have been.

*Tacey Ann Rosolowski, PhD*

**00:57:47**

So you were—it may have been on the periphery, but you were certainly involved in the effectiveness of these programs.

*Deborah Houston*

**00:57:53**

Yeah. I wouldn't say I was ever a research nurse.

*Tacey Ann Rosolowski, PhD*

**00:57:57**

Yeah, no, no. It's just interesting how these pieces—everybody's sort of a puzzle piece and it fits together. It makes it all work.

*Deborah Houston*

**00:58:06**

Yeah, we have a lot of specialized nursing roles.

*Tacey Ann Rosolowski, PhD*

**00:58:14**

Now, when you were talking earlier about the things that you are particularly glad about having achieved, were those things that were also instituted when you were the Center Administrative Director for Hematology—creating the lab. I'm wondering if they were—

*Deborah Houston*

**00:58:29**

Yes, they were.

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*Tacey Ann Rosolowski, PhD*

**00:58:30**

Okay. So that was all—

*Deborah Houston*

**00:58:32**

Yeah.

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## ***Chapter 6***

### **A: The Clinical Provider**

#### ***Inspirations and Observations: Changes in Nursing***

### **Story Codes**

A: Influences from People and Life Experiences

C: Portraits

B: MD Anderson History

B: MD Anderson Culture

B: Growth and/or Change

B: Obstacles, Challenges

#### ***Tacey Ann Rosolowski, PhD***

**00:58:33**

I guess we have gotten to the point where I wanted to ask you about the people who have really influenced you during that part of your career—your whole nursing phase—take a little pause here. Back on again.

#### ***Deborah Houston***

**00:58:49**

One of the people that—first people that I think of when I think about who has inspired me or mentored me in my career as an oncology nurse was probably the original Director of Nursing here at MD Anderson and that was Renilda Hilkemeyer. Everybody—when I saw her name everybody laughs because it's such a funny name, but she was—she was just a phenomenal woman and lived for oncology nursing and is one of those pioneers but really cared about her staff. I remember many things—her laugh is one of the things I always remember. There's a couple of things about her that I remember was one time when I was a student. We got paid very little money. Back then, that was big money. A friend of mine who worked here as well—we had worked a couple of weekends and were supposed to get paid. Paychecks came out on Friday. We came to get our paycheck, and we didn't have a paycheck. We were going to New Orleans for Mardi Gras, and we didn't have our seventy dollars or sixty dollars—whatever it was we were going to get paid. We were just irate and were probably making a scene in the nursing office. Back then, it was like three rooms, you know. She came out of her office. She wanted to know if we wanted her to write us a personal check for our sixty dollars—that she would do that, and it's like, “No ma'am, we're okay.” Probably from me making a fool of myself, she always remembered me. I remember we would go into her office and talk to her about various things. She was one of these people that wrote everything down on yellow tablets. You would go into her office and she had this huge wooden desk with all these stacks of yellow tablets everywhere. You'd say, “Ms. Hilkemeyer, remember I needed to talk to you about this.” She would go and in her stack she would pull out the yellow tablet that had her notes from when you had talked to



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her—how she did that I don't know. She was just a really kind woman that really wanted to promote the profession and wanted to keep up the practice.

***Tacey Ann Rosolowski, PhD***

**01:01:23**

What were some of the big messages that she communicated about oncology nursing that were so persuasive and powerful for people—for you?

***Deborah Houston***

**01:01:33**

I think for me it was that you have an opinion and your opinion counts and that you are the person that is making that patient's life different—affecting that patient's life. The physician is there for a few minutes a day, but you're there eight hours, twelve hours—whatever. The nurse is the one that is really providing the care for the patient. I think that's been a message that I've taken to heart. She was—she tried to be progressive. She was one of these people that wore her white uniform and her cap as the Director of Nursing. When she came in one day in a pantsuit, everybody was shocked because it was like, "Oh, my god. It's okay. We can wear pants now." She was one of those people. She would just laugh and we'd have a good time. She was a wonderful woman.

***Tacey Ann Rosolowski, PhD***

**01:02:33**

What was her style with patients herself?

***Deborah Houston***

**01:02:36**

You know, I never saw her take care of patients. I don't ever remember seeing her on the unit. There were supervisors that kind of did that role, so I don't know. It was just her style with us—with her staff that was memorable. She was always somebody that I felt like she would do—she knew what I was talking about and understood what I was talking about and would get up—I felt like she would get up and go do my job if she needed to. That's something I've always taken to heart is that I needed to be able to do the job of the people that work for me. When I was a head nurse, if you couldn't start the IV, I would go start the IV or if you didn't have time to catheterize a patient or do something like that, I would do it. There was not a job that I wanted you to do that I wouldn't do myself.

***Tacey Ann Rosolowski, PhD***

**01:03:32**

Now how does that make a difference?

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***Deborah Houston***

**01:03:34**

Well, I think it tells your staff that you're willing to work just like they are. You work hard just like they do. I think they will work with you when you work with them. That was a message I always gave the staff that I worked with. I was not someone that was in my—stayed in an office by myself. I was out visiting with the patients, helping the staff, passing food trays if lunch came and they were sitting there, making rounds with physicians, trying to help facilitate their care—their work so that everybody could get taken care of.

***Tacey Ann Rosolowski, PhD***

**01:04:16**

It was clearly you understood what their work was—

***Deborah Houston***

**01:04:19**

Well, and what was going on on the unit that I was responsible for. Life was different then. It was very different then.

***Tacey Ann Rosolowski, PhD***

**01:04:29**

How so?

***Deborah Houston***

**01:04:31**

It wasn't as technical. We didn't have as much documentation requirements. I mean, not that we didn't document appropriately, but it was—you hear about "life was simpler then." I think—I don't know. It was just different. People were, in many ways, more pleasant to each other. They weren't as rushed, even though the staffing model was crazy. When I first started working here at night, when I first got out of nursing school as a new graduate, I was the only nurse for thirty-four patients on the evening shift on a unit. One nurse. One registered nurse. If I was lucky, I had an LVN to help me give medications and a couple of aids for the 3:00 to 11:00 shift. That's unheard of today. It's just unbelievable—to think about that. There were no IV pumps. There were no central IV lines like we have today. It was just different.

***Tacey Ann Rosolowski, PhD***

**01:05:48**

I was going to ask you about technology and how that had changed the role of the oncology nurse. How did you—?

***Deborah Houston***

**01:05:57**

Well, I think one of the things was the advent of just chemotherapy. Everybody had to be in the

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hospital for chemotherapy when I first started working here. Pretty much everybody was in the hospital. If you had breast cancer, you came in the hospital for a week and got continuous infusion chemotherapy. With the invention of small portable infusion pumps and central IV lines, these catheters that they can put in patients, chemotherapy moved to an outpatient setting, which allowed us to admit more patients because you could—we weren't full of patients getting chemotherapy. They were in the clinic. That's one thing. Then, I just think the equipment at the bedside of the nurse today—the infusion pumps that they have that calculate drip rates and alarm and tell them when things are wrong. Bed alarms, when patient's try to get up. We didn't have those things like that. Computers that you can look up lab reports on instead of finding them in the chart in the little pieces of paper in the record—having to put them in the record with tape.

*Tacey Ann Rosolowski, PhD*

**01:07:20**

It's kind of interesting because you're telling me all these things which sound good, but they sort of added up to a work situation that seems like it's not quite as pleasant, maybe, as it used to be? Am I getting that right?

*Deborah Houston*

**01:07:33** Well, I don't know that it's not as pleasant, because I think today the nurse doesn't have that—you have time to spend with your patient today. I didn't have time—I mean, when I worked the evening shift by myself, I didn't have time to sit and talk to patients or really—you were rushed. If I would stop and talk to a patient about something or try to do teaching about their surgery the next day because a lot of people came in the day before for surgery—we don't do that anymore. They need pre-op instruction and all that kind of stuff. You would have to do that. Well, that meant you were late the antibiotics to the guy in the next bed or whatever. The physical environment was very different. We have four patients in a room connecting with a bathroom to four more patients.

*Tacey Ann Rosolowski, PhD*

**01:08:30**

How many patients are there per room now?

*Deborah Houston*

**01:08:31**

One. That's—everybody has their own bathroom. That's very different. We had beds that were not electric. It sounds like the ancient days, but that's when I started working here. That was our environment. Glass bottles that held chest tubes that were boxes made by the people down in facilities to put the bottle in. It was hard to ambulate people around and things like that. Those were challenges that you had. Today, the technology is better. The equipment is better, so the nurse is able to take care of the patient better. I don't know. We talk about the art of nursing. I sometimes think that the art of nursing is not the same, but probably my colleagues that are in

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nursing today would say it's better. It's been a long time since I've actually taken care of patients, so it's hard to say that.

***Tacey Ann Rosolowski, PhD***

**01:09:46**

When you made your shift, did you feel that the art of nursing had improved from the time that you began?

***Deborah Houston***

**01:09:58**

I think it was different. It was different. Nursing went from—nursing was a lot about physical care—physical comfort. Then we got into things that we could do to patients or provide patients that provided that comfort, so the nurse didn't have to do it, for example. I think that's where we kind of lost some things. We used to do what was called p.m. care. That was—we would chart that in the chart—p.m. care given.

***Tacey Ann Rosolowski, PhD***

**01:10:35**

And what is that?

***Deborah Houston***

**01:10:36**

The p.m. care was you made sure the patient got up, went to the bathroom, if they could. If they couldn't get up, you offered them a bed pan, washed their face, washed their hands, brushed their teeth—those kind of things. Gave them a back rub, positioned them, quieted things down—turn down the light. Just made sure they were comfortable in bed—offered them sleep medications or water or whatever. We put patients to bed, does that make sense?

***Tacey Ann Rosolowski, PhD***

**01:11:09**

Yeah.

***Deborah Houston***

**01:11:11**

That was what you did. I don't know that we do that anymore. Is it because we don't have time because there's so many other things that they have to do, or the patients are so sick you don't have time to do that. I don't know. Now is that something unique to oncology nursing? No. I don't think so. Those are things probably you would do if you were taking care of your mother in the hospital. "It's time to go to bed. Let's go to the bathroom. Okay. Let's go to sleep."

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***Tacey Ann Rosolowski, PhD***

**01:11:49**

Just somebody being attentive in that way.

***Deborah Houston***

**01:11:51**

Yeah. I don't know that we have time to do that anymore. So, we were talking about mentors—Ms. Hilkemeyer.

***Tacey Ann Rosolowski, PhD***

**01:12:01**

Yeah. I was going—

***Deborah Houston***

**01:12:02**

Another one was Joyce Alt, who was the second Director of Nursing. She was my mentor when I was in nursing school. She was the nurse manager of the recovery room here at Anderson at that point. That's where I did my management rotation. After that, when I came to work, Joyce became one of the supervisors and was my supervisor, so I learned a lot of things from Joyce about how to do projects, how to change, try new things.

***Tacey Ann Rosolowski, PhD***

**01:12:38**

Like what, give me an example. That's kind of neat.

***Deborah Houston***

**01:12:39**

Oh, we tried things like we had a thing where the nursing office tracked who was working on what shift, and they would kind of even up the numbers of staff. You might work on Five West today. You're going to work on Three West tomorrow. The phone would ring ten minutes into the shift, and they wanted you to send one of your people to another unit. One of the things we did—everybody hated that. So myself and my friend, Virginia, who was the nurse manager on the other end of the floor, we said, "Let's do something where we're not going to get help from anybody but ourselves." Joyce kind of helped us, and then her recovery room staff. So, if the recovery room wasn't busy. Believe it or not, they used to not be busy sometimes. They would come up and help, or if they had an emergency or something, we would send somebody in there to help them. That was just heretical, if that's even the right word. "Oh, my God. You're going to staff your own unit. You mean, we're going to call you if you have a call-in." It's like, "Yeah, we'll take care of it." That was very new and innovative and different. Joyce was like, "Let's try it and see how it works. If it doesn't work, we'll say King's X we made a mistake." She was one of these—she was supportive of new ideas, so I learned from her the ability to make a decision, try something new, and if it doesn't work say, "Okay. It didn't work. Let's go back." Let the

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people that work for me make decisions and support them in that. That was a skill or a trait I learned from her.

*Tacey Ann Rosolowski, PhD*

**01:14:39**

Yeah, real leadership role model, yeah.

*Deborah Houston*

**01:14:42**

Then, my husband, Gary Houston, was a nurse manager here. I met him here at work. He was also someone—he was in management more than—not more than I was but sooner than I was. He got into the management role—the tract—here in nursing. He was one that was encouraging me all along to do different things, try different things. He would get me involved in various activities. We had programs that he would try to make sure the clinical perspective, not just the management perspective, of the nursing staff was involved. That was helpful.

*Tacey Ann Rosolowski, PhD*

**01:15:31**

What were some of those programs?

*Deborah Houston*

**01:15:35**

We had the Career Ladder Program we had at MD Anderson back in the '70s where the nurses—the idea was you could have a clinical ladder that you could progress up or you could have a management level that you could progress up. That was one of the things that he was involved in—that I was involved with him in.

*Tacey Ann Rosolowski, PhD*

**01:16:02**

Did you take part in that Career Ladder Program?

*Deborah Houston*

**01:16:05**

Technically, yes, because I was a title called “Clinician four,” which was the title you could have before you got your master’s degree to become a Clinical Nurse Specialist.

*Tacey Ann Rosolowski, PhD*

**01:16:21**

And when did you get your master’s?

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*Deborah Houston*

**01:16:22**

'84.

*Tacey Ann Rosolowski, PhD*

**01:16:23**

'84.

*Deborah Houston*

**01:16:23**

1984.

*Tacey Ann Rosolowski, PhD*

**01:16:24**

Okay. And how did that Career Ladder Program work?

*Deborah Houston*

**01:16:26**

It was in effect for a long time. We sort of have a version—I think a version of that today. They don't call it the Career Ladder anymore, but they call it the Professional Development Model. It's similar. We had a Clinician one, two, three kind of thing before. Now I don't know exactly—they're called clinical nurses, but they have different levels within their—I think their performance measures that they use in nursing today. It's similar so that you can still be bedside nurse, but you can progress in what you're responsible for and your salary based on experience and performance.

*Tacey Ann Rosolowski, PhD*

**01:17:07**

Now how else did your husband support or influence you as you advanced?

*Deborah Houston*

**01:17:13**

Well, he was one of the people that encouraged me to apply for the Administrative Director job. Then, when we made the switch into the Center Administrative job back then, he encouraged me to do that. During that process, we were sort of influx, and nursing was sort of reorganizing. That's when John Crosley had come in, so they were kind of re-designing how we were going to organize nursing. At that point, Gary—there was going to be one less director job, and Gary made the decision to take an out, so he left Anderson at that point. He had been here about twenty-five years when he left Anderson.

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***Tacey Ann Rosolowski, PhD***

**01:18:06**

Before we kind of move on to your switch into the next (talking at once) part of your career, I wanted to ask you how you felt—let me back up a little bit. In a lot of conversations I have been having with people for this oral history project, people have talked about leadership development and how key it is. I'm wondering what your perspective is on that—how you felt you gained your skills. We have talked about some of the people who inspired you, but were there other things that you did to develop your leadership skills? Did you feel the institution offered you good opportunities and resources?

***Deborah Houston***

**01:18:50**

I think, well, again, when I started here, education was not what it is today at MD Anderson. I would say most of my leadership development has been on-the-job training, just life experience kind of thing. I got involved in the mid-'70s in the Oncology Nursing Society. Again, my husband, not at the time my husband—my friend, Gary, at the time—was active. There was a lot of—obviously lots of the staff here at Anderson are part of that organization. We got involved, and I got involved—I was in the local chapter involvement and leadership through that and then got involved with the national level in that society through committee work and then was on the Board of Directors of ONS for three years. I actually ran for president—didn't win—I think that organization itself helped me with leadership—developed with speaking, that kind of thing, as well.

***Tacey Ann Rosolowski, PhD***

**01:20:09**

So, it was the experience you got simply being involved with an organization at a pretty high level.

***Deborah Houston***

**01:20:16**

Uh-hunh (affirmative). Uh-hunh (affirmative). Then here, just day-to-day work. I think my leadership of people. Personally, I think people leadership is one of those things that you almost have to have in your soul to do it well. We have lots of leaders that aren't really leaders.

***Tacey Ann Rosolowski, PhD***

**01:20:41**

What is that distinction that you make? What do you mean they're not really leaders?

***Deborah Houston***

**01:20:44**

Well, I think there are people that do it well, I should say—they're not leaders—they're leaders, but they may not be as respected or as good a leader as others. I think it's the way they interact with people—the way they manage their staff. The things people are willing to do for you is a



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trait that leaders develop over time and with experience. As a leader, you have to be willing to take risks and try different things yourself and your staff. To me, it's a sign of a good leader when you go away on vacation for a couple of weeks and nobody even knows you're gone because your staff are managing and everything is going along just fine, or when you leave and change jobs, how many people want to follow you because they like the way you treat them, they like the way you manage and organize your staff. I think that's something that, hopefully, we have lots of people that apply here.

*Tacey Ann Rosolowski, PhD*

**01:21:58**

Over time, were there more mechanisms that were put in place to help nursing staff develop leadership skills?

*Deborah Houston*

**01:22:07**

Yeah. I think over the—nursing for many, many years was more on the clinical skills of the staff. Then I think over time, the management kind of fit in. I think, even today, a lot of that is through the HR education programs, not necessarily nursing. They have a new program, I think, now for how to—developing clinical leaders. Again, that's clinical care kind of things. I think the management of people, management of businesses, that's all done through kind of HR—things that anybody does, which you need to know that. It's appropriate. Faculty needs it.

*Tacey Ann Rosolowski, PhD*

**01:22:58**

Everybody needs it. Absolutely.

*Deborah Houston*

**01:23:01**

Depending on the school that you go to as a nurse, you get leadership or you don't. Texas Women's University, as a senior that was what you were expected to do. You took a class. You were expected to be a leader. That was the experience you did. I don't know that all schools have that as part of their curriculum. All bachelors' universities might. I'm not sure. That was just one of the—that was the expectation. That was the class you took—nursing leadership.

*Tacey Ann Rosolowski, PhD*

**01:23:42**

That's interesting. Yeah. Probably much stronger now and much more widespread as a philosophy in nursing schools, I'm sure.

*Deborah Houston*

**01:23:50**

What I think is interesting is—I know my nursing colleagues here laugh at me because I'll go to

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meetings and they'll be talking about something. I'll just sometimes just start laughing because it's things that we did thirty years ago. It's kind of like everything comes full circle and comes back—from the way they do nursing assignments, policy changes. It all comes back. So, I think that's kind of funny.

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## **Chapter 7**

### **B: Building the Institution**

#### ***A Career Change to Information Systems and the Challenges of New Technology***

#### **Story Codes**

- A: The Administrator
- A: Professional Path
- B: Institutional Processes
- B: Building/Transforming the Institution
- B: Multi-disciplinary Approaches
- B: Building/Transforming the Institution
- B: Institutional Processes

***Tacey Ann Rosolowski, PhD***

**01:24:25**

Would you like to tell me now about your shift in career?

***Deborah Houston***

**01:24:29**

Okay. Well, it was what '96, '97. I had been for many, many years involved in the Medical Records Committee. I was the documentation committee chair in nursing for a long time. That was the group that we made forms—the new vital sign record or the changes in the fluid balance record or whatever. I would have to go to this committee and present the form and say, “This is what we’re going to do.” So, for a couple of years the physician that was the chair of the committee who became our chief information officer at the time was like, “You need to come work on this project with us. You need to come work on our electronic medical record project.” I’m like, “No. I just took this new Center Administrative Director job. I cannot take on another project.” “Oh, you really—?” “No, I just can’t do it.” Then six to eight months would go by, and he would ask me again. “No, no, no.” Well, finally, I got asked one time at a medical records committee meeting, and I said yes. I thought, “Well, I must have had a really bad day that day or something.” It was like—I said, “I really can’t do another project.” The woman that I was talking to that day—she goes, “No. We’re talking about come transfer—come full-time work. We’re going to make a position and you come work.” I’m like, “Okay.” I said okay.

***Tacey Ann Rosolowski, PhD***

**01:26:13**

Let me just quick get the detail. Who was the person on the Medical Records Committee?

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***Deborah Houston***

**01:26:19**

Mitchell Morris was the Chief Information Officer at the time. He had been—I don't know if he was the chair at the time. He had been chair of that committee before, and that's kind of when I first knew him, but he'd been here for a long, long time. Then, the woman that I had the conversation with when I actually said yes was Susan Perry. She was like the director of—I think it was called Patient Care Information Systems. She worked for Dr. Morris, and the EMR project at the time was reporting to her.

***Tacey Ann Rosolowski, PhD***

**01:26:51**

What do you think it was that made the yes come out of your mouth?

***Deborah Houston***

**01:26:56**

I know. That's when I laugh. I said, you know, maybe I got yelled at by some physician that day in clinic or something. I don't know. I had a lot of things going on. My husband had left. We were going through this change, and my husband had left Anderson. I don't know. It's like I said okay. It took almost four months because they had to create a position. It may have been longer than that. Then when I said that I was going to leave, I took my letter to the person I reported to in Cancer Medicine at the time. He almost had a stroke. We had to have all these meetings with the physician in chief—why was I leaving—blah, blah, blah.

***Tacey Ann Rosolowski, PhD***

**01:27:42**

Who was the person you reported to?

***Deborah Houston***

**01:27:43**

Bill Simeone—I mean, I reported to many people. Fifty percent of my salary was paid by him, and the other half was paid for by nursing. Anyway, I just made the decision. It took—it was a good decision, I think.

***Tacey Ann Rosolowski, PhD***

**01:28:09**

What do you think they saw in you that made them so intent on getting you into that role?

***Deborah Houston***

**01:28:15**

I don't know. I think it was my knowledge of patient care. I knew—what I think. I had been there a long time. I knew lots of people. I knew inpatient and outpatient care. I knew about

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charts. I knew forms. I knew documentation. I knew how orders were—how you did things. That's all I can think of. I was a fun person—I don't know.

***Tacey Ann Rosolowski, PhD***

**01:28:51**

Well, you have to choose the people you live with pretty carefully.

***Deborah Houston***

**01:28:55**

Yeah, yeah. I said yes. I knew very little about a computer—about computers. I thought you plugged in a disc like you do Microsoft Word and up comes your stuff and there it is. I could hardly—I could do email. I couldn't set up an Excel spreadsheet. My secretary would do that, but I would fill it out—I still don't—I'm not very good at that. I didn't know what I was getting into. I truly did not. I went to a conference right before I transferred. It's called Health Information Management Systems Society—HIMSS. It's this big healthcare IT conference—vendors and sessions on how to do things and success stories—a huge exhibit hall full of software vendors and computer cart companies and whatever. I spent a week in San Diego, California at this convention going around. I had no idea—I went to sessions, but I was totally lost at what they were talking about. I went around looking at equipment like this—you know, computer carts or wall-mounted computer things—just because I could relate to that. I had no idea what they were talking about. Little did I know that it was not like Microsoft Word or the recipe software you bought at Best Buy to put your favorite recipes on. It is very different. It is a whole new language. I had my eyes opened. Again, didn't need to know how to program software. I didn't need to know how to build servers. I needed to hire the right people that knew how to do that.

***Tacey Ann Rosolowski, PhD***

**01:30:49**

Tell me about the role that you took on—Coordinator Clinical Systems-Patient Care—

***Deborah Houston***

**01:30:57**

Yeah, that was the title they came up with.

***Tacey Ann Rosolowski, PhD***

**01:30:58**

Right. Information Systems. That was '97 to '99.

***Deborah Houston***

**01:31:03**

I came in, and I was brought in to manage the---. At that time, it was called the computer-based patient record—CBPR project. We had signed a contract with a vendor about six months before

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that. When I was with Medical Records Committee before I took the job, I had been on committees looking at software solutions, but I was the nursing—one of the nursing people on the committee. I didn't care about the back-end structure. I was looking at it from a nurse. How does this software work for me as a nurse? From a nursing documentation perspective, almost all of them work about the same. To me, it didn't matter whether we went with Epic or Cerner or whoever because the functions of how I was going to document the patient's fluid balance or how I was going to document vital signs or the nursing assessment I did was going to be the same. I really—that's what I was worried about. I wasn't worried about everything else. When I got there, there were two people from MD Anderson. The rest was a consulting company we had contracted with to help with this. There were like four or five of those people and two MD Anderson employees. My job, first of all, was to get more MD Anderson employees involved and to figure out what these contractors were doing and why were they the ones managing the budget and why were they the ones—we should be doing that.

*Tacey Ann Rosolowski, PhD*

**01:32:47**

Just so I understand, these four to five people from the company, they were actually here on-site at MD Anderson.

*Deborah Houston*

**01:32:52**

Yeah. It wasn't the software vendor. We had consulted with—I think they were called IMG.

*Tacey Ann Rosolowski, PhD*

**01:32:58**

Oh, yeah. Okay.

*Deborah Houston*

**01:33:00**

That consulting company that became HealthLink that became IBM that's now called Encore Health. Everybody changes names. They were somebody that we had (phone call).

*Tacey Ann Rosolowski, PhD*

**01:33:19**

So you were interested in why are these people running this?

*Deborah Houston*

**01:33:20**

Well, it was like—we needed more MD Anderson people involved. There was a gentleman that was the manager, who is still here on a different role. It's like we just needed—we needed more people, but we also needed more Anderson people. We started looking for—I started looking for staff. We had—I think we had a database administrator and one other. I can't remember who it

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was. Oh, there was a nurse that they had hired. We started hiring staff. We hired a technical guy. We hired a bunch of people. Then it's like, "Okay. We don't need this consultant, and we don't need that consultant." It's kind of like—we don't need—we should keep this information with us.

*Tacey Ann Rosolowski, PhD*

**01:34:21**

Uh-hunh (affirmative). You know what you need.

*Deborah Houston*

**01:34:24**

Yeah. We kind of transitioned from—they were a great resource. They helped us a lot, but we didn't need them to be running the project. We should have been running—we needed to take over ownership of the process.

*Tacey Ann Rosolowski, PhD*

**01:34:38**

What did you discover about your needs when you took over that ownership? What were the criteria you (talking) look at?

*Deborah Houston*

**01:34:44**

Well, it was like where were we? What were the things that needed to occur? We needed to get requirements for what people wanted to see in the system. The software was very immature. That's what we were really starting to look at. We needed people to work on different sections of the record. You needed somebody to be working on getting all the clinical results in—the lab results—that kind of stuff—and organize how that was going to look in the chart. You needed somebody to start working on the pharmacy stuff. You needed somebody to start working on the physician dictation—all those kind of things. We just started identifying types of people that we needed and posted positions and hired staff. Several people that worked for me in other jobs came and applied. We hired people from outside. A lot of internal institutional people transferred in. It was great.

*Tacey Ann Rosolowski, PhD*

**01:35:47**

Just a quick question. This was occurring in '96—around then.

*Deborah Houston*

**01:35:52**

'97, yeah.

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***Tacey Ann Rosolowski, PhD***

**01:35:54**

Now, where was that—in terms of the national timeline of institutions going to electronic records?

***Deborah Houston***

**01:36:03**

We were considered an early adopter. People were moving, but we were—people had-- . Well, we were an early adopter for the technology. There were hospitals that had systems that were very much mainframe-based systems. You know the blue screen kind of computer, dot, dot, dot things. DOS. It's called DOS—whatever that stands for—DOS-based systems. The VA had one. Some hospitals had them, but we were looking for something for our institution that was more cutting edge, really—that was something that could go from an outpatient to an inpatient experience. Our patients had the same chart, the same record. You come in as a patient at MD Anderson, you get a medical record number the day you walk in the door, and that's your record number until you pass away. That's always your—always that number. That sounds bad that you're always a number because you're not a number.

***Tacey Ann Rosolowski, PhD***

**01:37:11**

Right. It identifies you—(talking at once).

***Deborah Houston***

**01:37:14**

All of your chart, all of your information is in one place. If you go to Methodist Hospital, for example, and you're in the hospital, you have one system that you're using in the hospital, but if you go see your doctor in his office at Scurlock Tower, he may have a different application. It's not talking to the hospital. He can probably on his computer pull up your record from the hospital, but he can't—the data is not together. With patients getting chemotherapy, for example, you need to know what they got when they were an outpatient and what they got when they were an inpatient because there's issues with total doses or drugs and things like that that you have to know. Most computer systems don't have an ambulatory and an inpatient component together. That's why the product that we bought—we were trying to make do that at the time.

***Tacey Ann Rosolowski, PhD***

**01:38:18**

What was the product?

***Deborah Houston***

**01:38:20**

Cerner Millennium.



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*Tacey Ann Rosolowski, PhD*

**01:38:21**

And that's C-E-R—

*Deborah Houston*

**01:38:21**

C-E-R-N-E-R. I don't know that we're going to—I don't know that we're going to want to put brand names of products—I don't know.

*Tacey Ann Rosolowski, PhD*

**01:38:32**

That's okay.

*Deborah Houston*

**01:38:32**

We'll have to think about that, but that was the product. We were an early adopter, meaning we knew we were buying code that had not been put into use yet.

*Tacey Ann Rosolowski, PhD*

**01:38:39**

Oh, really. It was brand new.

*Deborah Houston*

**01:38:41**

Yeah. Brand new. That's what we did. That's what I did. I helped do that. Over the next several years or couple years, actually, we made the decision to stop our implementation of that product. We've gone through several.

*Tacey Ann Rosolowski, PhD*

**01:39:07**

Really? Interesting.

*Deborah Houston*

**01:39:08**

Yeah.

*Tacey Ann Rosolowski, PhD*

**01:39:09**

Before we go on and ask you why, let me just ask you another question, which is, clearly, this adopting of electronic records is just huge—huge at the institution. So I'm wondering like how it meshed with really high upper administration images of how the institution was going to evolve and be financially effective. What's your view of that?

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***Deborah Houston***

**01:39:38**

Well, I think the whole idea was we were going—the idea was to put this in to make the physician more productive. He was going to be able to see more patients. We were going to have better communication. You were going to be able to see the chart anywhere you wanted to in the hospital. You didn't have to find a chart. You were going to save time, because the chart was there when you needed it, all those kind of things. We were going to get orders to pharmacy faster. The nurse will know what you want done right away.

***Tacey Ann Rosolowski, PhD***

**01:40:07**

So again, that's sort of a physician-driven aspect—

***Deborah Houston***

**01:40:08**

Right. That's the whole goal of an electronic medical record—to coordinate and consolidate care. That is still our goal—to make everybody—not just the physician, but make everybody more productive and quit doing double work and repeating things and make it better for the patient because you're not asking him the same question twelve times and all that kind of stuff.

***Tacey Ann Rosolowski, PhD***

**01:40:37**

Yeah. I was going to ask you. It seems like a really naïve question, but what does that information system mean for an institution of this kind and an institution that is going to be confronting increasingly more complicated twenty-first century issues?

***Deborah Houston***

**01:41:00**

Right. Well, I think one of the things an electronic record does is it gives you data that you can then use for all kinds of things. The system has to be configured so that you're getting the data that you want and in a manner that that data is retrievable and structured so that it can be queried or put into databases or whatever. That is the struggle. One of the things that we have done well—like lab data—a very numerical, structured information—vital signs. You have a diastolic and a systolic blood pressure. You have a hemoglobin, a hematocrit, and a platelet that are very easy to track, that you can tabulate, you can graph, you can do all kinds of things with. That's the beauty of electronic records. Then you can take that and a physician can say, "I want every patient that had this kind of lab test, that have this diagnosis, and I want to see that over the last year or whatever." They can get that out of the computer systems if it's built correctly and the data bases are there to support it. That's our goal. That's what the electronic record is going to give us. I wouldn't say we're struggling, but we're in the middle of that transition because we have some things very structured—lab data, other things like that. We have other things that are

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not. They are free text or they are text documents that aren't structured. We have lots of things on the computer. A physician can see a patient today without any—everything is on the computer, either lab results are there, the images—the x-ray images are there, the text report of the last visit, all the consultants, all the x-ray, all the pathology. Everything is there. The nurses' vital signs are there. The medications a patient is on. It's all there, but you can't query it. You know what I'm saying?

*Tacey Ann Rosolowski, PhD*

**01:43:11**

Yeah.

*Deborah Houston*

**01:43:12**

That text blob of information that the physician dictated is exactly that.

*Tacey Ann Rosolowski, PhD*

**01:43:16**

So there's no real way of getting access to the specifics that's in that document.

*Deborah Houston*

**01:43:21**

That's where we're trying to now move into the piece of, "Okay. The data that is going in needs to be in a structured form."

*Tacey Ann Rosolowski, PhD*

**01:43:29**

In a structured form. So how are you addressing that challenge?

*Deborah Houston*

**01:43:34**

Well, the technology has gotten better. The systems we're developing. That's some of the initiatives we're doing today.

*Tacey Ann Rosolowski, PhD*

**01:43:43**

Can you give me an example?

*Deborah Houston*

**01:43:45**

Physician dictation. Structured Clinical Documentation. We have a project called "Structured Clinical Documentation—SCD," where we have built tools, primarily for the Head and Neck Service—Surgery Service where instead of dictating a note that go in and do—call it point and

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click—the patient’s physical exam. Cardiac—you can click normal or you can say he’s got increased heart rate, hypertension, whatever, and it creates a note. In the end, when you look at it, it looks like it’s dictated, but those are all structured elements.

*Tacey Ann Rosolowski, PhD*

**01:44:22**

So, basically, it’s not dictated. It’s—

*Deborah Houston*

**01:44:24**

Well, the physician does click, click, click, or the physician’s mid-level provider and the physician then approves it in the end. That is one way. The other piece if we have signed a contractor with a vendor called M\*Modal. M and then another capital M-O-D-A-L or E-L—I don’t know. It is a transcription vendor, but that does natural language processing. What this is I say the word lung, and it converts that into a structured data format so that you can then query those items within the record.

*Tacey Ann Rosolowski, PhD*

**01:45:07**

So it’s kind of a key word search—

*Deborah Houston*

**01:45:09**

Kind of, yeah. So, the physician, who is used to dictating—every physician learns how to dictate when he goes to school and starts being—seeing patients. He dictates, but the output of that is a structured document that can then be queried. Then, the plan is that we, also, then have a modified version of that where it’s a template that’s set up. You just dictate in certain pieces. That’s what we’re doing for physicians. Nurses, I think, will thrive on the structured format of the point-and-click because they already check boxes on assessment forms.

*Tacey Ann Rosolowski, PhD*

**01:45:5**

We’re at about five minutes of five. Do you want to—?

*Deborah Houston*

**01:46:01**

Yeah, we can quit and start tomorrow. That sounds good.

*Tacey Ann Rosolowski, PhD*

**01:46:01**

So, it’s five minutes of five, and I am turning of the recorder now.

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**01:46:04** (End of Audio Session One)

## **Deborah Houston**

Interview Session 2—July 27, 2012

### **Chapter 0** **Interview Identifier**

*Tacey Ann Rosolowski, PhD*

**00:00.00**

Okay. We are recording. I am Tacey Ann Rosolowski. I am sitting here in the Fannin Bank Building on the eighth floor with Debbie Houston. We are about to have our second interview session. It is July 27, and the time is about seven minutes of two.

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## **Chapter 8**

### **B: Institutional Processes**

#### ***Recognizing Nurses and Nursing: The Brown Foundation Outstanding Nurse Oncologist Award***

### **Story Codes**

- A: Career and Accomplishments
- B: MD Anderson History
- B: Institutional Processes
- B: MD Anderson Culture
- C: Giving Recognition

***Tacey Ann Rosolowski, PhD***

**00:00.00+**

We were talking just before the recorder went on, and you said that you had wanted to talk a bit more about the Arceneaux Award. Maybe you could tell me what the origin of that award is, and you also won it, so maybe you can me about all of that.

***Deborah Houston***

**00:00:42**

Well, okay. The first year that award was given out was in 1982. The original name of the award was the Brown Foundation Outstanding Nurse Oncologist Award; I think is what they called it. It was aimed at a clinical nurse or someone with clinical—a clinical assignment.

***Tacey Ann Rosolowski, PhD***

**00:01:10**

Now is that an institution award?

***Deborah Houston***

**00:01:11**

It is an institution award.

***Tacey Ann Rosolowski, PhD***

**00:01:12**

Okay.

***Deborah Houston***

**00:01:13**

Sponsored by the Brown Foundation. They still sponsor the award—the Brown Foundation does. When it started, it was a \$10,000 award that was tax-free, but the tax laws have changed since then. The first year it was done very much in secret. There was a little thing in the newspaper

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about it being done, and there was something in the hospital's newsletter that went out that this was being done, but it was—there was a committee but there were no nominations by staff or anything like that. It was all done in secret.

***Tacey Ann Rosolowski, PhD***

**00:01:55**

Why was that?

***Deborah Houston***

**00:01:55**

Because it was a big deal, I guess. I don't know. I remember joking with my mother—with my family—about “Ha ha ha, wouldn't it be funny, you know, if I won.” They were like, “Yeah, right.” Well, I did. I was very shocked, but I did and was nominated by the physician—one of the physicians that I was working with at the time.

***Tacey Ann Rosolowski, PhD***

**00:02:18**

And who was this?

***Deborah Houston***

**00:02:19**

Clifton Mountain, who was the head of the Thoracic Surgery Department. The first few years they gave the award to two nurses. Then, it went to—really they gave it—there were some nurse managers that won it. Nobody at the director level. They did give it to nurse managers. Then, they went to one nurse a year. Then, the award changed to the Ethel Fleming Arceneaux Outstanding Nurse—Oncology Nurse Award. Ethel Arceneaux was a nurse at MD Anderson for many, many years—very much focused on clinical nursing, worked here twenty-five plus years. Actually, passed away here from pancreatic cancer after she had retired. They have now named the award after Ethel. It's very, very nice. Her daughter had worked here, as well. It now continues on with an annual award. It's a \$15,000 a year award now. With the tax laws, you have to pay taxes on it. The foundation was gracious enough to extend the award so that it covers your tax burden. Now, the award is very clearly for bedside nursing staff—people that have—for several years, there were a lot of advanced practice nurses that won because it had a lot about your publications and presentations, which was—and they're all very fine nurses and very deserving, but it was felt like we were missing the bulk of the staff, which was the bedside, care-giving nurse, so the award now is aimed at that type of staff. The nomination is—a lot of nurses are involved in the nomination. There are some physicians that are on the committee, but it is a very nurse-run committee and selection. To me, it means more. Well, it meant a lot when I won it—no question—and it's meant a lot to everyone that's won it, but the fact that your nurse colleagues are the ones that are reviewing the nominations. It's been recently awarded, this past year, to a nurse that works in one of our regional care centers, so it's been really nice.



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***Tacey Ann Rosolowski, PhD***

**00:04:51**

Now why do you think it was decided at this time in 1982 to start this kind of an award? What was happening in the hospital or maybe in medicine in general that made it time to—

***Deborah Houston***

**00:05:02**

Well, you know, I don't know. I don't know exactly how the—Joyce Alt was the director or—the head of nursing at the time—whether she was out trying to recruit donations or other the foundation came to us to reward—to say, “Let's honor nursing.” I'm not sure. There had always been lots of awards, of course, for physicians throughout the years. There had never been anything for nursing staff of that caliber. I think it was a real testament to the institution to take that donation and put it toward nursing, and it has continued today. Now, the Brown Foundation does a similar sort of award at other hospitals within the Medical Center. I know they do it at Methodist. That was a real special time. The other nurse that won, whose name was Eufemia Chua—we knew about it. We found out about it, but we couldn't tell anybody. The only person that knew about it was the head of nursing. We couldn't tell anybody, and they gave the award to us at a Board of Visitors Dinner. It was a very fancy, formal dinner and all that. They don't do that anymore.

***Tacey Ann Rosolowski, PhD***

**00:06:26**

You couldn't—

***Deborah Houston***

**00:06:26**

We couldn't tell our staff. I mean, I could tell my family. We couldn't tell anybody yet. They were coming around taking pictures of us, doing things, you know, because there was a lot of publicity about it in the paper when the first one was given. That was kind of weird.

***Tacey Ann Rosolowski, PhD***

**00:06:44**

When were you actually able to announce it generally to people?

***Deborah Houston***

**00:06:48**

After the Board of Visitors dinner.

***Tacey Ann Rosolowski, PhD***

**00:06:50**

How interesting that they handled it that way.

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*Deborah Houston*

**00:06:54**

Anyway, it was exciting.

*Tacey Ann Rosolowski, PhD*

**00:06:58**

Yeah. How did that—how did the establishment of that award affect kind of the morale of nurses?

*Deborah Houston*

**00:07:06**

I think everyone was very, very excited because it was like, “We’re finally being recognized for the contributions that we give to patient care and that they’re seeing that there’s value in what we do.” I think it was great. Today, it is—every year when we have the award the former winners that are still here—even some that have retired come back. It is wonderful to see these people and the staff that now win the award—several of them have mentored some of—older staff have mentored people that are winning the awards now. It is really nice to see that kind of relationship that has been built over the years. You may reward a nurse that works on a particular unit, but with the publicity that she gets within the institution—it’s like people come up—they’re treated like they’re special, which is really nice—and they are. It’s really, really nice.

*Tacey Ann Rosolowski, PhD*

**00:08:06**

Have you ever been involved in the selection committee or—

*Deborah Houston*

**00:08:07**

Yes, I have. The last couple of years.

*Tacey Ann Rosolowski, PhD*

**00:08:11**

What kind of criteria does the committee look at for the selection of those winners?

*Deborah Houston*

**00:08:16**

Well, we look at things that they do—well, obviously, we get recommendations from physicians, from their co-workers, from their supervisor, from patients. It is stories that are written about them, and they write a profile as to what being an oncology nurse and what working at MD Anderson means to them. We really try to look at things that they have done in their career here—or elsewhere—but primarily here that have made an impact on the profession of nursing or on the patients that they take care of. Being an excellent nurse, a caring nurse, follows up with their patients, provides good education, gives wonderful care, gives me my medicine on time—to

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me that's an expectation of all nurses, but what are those things that made you special that you went above and beyond with the patients on. Some of it has been with programs nurses have—even clinic staff nurses have done—or special material they've developed or things patients have told us about interactions with them that really make it special.

*Tacey Ann Rosolowski, PhD*

**00:09:29**

That's really exciting.

*Deborah Houston*

**00:09:31**

There is a review process and a scoring—we review everyone's packets. They're all—all the nominations are blinded. Only the chairman knows who--and her secretary that helps her do the packets—are the only people that know who the people that were actually nominated, so you can't be biased on where they work or who they are or their title even—well, I think we left their title in. We knew they were a clinical nurse or whatever, but you didn't know where they worked necessarily. They're scored. We usually narrow it down to three, the top three finalists. Everyone agrees on who those 3 are. Then, we have lunch—the last few years we have had lunch with those people—just an opportunity to talk to them. Their work and their resumes have sort of reflected what they've done, so it's just an opportunity to get to know them. We then fold blindly, individually, and come up with who the winner will be. We had excellent candidates this year, again.

*Tacey Ann Rosolowski, PhD*

**00:10:46**

Who was the winner this year?

*Deborah Houston*

**00:10:47**

A nurse from the Regional Care Center in Sugarland, whose name—she is from Lebanon, so it's unusual— [Claudine] Jreissaty—and I can't think of her last name.

*Tacey Ann Rosolowski, PhD*

**00:11:01**

We can find it.

*Deborah Houston*

**00:11:05**

Who worked on the main campus in the Breast Center and then moved to the Regional Care Center at Sugarland.

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***Tacey Ann Rosolowski, PhD***

**00:11:13**

Do you remember anything special about her that convinced you she was the one who should be the winner?

***Deborah Houston***

**00:11:19**

She had done a lot of development of materials for the staff about breast—I think it was about breast cancer and chemo—things like that that are being used as training materials in all of the regional care centers now.

***Tacey Ann Rosolowski, PhD***

**00:11:36**

Wow.

***Deborah Houston***

**00:11:36**

She had a real wonderful story about how cancer had touched her life with family and how she had always wanted to be a nurse and be at MD Anderson and how she finally got to this country and got the ability to do that. It was really special. It's a great award and, hopefully, it will continue for many, many years.

***Tacey Ann Rosolowski, PhD***

**00:11:58**

Was there anything else from last time that you wanted to revisit or—?

***Deborah Houston***

**00:12:05**

I don't think so. I'm sure something will come up.

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## **Chapter 9**

### **B: Building the Institution**

#### *Information Systems at MD Anderson*

#### **Story Codes**

B: Institutional Processes  
A: The Administrator  
A: Professional Path  
B: Building/Transforming the Institution  
C: Professional Practice  
C: The Professional at Work  
B: The Business of MD Anderson

*Tacey Ann Rosolowski, PhD*

**00:12:10**

Okay. Well, we were starting to talk about your work in information technology. You talked about how you made that switch. We were starting to talk about the various projects that you worked on to start installing the first electronic record system. You talked about the first system you used and now the one that you—then the one that you switched to. Oh, I meant to say you had said that maybe you weren't so sure about whether you should use product names. If you want to just leave them out, we can always put them in the transcript later on—

*Deborah Houston*

**00:12:46**

Okay.

*Tacey Ann Rosolowski, PhD*

**00:12:46**

If you're concerned.

*Deborah Houston*

**00:12:47**

I don't—

*Tacey Ann Rosolowski, PhD*

**00:12:47**

If you're concerned about that, we can handle it that way.

*Deborah Houston*

**00:12:53**

Okay.

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*Tacey Ann Rosolowski, PhD*

**00:12:53**

Yeah. What I wanted to get a sense of was how you went—you went from coordinator to the Director of Enterprise Applications and then Director of Perioperative and Critical Care Informatics. Then, finally to the position you hold now, Director of Information Systems/Services?

*Deborah Houston*

**00:13:13**

Services.

*Tacey Ann Rosolowski, PhD*

**00:13:13**

Clinical Operations and Projects. I wanted to get a sense of your career track through the information systems, and what were the big projects that you worked on—

*Deborah Houston*

**00:13:24**

Okay.

*Tacey Ann Rosolowski, PhD*

**00:13:25**

—to help push MD Anderson into the twenty-first century.

*Deborah Houston*

**00:13:31**

Electronic Age.

*Tacey Ann Rosolowski, PhD*

**00:13:32**

Yeah.

*Deborah Houston*

**00:13:33**

Like we said previously, I came to IS sort of as a lateral move, and they created a title. With that title, sort of, became—I was over, at the time, it was called the computer-based record project. Then, when we put that first vendor project on hold, it's like I needed something to do, so I started managing all of the various clinical applications that we had in the department. That was kind of—being more of a manager, again, of people that were working on projects. Then, we had a change—the woman that was the director left the department. Then I got a promotion to the Director. We called it, I think, Enterprise Applications.

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*Tacey Ann Rosolowski, PhD*

**00:14:33**

Uh-hunh (affirmative). Management Information Systems (talking at once).

*Deborah Houston*

**00:14:36**

—Information Systems, yeah.

*Tacey Ann Rosolowski, PhD*

**00:14:37**

That was '99 to '05.

*Deborah Houston*

**00:14:40**

Yeah. That was the old—the department had changed names. Management Information Systems was a large department and, again, I was managing the managers and the staff that were working on all the various clinical applications and, at that point, administrative applications.

*Tacey Ann Rosolowski, PhD*

**00:14:55**

Now, when you saw clinical operations—

*Deborah Houston*

**00:15:00**

Clinical applications like the critical care system we were installing, the system that does patient registration, working on a new system for pharmacy, working on a new system for lab, those kind of things. Administrative applications would be things like PeopleSoft—that is our human resource application—that kind of thing. The MIS Department was quite large. We had a restructure back in 2005 of the IS Department Division. Our CIO at that time left—a different CIO than the one that had brought me to IT. He left. We had a new CIO, and we reorganized the way IS was configured, so the MIS Department as a whole, got actually split up.

*Tacey Ann Rosolowski, PhD*

**00:15:56**

Why was that?

*Deborah Houston*

**00:15:58**

It was a huge department. I mean, it was a big department, so they took the administrative applications and the human resource stuff with some departmental and other department stuff and made the Department of Administrative and Financial Services. The clinical applications

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became Clinical Applications and Support. We had a new EMR Development and Support Department created. That's when I changed and took the position I have now, which has morphed in different job wording titles, but sort of a position where I work as sort of a liaison between the IS Division and the Clinical Operations of the hospital. Originally, I didn't have any direct employees. It was really nice for a couple of years to have no one reporting to me. It was fabulous. I reported to the Chief Information Officer but had an indirect report to Dr. [Thomas] Burke, who is our Executive Vice President and Physician in Chief, and officed in the Clinical Operations side of the hospital, which is where I talked with you yesterday. That allowed me to be aware and know what was going on with all the various clinical areas and be involved in discussions and part of decisions on directions they wanted to go and helped oversee the overall clinical application portfolio for the hospital and the funding and requests for funding for those solutions.

***Tacey Ann Rosolowski, PhD***

**00:17:34**

Could you talk about some specific projects that you found really interesting—just so I can get a real sense of what you were doing?

***Deborah Houston***

**00:17:40**

Well, one of the things we did when I was in MIS and then it completed later was the implementation of the PICIS suite of products for the operating room and intensive care units.

***Tacey Ann Rosolowski, PhD***

**00:18:00**

What was that PICIC?

***Deborah Houston***

**00:18:01**

P-I-C-I-S. It is the system that does pre-op evaluation of patients—the actual during surgery documentation that the nurses do, the anesthesia documentation, and then the post-operative and ICU documentation that the patients need before they go back to the floors. It is a critical care suite of products by a vendor. That had been implemented over several years. It took a while because it was a product that matured over time. That was a big effort.

***Tacey Ann Rosolowski, PhD***

**00:18:43**

Let me ask you this. I mean, because people don't like change. What was it like to come in—how did it work? You said you were the liaison, so was your role, in part, to design how this product would be introduced to the individuals who were going to be using it?



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***Deborah Houston***

**00:19:01**

No. One of the things that we did with our restructuring in 2005—the perception prior to that was that IS was making all the decisions on what we were doing for the customer. I don't know that that was necessarily true, but that was kind of the perception. The way the process worked now is we have a new governance structure where the users—the business areas—the clinical users, for example, were the ones that made the decisions about what we were going to do related to information systems. If the lab had a problem or wanted a new system, the lab was the one that was driving the selection of the system and the buy-in by the users. Then, the IT staff was there to help with the correct configuration and implementation of the system.

***Tacey Ann Rosolowski, PhD***

**00:19:59**

Who chose the PICIS system then?

***Deborah Houston***

**00:20:00**

Dr. [Thomas] Feeley, who is still the head of Anesthesia and Critical Care—again, who chose it. We're a state institution. I've learned so much over the years. We're a state institution, so something of that value has to go out to bids. We did a request for proposal that was posted, and we had—I don't remember how many—venders that responded that you had to then review them all and do true system selection, and then PICIS was chosen. He was the driver of that project and the executive sponsor.

***Tacey Ann Rosolowski, PhD***

**00:20:44**

Where did the funds come for something like this?

***Deborah Houston***

**00:20:47**

The institution has capital funding, and our capital funding goes for building buildings and for IT infrastructure, so every year the institution determines how much money that we are going to have for IT development or IT use. That money comes from, I believe, it is a certain percentage of the margin that we make, and it goes into capital for future—for long-term use. We have been very lucky, even though this institution has a huge appetite for information technology now—everybody wants something right now. We have been very lucky that we have had a large allocation, which is again never enough for what people want. In our governance structure, committees get allocated a certain amount of that money. In my role, I help Dr. Burke, who chairs the clinical committee, to with the committee membership prioritize what is going to be funded and how much is going to be given to each project. That is the basic principle of how we do it today. Based on some projects that take many, many years, like our EMR development, there is a certain amount of money that has to be—you already know you're going to spend. For

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example, this coming year, we already know how much we are going to need at a minimum for our EMR development. We have a huge project to replace our hospital information system that does our registration, patient scheduling, patient billing. We know the amount of that—the financial burden of that for this next year. We know the financial burden of a financial system that has been going in and some other systems that are in process. A lot of our money is already spoken for, so the amount of money that we have to do new—brand new starts of projects is limited. Then, you have to prioritize. Sometimes, it is not the money, it's the people. If everyone is tied up doing these other projects, we don't have people to do the projects. A department frequently does not understand that, yeah, they want a new system. Infection Control is a good example. They have been on the list to get a new system for quite a while, and they are at the top of the list, but we have not had the resources available to do the project. The funding has been available, but the people have not been. The Infection Control physician and nurse practitioner are not in the position to install hardware and software and configure systems. You have to have programmers and people to do that. We potentially then go the route of we will contract that in and that happens sometimes, but that increases the price because contractors are always more expensive than a full-time employee. We have to—still once it is in you have to support it.

*Tacey Ann Rosolowski, PhD*

**00:24:03**

Right.

*Deborah Houston*

**00:24:04**

You have to have somebody within the institution that knows something about it before the contractor leaves, so those are the things that I deal with on a daily basis.

*Tacey Ann Rosolowski, PhD*

**00:24:14**

Right.

*Deborah Houston*

**00:24:16**

Fun.

*Tacey Ann Rosolowski, PhD*

**00:24:17**

You mentioned something about the PICIS system. You said it was kind of in flux. I was wondering what that meant and if that's usual with putting in a system.

*Deborah Houston*

**00:24:26**

Well, a lot of times--I don't remember how exactly I said it. The software itself—the vendor—

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the product that we got delivered when we first started that product. If you bought that product today, it comes to you with a set of pre-built templates and things that they didn't have when we first started. Just like the first EMR product that we used—Cerner—it came without any of that, so we were having to build it, whereas now if you were to select that vendor today it comes in sort of pre-built and then you just kind of tweak it, which is common with software that is newly developed or you are one of the initial users of the software. That's not uncommon. MD Anderson tends to want to have the newest, the best, the greatest, so we in the past have been willing to take software that is—it is not really ready for full-blown use and work on it.

***Tacey Ann Rosolowski, PhD***

**00:25:40**

Do you get a price break on that?

***Deborah Houston***

**00:25:45**

Sometimes. You sometimes get the ability to have additional features put in that you might not have—influence the development of the product. Frequently, there's a lot of risks or negative things because it can take longer. It might not work the way you think it's going to work or whatever.

***Tacey Ann Rosolowski, PhD***

**00:26:07**

Is that a wise decision, you think, on the part of MD Anderson—to always want the newest as opposed to maybe waiting a bit and getting something that is more tried?

***Deborah Houston***

**00:26:19**

I think it's a fifty-fifty proposition. I think we have been burned, if you want to say that, by going with the best, brightest, coolest, newest features, and we have spent a lot of time and effort, sometimes without anything to show at the end of it. Others, you know, great products at the end of it. I think it just depends on what we're looking for. The thing to remember is at MD Anderson—everybody says we're different. We're MD Anderson. We're different. We're different in a few ways that software vendors have to realize. The two biggest things are probably the fact that our patients have one record that follows them through the continuum of care, and the fact that we have chemotherapy ordering. The dosing of the chemotherapy, total dosing of drugs, and the ability to change doses is more complex than ordering antibiotics or pain medicine for somebody. In a general hospital, oncology is not your—it might be a unit or it might be a subset of a unit or you may not even do oncology care—you're doing general/medical/surgical care. Your system—and most vendors are selling products to those kind of institutions and those kind of community hospitals—100-bed hospitals, 200-bed hospitals, or a med/surg, academic medical center. That's not what we are, so it makes it difficult.

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***Tacey Ann Rosolowski, PhD***

**00:28:06**

Explain to me about—I understand with the patients that have one record that follows them, but what about the issue of chemotherapy and ordering and dosing? How does that influence what the software needs to do?

***Deborah Houston***

**00:28:19**

Well, again, if the system doesn't follow the patient through the whole care and you have an outpatient system and an inpatient system, you have to assume that the outpatient system—the amount of drug you got as an outpatient—that information can be transmitted to the inpatient system, so you don't give the patient too much. There are drugs that affect your heart, your lung function. If you get too much, the patient becomes a cardiac cripple or a pulmonary crippled.

***Tacey Ann Rosolowski, PhD***

**00:28:49**

So is that issue of the chemotherapy, is that kind of a subset of the patients having one record or is there something in the software that actually keeps track of the amount that they've been—the amount of drug that the patient has been given?

***Deborah Houston***

**00:29:00**

Well, you want the—well, both. You want the software to be able to do that. We can tell you today, pretty much, we can tell you how much drug a patient has had that they got here at MD Anderson. If the patient also gets therapy at home, which a lot of our patients do, you have a bigger problem. The physician is trying to track that through the continued record.

***Tacey Ann Rosolowski, PhD***

**00:29:28**

Interesting.

***Deborah Houston***

**00:29:31**

That's just one of the things. I mean, again, when you look at systems, a lab system can work in any hospital. We have specialty labs here. Flow cytometry, for example, molecular diagnostic kind of labs that a general hospital may not have. A lab system, if we're going to replace it, they've got to be able to do all of those kind of things or we end up building up something for the specialty lab and have they have to talk to each other—is an example. Then it's the volume of testing, the volume of things. Can the vendors keep up with our transaction volumes of things?

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***Tacey Ann Rosolowski, PhD***

**00:30:21**

What affects that? What affects their ability to do that?

***Deborah Houston***

**00:30:26**

Well, I'm not a technical person, but the way their system is architected, the way it's programmed, the hardware that it runs on. That's why I hire those technical people because I don't—I don't have a great understanding of that—how fast the computers have to be.

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## **Chapter 10**

### **A: The Administrator**

#### ***A Reality Check for Information Systems – Building Systems for Teams***

##### **Story Codes**

A: Character, Values, Beliefs, Talents  
A: The Administrator  
A: The Leader  
B: Institutional Processes  
B: Devices, Drugs, Procedures  
B: Building/Transforming the Institution  
C: Portraits  
C: Professional Practice  
C: The Professional at Work  
C: Diversity at MD Anderson

***Tacey Ann Rosolowski, PhD***

**00:30:47**

Right. You mentioned a number of times the skill sets that you don't have. What have you discovered that you have brought to this particular role that makes you so valuable in it?

***Deborah Houston***

**00:31:00**

I think I brought the realistic—I hope—I brought the realistic face of this is what users that take care of people—patients—need the system to do and been able to say, “No, a user does not want to go between three different folders to look at one thing,” or kind of the mechanics of how the system is going to work. How many applications is somebody going to have to go into to take care of a patient? Then sort of a reality check on the way people navigate through screens on a computer. Does it make sense? Is it worded correctly? Have they thought through the logic? Not that I can program it in the back-end, but does it make sense that you have to have height and weight entered first before you get down farther or the way the physician gets some kind of an alert of an error in what he has done before he gets to the bottom, signed it, and has left the application. You are trying to streamline the way the applications work.

***Tacey Ann Rosolowski, PhD***

**00:32:18**

You bring the really detailed knowledge of how it operates at the bedside.

***Deborah Houston***

**00:32:23**

Right, and I have also worked both with surgical and medical physicians and had some exposure

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to other—radiation and that kind of stuff—in an outpatient, so I’ve seen how—granted, it’s been a long time since I have actually worked clinically but, at least, I have some knowledge of what they’re talking about and what they’re doing. One of the things I did years ago when I was in MIS was I set up a class. I don’t remember what I called the class, actually, but it was sort of a class for the technical people in department about cancer and about—kind of medical things. It is like you speak a totally different language. Yes, you work at a hospital and you’re over here doing a very important thing to help make cancer history, working in this building, doing your IT thing, but you need to understand what that means to the people across the street that are the actual patients. I did—like kinds of cancers. When they hear things, you know, “what’s the difference between a surgical and a hematology patient?” When you hear people talk about that—what’s a solid tumor versus a liquid tumor? When they are in meetings they don’t fall asleep or they, at least, understand what people are saying. I did a one-day kind of thing for everybody—types of treatment. What is surgery? What is radiation? What is chemotherapy?

*Tacey Ann Rosolowski, PhD*

**00:33:54**

What was the effect of that?

*Deborah Houston*

**00:33:56**

I think it gave—well, hopefully—they said they liked it. I hope it gave them more understanding and a greater appreciation for what they were doing. Things like—and IT person calls a disc something different than a person over here in the hospital. You have a disc problem. Your disc problem in the hospital is something is wrong with your back. A disk problem over here is something is wrong with the computer. When you are on the phone talking to people, you kind of have to have a frame of reference, so I think it helped them. We don’t do that anymore, but it was fun when we did it. We did it a couple of times.

*Tacey Ann Rosolowski, PhD*

**00:34:36**

The class?

*Deborah Houston*

**00:34:36**

Yeah. We did it a couple of times.

*Tacey Ann Rosolowski, PhD*

**00:34:37**

Interesting. What do you think gave you that ability to talk to people on both sides of the problem—the technical people and the clinical people? It’s an interesting translational skill.

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***Deborah Houston***

**00:34:51**

I don't know. I will talk to anybody; probably my personality and my lack of fear. I don't know. I don't have a problem saying, "I don't understand that. Can you explain that to me in language—tell me what that really means." We'll be in meetings today, and they'll be talking about "we have this and that" and "we're going to blah, blah, blah." I say, "Well, I hope you don't tell them that way because they're not going to understand that. They'll hand out something that is going to be a communication that is going to go out to users, and it's like, "This just makes no sense to the nurse at the bedside or the physician." That's an interpreter, I guess, is what I've been over time.

***Tacey Ann Rosolowski, PhD***

**00:35:43**

Yeah. That's interesting. Obviously, they take you seriously and understand—that take what you say at face value. It needs to be done.

***Deborah Houston***

**00:35:52**

Well, I know when I first came into IT, there were some of the directors that had been in IT forever. It was like, "Why is that little nurse in here? What is she going to provide? She doesn't know anything about IT." I didn't claim to know anything, which I think was beneficial because I didn't try to make something up—act like I knew.

***Tacey Ann Rosolowski, PhD***

**00:36:24**

Right.

***Deborah Houston***

**00:36:25**

Even today. I will be over and one of the VPs will come in my office and say, you know, "This doesn't work." I say, "You think I know how to fix that? Let me look, but let's call for info. Let's call and get somebody—." I'll give it a shot, but I don't know how to fix anything, usually.

***Tacey Ann Rosolowski, PhD***

**00:36:50**

With your comment about the directors when you first came into IT, you're kind of broaching an issue I wanted to talk about, which is how many women were in IT when you joined and what was it like operating as a woman?



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***Deborah Houston***

**00:37:07**

The woman that was my boss. My boss was a woman. She was the director of MIS.

***Tacey Ann Rosolowski, PhD***

**00:37:14**

And what was her name?

***Deborah Houston***

**00:37:15**

Susan Perry. At the time, she was the only director. I'm just trying to remember, but she was the only woman. Then we had—there were a couple of other people that came in—not jobs like mine, but were like project manager kind of jobs that were women. Today, we have-- IT is a pretty male-dominated profession. Today at the director level in IT, we have—there's three of us.

***Tacey Ann Rosolowski, PhD***

**00:37:58**

Out of?

***Deborah Houston***

**00:37:59**

Out of twelve, I think it's twelve. Patty Layne is the Director of Project Support and Coordination Services, which is kind of our project management office. Leslie Smith is the Director of Clinical Applications and Support. Patty is a lab technician by background. Leslie is a nurse by background. That's nice. Then we have one other—one associate director that is a nurse, that's in the desk-top network group. We have several managers that are nurses, so there's a few, but most are men.

***Tacey Ann Rosolowski, PhD***

**00:39:00**

How did you get that message—"what's that little nurse doing here, what could she know about—?"

***Deborah Houston***

**00:39:06**

You could tell. You could tell, just by body language-the way they—. My mother used to say, "Don't tsk and roll you eyes at me." The way they would like—when you would say something. They wouldn't take your comment seriously or whatever.

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*Tacey Ann Rosolowski, PhD*

**00:39:23**

What was the process of turning that around?

*Deborah Houston*

**00:39:28**

You just keep after them—say something and your boss supports your or, “Yes, that’s a good idea. We’re going to do that.” You’re taken seriously by more than that person. You’ve proved them wrong.

*Tacey Ann Rosolowski, PhD*

**00:39:47**

You kind of had a coalition since your boss was a woman and—

*Deborah Houston*

**00:39:51**

And my boss’ boss wanted me to come into the job—that was their boss, too.

*Tacey Ann Rosolowski, PhD*

**00:39:58**

Is the attitude a little different now?

*Deborah Houston*

**00:40:00**

I think so.

*Tacey Ann Rosolowski, PhD*

**00:40:01**

Yeah.

*Deborah Houston*

**00:40:02**

I think so—with women in general, yeah. I think my role in IT was very different. I think now having someone come in like me with absolutely no IT experience would probably be more difficult. One of the things—I have talked to my previous boss before he left, and we need to think about it—what are we going to do when I retire because I’m not working forever. What is the plan to replace someone in this job? If that is not the plan, what are we going to do to have this kind of service within the IT division for the clinical areas of the hospital? We have a few years, hopefully, to kind of figure that out. There isn’t anybody, I don’t think, in the division today that if I were to get hit by a bus that could walk in and take—do what I do. There isn’t anybody. It’s terrible to—it sounds very self-effacing to say that, but there isn’t anybody that has the knowledge of how stuff is kind of fitting together—because of the background I had when I

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came into IT and—it is not just my clinical knowledge—my old clinical knowledge—that is of help now. It is the past ten years in IT, or however many years I've been here, fifteen I guess. As we have added departments and added applications and knowing the background of that and the plan for how that is going to fit—we don't have anybody else here that knows that and has kept up with—. Patty and Leslie are probably the closest, but in their jobs that they are in today, they are not as familiar as everything else out there. That's just—the respect and the collaboration I have with the people in the clinical and operation side of the hospital is something that's—that takes time and effort and we just don't have anybody. That's something we're going to have to address over the next couple of years. We will.

***Tacey Ann Rosolowski, PhD***

**00:42:48**

What do you think are the key pieces? What you're describing is sort of the irreplaceable or the difficult—?

***Deborah Houston***

**00:42:58**

No one is irreplaceable. (Talking at once).

***Tacey Ann Rosolowski, PhD***

**00:43:02**

It sounds like you've got this very unique set of perspectives and a certain level of people are—at that level. I'm just wondering, what is the key piece? Is there kind of a culture that's been established about the installation of electronic records, and you need to know that culture? What is it about?

***Deborah Houston***

**00:43:30**

I don't know that it's the culture of installing systems or anything. I think it's the relationships that you've built up over time and the ability to go out there and talk to people and figure out what people need versus what they want. What do they really need and help them identify what is the real problem they're trying to solve? Everybody thinks a computer system is going to fix their problem—whatever it is. From the parking is too expensive, a new system will help us get people in and out of the parking garage faster, for example. A new scheduling system is going to make our physicians show up in clinic on time and be more productive. That's really not the issue. A new something is going to help us transport patients faster or whatever. Sometimes there is a solution for that and sometimes it's not. It's a process change that people need to make. That is something that I have learned over the years is that it is not always the application. An example, a very recent example, we have installed an application for electronic prescriptions. A lot of people—you go to your doctor's office and instead of giving you a piece of paper, they go to the computer, they put it in, and your prescription goes to CVS by your house. You go to CVS, and it is ready. You're not having to go twice to the pharmacy. We have installed a system,

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built it, installed it within ClinicStation, so the physicians go use the application they're used to all the time, ClinicStation, and order a prescription. It works. There's lots of things wrong with it or it's not perfect, but it's a commercial product we installed, embedded within our EMR. It is a product used by thousands of doctors, thousands of hospitals, and doctor's offices throughout the country. It's not, you know, Joe Blow's system. You have doctors that go in and do it. Then, you have other people that can write prescriptions for doctors. In your doctor's office, probably his secretary calls in your antibiotic prescription for him. He probably doesn't do it himself. There's a role—it's called a provider agent—for the nurse or whoever to, on behalf of the doctor, she is ordering a prescription for him. Then, there's a clinical role where if she orders it it has to go to him to sign first before it goes to the pharmacy. The other one, it goes right to the pharmacy. We installed it. In the inpatient area, the nurse just—they don't every write prescriptions, so she has the clinical role where she can see what he is doing, but she can't really do anything with prescriptions. In the outpatient role, they have been calling in prescriptions and faxing prescriptions for the physicians forever, so they have the provider agent role. We finally got that resolved. What is happening is the physicians are telling the nurses, "Well, he's here, and I'm here." He's saying go send a prescription to whatever, instead of doing it himself, because that's what he's done for years and that has been accepted. We have now had all these issues about the system doesn't let us do this. The system is letting the nurses do what they want. It is like, it isn't the system. It's the process behind the system, which finally this week after many meetings and many—they finally understand that. They are wanting to change things in the system that will then obstruct care of the patient, yet it is the process that they have behind it that was old behavior that they didn't change.

***Tacey Ann Rosolowski, PhD***

**00:47:44**

Have you been part of suggesting how that process can change?

***Deborah Houston***

**00:47:50**

To some extent, but it is sort of—as opposed to suggesting how it will change, I feel like I have been able to bring reality back to the table. It is like, "We don't want to be able to have the order go to the pharmacy before the physician signs it. No. We can't do that." It is like, okay, what do you do today. If you don't have you prescribe it, what did you do today? How did you get a prescription to the patient if the physician called you and said, "Order the nausea medicine for the—." Do you want the patient who is throwing up at home to have to wait two days for the patient to sign the prescription before they can get their medicine? Well, no we don't want that to happen. Then they have to have this role, that kind of thing. What if the nurse is writing prescriptions without talking to the doctor? Well, what do you do today? Is that happening today? What are you doing today for that kind of behavior? If you find that out? That's what I've been doing as opposed to saying, "This is what you ought to do." That's what I try to do. That's one of those things that you do well and things you don't do so well—I think one of the things I do relatively well is get the people at the room and at the table to help facilitate those

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kind of discussions. Sometimes, I go to meetings and it's like, yes, we can change the system. We can talk to the vendor, and we can maybe change the system to do this, this, this, and this. If it's something we've built, yeah, we can change it. Then, it's like be careful what you wish for too. Sometimes they ask for things, and it's like have they asked all the right people. They will make a change for one area that really negatively impacts somebody else. We try to make sure we've got all the right people to talk to.

***Tacey Ann Rosolowski, PhD***

**00:49:47**

You spend a lot of time in meetings?

***Deborah Houston***

**00:49:48**

I spend a lot of time in meetings. I spend a lot of time in meetings. My nephew, when he was little, one time said, "Aunt Debbie, what do you do all day?" I said, "I go to meetings." He goes, "That doesn't sound very fun." It's like, "It's not." Yes, I spend a lot of time in meetings for various reasons—listening to complaints; then, getting the right people to fix whatever the issue was or address the issue.

***Tacey Ann Rosolowski, PhD***

**00:50:19**

Yeah, I mean, it's the kind of role—people come to you when they're really psyched and think they have a solution and, then, they come to you when it's blown up in their face.

***Deborah Houston***

**00:50:26**

Yeah, both. They do. They come to me with, "How do we make this happen?" or "This is what we need. Is it reasonable?" or "This is a pile of you-know-what and it doesn't work." That's the piece that I try to prevent from happening—to make sure we did it right the first time.

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## **Chapter 11**

### **B: Building the Institution**

#### *Medical Records and System Design for Faster Work and Better Patient Care*

#### **Story Codes**

- A: The Administrator
- B: Institutional Processes
- B: Devices, Drugs, Procedures
- B: Building/Transforming the Institution
- C: Professional Practice
- C: The Professional at Work
- C: Diversity at MD Anderson

*Tacey Ann Rosolowski, PhD*

**00:50:46**

Yeah, yeah. I know in 2010, there was the new expansion of the Alkek Hospital. To what degree did you work on that—installing the electronic system for that?

*Deborah Houston*

**00:51:07**

We had IT people involved, of course, in the building. One of the things—you want me personally, what I personally did?

*Tacey Ann Rosolowski, PhD*

**00:51:16**

Yeah. I'm just curious.

*Deborah Houston*

**00:51:20**

One of the things was the way they new units are configured. They don't have line of sight of the reception area. Does that make sense?

*Tacey Ann Rosolowski, PhD*

**00:51:32**

No. Actually, for the recorder, let me just say that what we are talking about is the bed tower expansion of the Alkek Hospital, which was completed in November of 2010.

*Deborah Houston*

**00:51:42**

Yeah.

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***Tacey Ann Rosolowski, PhD***

**00:51:42**

It had a lot of really interesting electronic bells and whistles.

***Deborah Houston***

**00:51:47**

Right.

***Tacey Ann Rosolowski, PhD***

**00:51:49**

What does that mean, the line of sight issue?

***Deborah Houston***

**00:51:51**

Well, when you go into a nursing unit or on a floor, frequently there is a central nursing station. Rooms are either down the hall on either side of it or they're around it—most of our rooms here, there is a station and rooms are around it in some kind of configuration. In this facility, the new building, there is—at that nurses' station, there is usually a clerk or somebody that is sitting there all the time, answering the phone, directing people, looking at charts or the computers or whatever. The way it is set out now is there are little pods of room and there is no real nurse station anymore. The receptionist that is answering the phone or whatever is really kind of around a corner. You come in—the hallways go like this and the rooms are kind of back there. If you need help or you need somebody else, they are not right out there at the nurses' station. They are down other hallways and things. One of the things we had implemented in the outpatient clinics is a device called a Vocera communication badge. It is like a hands-free device—I say hands-free—you push a button to make it work. You log onto the system everyday and it knows which device you are carrying. When you want to call somebody, you hit a button and it talks to you and you say, “Call Debbie Houston, or call Dr. So-and-so, or page somebody” or whatever. You can call to a phone number. You can call to another person's badge. You can call to a pager. We implemented that for the nursing staff on those new units because if they are down in a hallway, they're in a room or something, and they need help, they can use that to call for assistance or find somebody.

***Tacey Ann Rosolowski, PhD***

**00:54:01**

Why were those units designed on that pod configuration in the first place?

***Deborah Houston***

**00:54:08**

I have no idea.

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*Tacey Ann Rosolowski, PhD*

**00:54:09**

Oh.

*Deborah Houston*

**00:54:09**

I was not involved in that at all.

*Tacey Ann Rosolowski, PhD*

**00:54:12**

You came in with the Vocera system basically to kind of do a little trouble-shooting—

*Deborah Houston*

**00:54:18**

Well, yeah. (talking at once). We had been using it in the outpatient clinics for a while, and it worked well. We thought it would work. It has been helpful. Now we're expanding that to all of the nursing units—inpatient units. We have had them in the clinic, but we are putting them in the inpatient units, as well.

*Tacey Ann Rosolowski, PhD*

**00:54:33**

What do you find it enables?

*Deborah Houston*

**00:54:37**

Quick communication. The main thing is you call a physician. You tell the clerk to page Dr. So-and-so. He calls back. You're in the room with a patient. They don't know where you went. They don't know who called him. The doctor hangs us. You come out, "Did Dr. So-and-so call?" "Oh, yeah. I didn't know where you were." You call him again. You're in another room. This way they can call back right to the badge. They can call back and talk to you—you can be in a room with a patient and it says, "Can you accept a call from—?" You can answer it, go out in the hall and talk to him, go to a phone and talk to him or whatever. It is really nice. When you're in the room—when they say hands-free—if you have your hands full of stuff, you don't have to do anything. You can just talk to it, and it does what you want.

*Tacey Ann Rosolowski, PhD*

**00:55:38**

Wow. That's amazing.

*Deborah Houston*

**00:55:40**

You can have the conversation. Yeah. It's nice.



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***Tacey Ann Rosolowski, PhD***

**00:55:43**

What other projects did you work on with—?

***Deborah Houston***

**00:55:44**

That one and, then, we put tablet PCs—computers—the small tablet computers in the patient rooms for the nurses to utilize to document vital signs and use for documentation purposes. That hasn't been as successful as we thought because of the size of the device. The rooms were not wired to have computers in the room at the time they built the building. I shouldn't say they weren't designed that way. Well, no, they weren't designed that way because we're running them wireless. Again, the designing of buildings is years and years before you're going to do anything. Now, we're having to go back in and change that. They are going to be putting some type of wall-mounted computer in all of the rooms. We are going to end up with them in every patient room. We will have to do wiring for that.

***Tacey Ann Rosolowski, PhD***

**00:56:54**

What was the problem with the tablets?

***Deborah Houston***

**00:56:58**

The smaller device? We actually gave them to the nurses on the units they were one before they moved to the new unit so they could get used to them. I think, again, it is process. It is habit. They're used to going in and taking vital signs, writing them on a piece of paper, and going out and charting it. All of these rooms have computers, most of them right outside the door, as well. The idea was you're in there and you do it while you're—

***Tacey Ann Rosolowski, PhD***

**00:57:29**

Yeah, you're not doubling your work.

***Deborah Houston***

**00:57:40**

The idea was a good one. I think we just didn't have enough for them to do on the device at the time. A couple of other things—when patients get admitted, we check their medications. There is an application that runs on it that they can do that. I think part of it was we didn't have enough working on it. They're expensive. They're more expensive than a regular computer, so we're not buying anymore.

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*Tacey Ann Rosolowski, PhD*

**00:58:14**

What are you going to be doing with the ones you've got now?

*Deborah Houston*

**00:58:18**

They're leased, so they'll go back.

*Tacey Ann Rosolowski, PhD*

**00:58:20**

Oh, okay. Yeah, interesting. So the larger computer will be—enable more things to be done on it, so they'll be more of an incentive?

*Deborah Houston*

**00:58:30**

Well, not necessarily more things to be done it. It'll be easier to see. It'll be a regular—the other thing was if you—it didn't have a—the keyboard that works with it was over away from the patient because when you took it out to use it by the patient's bedside—when you take it out to use it at the bedside, the keyboard is on the screen. When you open up the keyboard, the screen shrinks down. It's harder to use. There is a keyboard that you can mount. There is a little mounting thing with the keyboard, but it's here and the patient is over there. They are going to mount one of those reticulated arms that will have a keyboard drawer and a monitor—a big monitor—so it will be easier to see and a regular keyboard.

*Tacey Ann Rosolowski, PhD*

**00:59:35**

A more ergonomic thing.

*Deborah Houston*

**00:59:37**

Yeah. The nurse can use it. The physician can use it when they're in the room.

*Tacey Ann Rosolowski, PhD*

**00:59:39**

Right. I can see how that—if the keyboard is on the other side of the room—

*Deborah Houston*

**00:59:44**

Right. That's what we should have done anyway. We were trying to do something—

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***Tacey Ann Rosolowski, PhD***

**00:59:54**

Were there any other things you worked on?

***Deborah Houston***

**00:59:57**

Those are the main things that I was involved in. There are some subsequent things that have happened. We have put in something called white boards, which are like—well, we did do that for those new buildings—those units, now that I think about it. On all the nursing units, we have a big grease board where they have the patient's room number and their name and the doctor and kind of things that might be going on with the patient—cryptic things—people walking by wouldn't know what it was. There was no wall. That was not planned for in the new facility, so we did an electronic version of that. It is a big monitor on the wall that is the same kind of functionality that shows rooms patients are in, doctor. The nurses go in and can put things in the other columns. It shows when new orders are written for the patient. The nurses can look and see. Again, because the nurses' station where the charts would have been located or are located is not where—it is around where this clerk is, and she has a fifty-two-bed unit—well, they're half-and-half, so twenty-seven or whatever—twenty-six patients on each side. The charts are there, and they're not—back in the back.

***Tacey Ann Rosolowski, PhD***

**01:01:22**

These white boards are kind of in where all the pods are—

***Deborah Houston***

**01:01:28**

Yeah. It's like you see status boards in airports and things like that—that kind of a status board, that kind of function. We implemented that. We had a version of that in the Radiology Department and in the Emergency Center, so we implemented that. That's going to all units now.

***Tacey Ann Rosolowski, PhD***

**01:01:44**

What's the advantage of that?

***Deborah Houston***

**01:01:47**

It's neat. I mean, you know, it's up-to-date. As soon as a patient changes a location, it changes. As soon as an order is written, it puts a flag up there so you know.

***Tacey Ann Rosolowski, PhD***

**01:02:00**

It's really an immediacy kind of thing. It's directly connected to the computer, so it updates itself without a person having to go in—

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*Deborah Houston*

**01:02:07**

Yes, yes.

*Tacey Ann Rosolowski, PhD*

**01:02:08**

Oh, that's very cool.

*Deborah Houston*

**01:02:09**

Some of the stuff the nurses have to go in to update. As we get more and more functionality built within ClinicStation, a lot of it will be more automated.

*Tacey Ann Rosolowski, PhD*

**01:02:18**

You mentioned ClinicStation before in the context of writing prescriptions. I think I read in one of the background materials that the wireless network in Alkek wasn't powerful enough to handle ClinicStation, or did I misunderstand that?

*Deborah Houston*

**01:02:41**

When we first—okay—the institution's wireless network has had to be upgraded in the last couple of years. When we first—the new Alkek units had the new upgraded wireless network when they opened. That's why we could have Vocera and use those tablet PCs on the wireless network. The lower Alkek floors and the Purple Zone, the Lutheran Pavilion, did not have the upgraded wireless network at the same time, so they couldn't use Vocera. Wireless worked sporadically. Since then, we have completed the upgrade of the wireless network, so we're rolling out Vocera—hope to roll Vocera out to everywhere else.

*Tacey Ann Rosolowski, PhD*

**01:03:32**

What was the issue with ClinicStation?

*Deborah Houston*

**01:03:34**

I don't—

*Tacey Ann Rosolowski, PhD*

**01:03:37**

Okay, so I must have—

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*Deborah Houston*

**01:03:37**

Yeah.

*Tacey Ann Rosolowski, PhD*

**01:03:38**

Yeah. Okay. I was curious about that.

*Deborah Houston*

**01:03:42**

One of the things—I don't know that we every talked about was we made the decision back in 2005 that ClinicStation would become our electronic medical record for the institution.

*Tacey Ann Rosolowski, PhD*

**01:03:52**

No, we didn't talk about that. How was that—?

*Deborah Houston*

**01:03:54**

We had tried three other commercial vendors prior to that in different variations that were not successful in our environment. Back in 2005, when we reorganized IS and everything, one of the things that was done at that point, as well, as assess our EMR strategy. The decision was to use ClinicStation. ClinicStation had been built originally as a data viewing tool for radiologists. When radiologists want to look at x-rays, they like to know history of the patient, and they couldn't get charts or they couldn't get results or it was difficult in the old computer systems to see x-rays and old x-ray reports and lab reports and whatever. So the guys that work in ClinicStation today developed an application that pulled all that data for the radiologist so he could see the x-ray image on the computer and he could see over here—here's the patient's pathology report or here is what his doctor said at the last visit so they could collaborate and consolidate results. Other physicians started seeing that, and it was like, "Well, we could use that as our EMR." That's how it came about. Subsequently to that, we developed ClinicStation into our electronic record and it is a certified electronic health record for both in- and outpatient use.

*Tacey Ann Rosolowski, PhD*

**01:05:31**

What does that mean, "certified?"

*Deborah Houston*

**01:05:32**

It's a governmental regulatory thing that we applied for, and you have to meet standards. We got that certification last year, I guess, which is a springboard to sort of other things the physicians can get reimbursed for, because they're using a certified electronic medical record.

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***Tacey Ann Rosolowski, PhD***

**01:05:57**

Oh, really?

***Deborah Houston***

**01:06:00**

There's a program called "Meaningful Use of Electronic Medical Records," and the government is giving physicians money to do that, so much per year based on certain things they have to be doing with an electronic record. We couldn't apply for that until our system was certified. Now we're in the process—well, the system as of July has everything in it to meet the first phase of meaningful use. Our physicians will be starting this fall. Right after the first of the year, they will be applying for monies. The institution will get money per physicians that are eligible.

***Tacey Ann Rosolowski, PhD***

**01:06:42**

Now, why is the government doing that?

***Deborah Houston***

**01:06:46**

Well, the idea is that if the electronic records—the whole idea is if electronic records—if patient's records are electronic, they can easily "be transmitted" and transferred among providers and institutions, so your care is more collaborative. You're not duplicating tests. You didn't go here and have a chest x-ray, and you go somewhere else and he can't see this chest x-ray, so you have another chest x-ray, for example, or you get a lab test repeated over and over because you don't know what the last one said. That's kind of the idea is that it is going to overall decrease the cost of healthcare in the end, because we're going to prevent duplication.

***Tacey Ann Rosolowski, PhD***

**01:07:33**

What's your view of that?

***Deborah Houston***

**01:07:35**

I think it will happen. I don't know if it will happen in my lifetime. I think it will happen. As we build things like orders that tell you, "You just ordered that test—" it's not something that is going to change in twelve hours or there should only be so many chest x-rays ordered on somebody. An example is our patients, because they see many different providers, you could order an x-ray and I could order an x-ray and you may not know I ordered the x-ray and two different clerks are scheduling it and they don't bother to look. The patient gets two x-rays. Some of our patients, bless them, don't know enough to say, "I just had that done this morning. Why am I having it done again?" or "I just had a lab drawn." That will help. With electronic order

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entry, you can build in alerts and things like that that say, “You just ordered that” or “Don’t give that medication, the patient is allergic to it,” or “Don’t give that medication or that dose of a medication because the patient’s kidney function isn’t good enough, or they are too old, or it’s too much for the size—or their weight or whatever.” Those are things—it’s safety and productivity and decrease in cost—are some of the main reasons why the government is interested.

***Tacey Ann Rosolowski, PhD***

**01:09:00**

After you decided on ClinicStation in 2005, were there particular ways in which you tweaked the system to make it more useful for MD Anderson or was it great just from the beginning as-is?

***Deborah Houston***

**01:09:21**

The system was built, again, as a viewer of results. That was the original intent of the system. We were doing some data entry into it at that point. The nurses were putting in vital signs. We were putting in medications for medication reconciliation, which is a list of all the meds the patient has taken home so that when they come in and out of the hospital we know what they have been taking. Their allergy information was in the record. The tweaking that was done originally was more, “Let’s add this result. Let’s add these video files of swallowing studies by the speech pathologist” or “Let’s add this new cardiac test,” or “Let’s add reports from physical therapy,” for example. I don’t know. Things like that. That has been done consistently over time. What we are doing now is we are implementing features where the nurse, the physician, all the clinical providers are interacting with it. They are entering orders. They are entering documentation. That is a real change in practice—a change in behavior that we are having to deal with; entering prescriptions electronically instead of writing them on a piece of paper.

***Tacey Ann Rosolowski, PhD***

**01:10:45**

What are some of the challenges that come with that? I mean, you mentioned about the prescriptions earlier and how that kind of created a lot of—

***Deborah Houston***

**01:10:51**

Well, it’s a change in—well, it’s very easy for physicians—a lot of them have been used to—let’s say in the outpatient clinic. They had a chart or the nurse had their papers. They don’t even have the charts anymore because they can see a patient without the chart. They can look at stuff on the clinic, but he would have a piece of paper that would be the requisition for what the patient needed to have done when he came back the next day—the next visit. It already had the patient’s name on it. It was already there. The doctor would go, “Three months, chest x-ray, check some labs.” Sign it. That was it. I mean—very quick. Now, when he wants to do his orders, he has to go to the work—which they were doing in a work room. He has to log onto the

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computer. He has to select the patient. He has to go to the orders. He has, depending on how he has it set up, hopefully, it has been set up correctly and he has a favorites tab that says “returning patient” that he clicks on and he orders everything. Most physicians are creatures of habit. We all are. Our physicians are so specialized that they’re seeing breast cancer patients. They probably order, probably ninety percent of the time or more, the same tests on a breast cancer patient that is of a certain status—A post-op patient or a post-chemo. They are ordering primarily the same things. We have a function where it is set up where all those tests are already pre-selected for them. Click, signs it, and he’s done. It’s different. It’s a different way to work, so getting people to learn to do that. “The computer is slow. I can’t get a computer. I can’t find my tests. That’s not the way I—.”

*Tacey Ann Rosolowski, PhD*

**01:12:46**

Well, I’ve noticed myself going to the doctor when there is a computer present, part of your conversation with the physician becomes about what the computer is doing. Like, “Oh, I can’t find this. Hang on a minute.” Yeah, it’s interesting.

*Deborah Houston*

**01:12:59**

Yeah.

*Tacey Ann Rosolowski, PhD*

**01:13:03**

It’s like a presence as the person is learning how to navigate it.

*Deborah Houston*

**01:13:03**

Right. So, that’s it. They’re busy, and they’re used to stacking all that up and doing it at the end of the day, which they can still do it at the end of the day, but that’s not really helping anything. It’s just different work. It’s different work. We’re trying to make things as painless—I wouldn’t say easy—but painless for the providers as we can because they’re going to dump it all on the mid-level provider that’s just not helping anything. We get—we deal with—“Is this going to take me more time. Is this going to slow me down? You want me to do more.” When I go with staff to meetings to present things, I’m the one because I know a lot of these people because I’ve been here forever, and they know me. I’ve worked with a lot of them in my various jobs when I was in nursing. They are not yelling at me but, you know, telling me. I’m like, “I understand. We’re going to try to make it work for you.” I think it helps because they know I know the work they do. I can’t always make it better for them, but we try. That’s what we’re trying to do as we roll out functionality now is make the system work and show them the end result. The orders are going to get to the pharmacy faster. When you’re in the hospital, you’re going to get things quicker. “But you’re making me do all the work—making the most expensive provider do the work up front.” That’s a very common thing we hear. The physician is the one that should get



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the alerts in the system when they're ordering things incorrectly.

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## **Chapter 12**

### **B: An Institutional Unit, Program**

#### *Information Systems as a Service Provider*

### **Story Codes**

*Tacey Ann Rosolowski, PhD*

**01:14:54**

Absolutely. Yeah. That makes sense. Yeah. I want to make sure that we are hitting everything. You mentioned that as you advanced through these different positions, some of them were simply re-naming the position you have already. I just want to make sure. You were the Director of Enterprise Applications from '99 to '05, and then there was a change to Director of Perioperative and Critical Care Informatics. What was that change like or was it really a name change?

*Deborah Houston*

**01:15:29**

It was probably a name change. What happened was—that was in 2005, is that when I put that?

*Tacey Ann Rosolowski, PhD*

**01:15:40**

Yes, 2005-06.

*Deborah Houston*

**01:15:41**

We had changed. I was in my new job. The Perioperative Enterprise for the Institution got developed. They consolidated people from the operating room, and there was a new Perioperative Enterprise. They wanted to have their own IT Department. It was like, “No. You’re not going to have your own IT Department.” We gave them a group of people, and they needed somebody to report to, so they came to me.

*Tacey Ann Rosolowski, PhD*

**01:16:14**

Why did they want that? Why did they want their own IT service?

*Deborah Houston*

**01:16:18**

Because the physician that was in charge of it was from surgery that has their own—parts of the institution has their own IT support groups. They wanted their own, so we showed them they didn’t need their own—that we could provide that. Lynn Vogel was the Chief Information Officer and was like, “No, we’re going to do that differently.” We met, and they needed to

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report to somebody, and I had no one reporting to me at the time. I knew those people, and I knew the position, so they reported to me.

***Tacey Ann Rosolowski, PhD***

**01:16:55**

I am just curious. Why is it that certain divisions within MD Anderson have their own IT system?

***Deborah Houston***

**01:17:01**

Not their own systems. It is mostly support (talking at once) staff. Well, some of them have their own because they actually have big systems, like Radiation/Oncology has a group. They support their systems, but like the Division of Surgery, the Division of Cancer Medicine, they have their own people. A lot of it has been over time because, potentially, Central IS have not been able to provide them the service that they wanted—that the physicians expected. A lot of it has been to provide that special service to physicians—the things that they want immediately. They want their own thing. They don't care what anybody else wants, you know. That has been allowed to occur. The institution as a whole now is sort of looking at that, and we are absorbing people back into Central IS. I think that will continue. We just brought in the Diagnostic Imaging people. We brought in the--the lab people are coming in—the Lab Department. We brought in the people—we have people in physical plant facilities. We had people in Human Resources. We have people in Finance. They've all been consolidated. The business side of the house has already been consolidated back into Central IS. We are now starting to bring in the clinical side of the house.

***Tacey Ann Rosolowski, PhD***

**01:18:24**

Is there an advantage that you see to that—of consolidating everything?

***Deborah Houston***

**01:18:28**

I think economy of scale standards. We go out to try to deploy something across the—we have automated tools that will send updates across the network. If they have the computers configured differently, which they do, it doesn't work. Then, you have to manually send—somebody has to go out and manually do it. They are using equipment that is not potentially—appropriate is probably is not the right word, but that may not have been approved for use within the institution. We don't know they're using it and all of a sudden everybody wants it and it is something that we're not ready to support. We get called about it, for example. Viruses can get into the network. That has happened. Just things like that.

***Tacey Ann Rosolowski, PhD***

**01:19:24**

Yeah. I mean, I was—yeah, I was just kind of curious.

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***Deborah Houston***

**01:19:24**

However, we need to be able to provide the support to those physicians who want a custom film reader attached to their reader because that's what they need for their specialty or they need help in incorporating images into their presentations or they need video of procedures put into—we need to be able to provide that service, if and when we absorb that from a department. That's going to be a challenge.

***Tacey Ann Rosolowski, PhD***

**01:20:02**

Why is that going to be a challenge?

***Deborah Houston***

**01:20:08**

I think it's going to be a challenge because it's going to be one-offs in some instances that will be seen as being hard to support. It'll take longer and longer and the physicians will get more and more unhappy. That's not what we want. We have to approach it that we are going to provide you service better than you had before.

***Tacey Ann Rosolowski, PhD***

**01:20:26**

Does the image work—the images and video—does that provide a particular challenge for some reason, or are there just special services in general that are a challenge?

***Deborah Houston***

**01:20:39**

I don't think that there's special services that are a challenge. No. The video is not a challenge. It is just a matter of how you do it and how accessible. Are they getting the right permissions for use of those videos? Have they got the patient's permission to video the surgery before they go showing it on the big screen at the ASCO meeting or the surgery conference or whatever? My assumption is yes, they have.

***Tacey Ann Rosolowski, PhD***

**01:21:14**

It can happen. Certainly, yeah.

***Deborah Houston***

**01:21:18**

The Periop—that was the job we were talking about. That was one of the jobs I had was specifically the director of that group, along with other stuff I did, so I called it out because it was a little different work.

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*Tacey Ann Rosolowski, PhD*

**01:21:35**

Sure. Was there anything else from that period that was—?

*Deborah Houston*

**01:21:38**

I think that's probably the main one.

*Tacey Ann Rosolowski, PhD*

**01:21:39**

The main one? So then in '09, am I reading this—oh, yes. So from 2005 to the present—am I reading that correctly? Okay. I see. I'm sorry. So from '05 to the present, you were also the Director of IS Clinical Operations and Projects.

*Deborah Houston*

**01:22:01**

Right, and that title changed. That's my current title, but originally I was the Area IS Director for Clinical Operations. We got rid of the area. It's the same job.

*Tacey Ann Rosolowski, PhD*

**01:22:18**

Okay. So, was there a responsibility change with that at all?

*Deborah Houston*

**01:22:21**

From?

*Tacey Ann Rosolowski, PhD*

**01:22:25**

How is the role that you serve now under that title different from the other directorship roles that you served, or is it pretty much the same?

*Deborah Houston*

**01:22:37**

Well, when I left being the director of MIS and, basically, have been doing what I am doing now—pretty much the same—with some addition/subtractions of activities. I initially started working primarily with the project work—the clinical projects, trying to get people funding and get a handle on that. Over time, I have absorbed different kinds of things, like the Perioperative Group for a while and, now, they're in another area. I have reporting to me now the Institutional Bar Code for Patient Safety Project where we're—going to be implementing bar coding for medication administration and specimen collection—that kind of thing—reports to me.

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*Tacey Ann Rosolowski, PhD*

**01:23:28**

Could you talk a little bit about that? How exactly does that work—the bar coding?

*Deborah Houston*

**01:23:36**

How is it going to work?

*Tacey Ann Rosolowski, PhD*

**01:23:37**

Yeah, I'm just curious because I was talking, I think it was Janet Bruner [Oral History Interview] that was talking about how everything in Pathology is bar coded—

*Deborah Houston*

**01:23:48**

Right, today. Today. They already have a lot of bar coding (talking at once).

*Tacey Ann Rosolowski, PhD*

**01:23:50**

I wondering if that is a similar kind of thing that you're going to be working with—that you're trying institute.

*Deborah Houston*

**01:23:56**

Kind of, but what we're going to do is on the front-end. They are working on it—they have the bar coding—they've got the specimen and they are processing it in the lab.

*Tacey Ann Rosolowski, PhD*

**01:24:02**

Right.

*Deborah Houston*

**01:24:03**

What we're doing is when you are a patient and you walk into the hospital, you're going to have an arm band put on you, regardless of what you're here for, that has your name and bar codes on it. So when you go to the lab—to the diagnostic center—if that's the first thing you go in the hospital or when you come into the clinic or if you go in as an inpatient. The first place you visit, they are going to put an arm band on you. Most people, that's the lab or x-ray. When you do that—when they scan that—they are going to verify who you are. You're Tacey. Here's your name. You're going to verify that. They're going to slap it on you. ClinicStation has your picture

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because we have your picture in there. We are going to know that's you. We'll slap that arm band—slap it—attach the arm band to you—the wrist band to you—

***Tacey Ann Rosolowski, PhD***

**01:24:53**

Gently apply—

***Deborah Houston***

**01:24:54**

Yes, gently, gently apply, and then when you go to have your lab drawn, the technician is going to scan the bar code. She's going to know that's you. She's going to scan her badge. It's going to say she's drawn the blood. She is going to draw the blood. No—yeah. She's going to do that. When she scans that, it is going to print the labels that you have ordered for the day on a little thing—well, in the clinic it'll probably be a little machine, but if you're in the hospital, she'll have one of those little things like the Avis guy—print out your labels. She is going to draw your blood, put the label on the blood before she leaves the room, so we know your blood has your name on it and it goes to the lab. Then, it processes through the bar coding within the lab. It's not she brings your blood out and puts it here and she's got my blood over here and misses—mixes them up.

***Tacey Ann Rosolowski, PhD***

**01:25:51**

Right.

***Deborah Houston***

**01:25:57**

When you're getting a medication, we are going to scan your bar code, scan mine as the nurse. It is going to bring it up in the computer that you have these four medicines to be given. I am going to have the medicine here. I am going to scan the package and it's going to tell me, yes, that's the right medicine at the right time—at the right dose and everything. I'm going to give it to you, or it's going to scan the pump, the bag of IV solution, and the pump that you're going to put it on, and it's going to program the pump to administer it correctly. It's then going to turn around and document in the chart that you've got the drug at the right time.

***Tacey Ann Rosolowski, PhD***

**01:26:40**

I was just going to ask because it would be linked with ClinicStation (talking at once).

***Deborah Houston***

**01:26:43**

Right. It will be in ClinicStation. We are using a commercial product from Cerner Corporation—Cerner Bridge is the name of the product that's a bar coding system. We will be using it for

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specimens, for medication administration, and for blood administration. That's—we're in the process. We've selected the vendor. We're in the process of finalizing that.

***Tacey Ann Rosolowski, PhD***

**01:27:13**

Wow.

***Deborah Houston***

**01:27:13**

So, part of the project is getting the equipment that we need in every patient room, so those computer arms and all that will have to be installed in every patient room. Scanners, the equipment for the lab techs—

***Tacey Ann Rosolowski, PhD***

**01:27:31**

Training.

***Deborah Houston***

**01:27:34**

Training, yeah. Patient education, as well as staff education, because patients need to understand what we're doing.

***Tacey Ann Rosolowski, PhD***

**01:27:39**

Making sure you tell people not to just look at the bar coding—look in their eyes once in a while.

***Deborah Houston***

**01:27:44**

And to know that you're scanning the bar code on you, so it's got some—called check digits—some special prefixes on the bar code, so I know you're scanning an arm band—wristband—and not a label you've put over here on another piece of paper.

***Tacey Ann Rosolowski, PhD***

**01:28:02**

Interesting.

***Deborah Houston***

**01:28:03**

Nurses can think of all kinds of work-arounds. Then that project—that's the commercial product side. The fourth arm of that is a home-grown thing we're developing for Pathology for specimens from the operating room. It's not blood. You've done a biopsy in the clinic. You've



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got a piece of tumor from surgery or whatever—it's going to do that, as well. Same thing. Bar coding.

*Tacey Ann Rosolowski, PhD*

**01:28:34**

Wow.

*Deborah Houston*

**01:28:34**

Medicines will be administered, for example, using bar coding wherever we give medicines in the institution.

*Tacey Ann Rosolowski, PhD*

**01:28:42**

I see why you call it Institutional Bar Code for Patient Safety.

*Deborah Houston*

**01:28:47**

Yeah. It's a big initiative. We've been working on it for a while.

*Tacey Ann Rosolowski, PhD*

**01:28:52**

How many years?

*Deborah Houston*

**01:28:54**

A couple. (talking at once) It's going to take another couple of years to be fully rolled out.

*Tacey Ann Rosolowski, PhD*

**01:29:02**

What other projects are you working on right now?

*Deborah Houston*

**01:29:06**

Well, EMR development because part of that department now reports to me in my general job, that kind of thing. The project managers and the business analysts and the support deployment group report to me. It's the people that have the customer facing part of the EMR, not the developers and programmers in the back and the testing people. It's the people that are out there with the users.

*Tacey Ann Rosolowski, PhD*

**01:29:41**

What are you hearing from them?

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***Deborah Houston***

**01:29:43**

When is it coming? When are we going to have more functionality? Why does it work like this? I don't like it. Positives and negatives. Those are the main things. A new—recently, the Diagnostic Imaging IT group now report to me. They are working on an upgrade to the Radiology Information System. Then, I have 4 other people that report to me that are sort of like department liaisons or division liaisons for IT that kind of do what I do for the clinical—whole clinical area—they do for a particular group. I have one that works with Diagnostic Imaging. I have one that works with the Regional Care centers. I have one that works with Global Oncology, and one that works with primarily the outpatient/ambulatory operations areas. They have been very helpful, because I don't have to worry about Diagnostic Imaging, because I know that Mike [Adams] is going to tell me when they have issues or when they need things or I can have him follow up on it. I don't have to do it.

***Tacey Ann Rosolowski, PhD***

**01:30:56**

And Mike's last name is?

***Deborah Houston***

**01:30:56**

Adams.

***Tacey Ann Rosolowski, PhD***

**01:30:59**

With the Radiology upgrade, what is that involving exactly?

***Deborah Houston***

**01:31:04**

The software that runs our Radiology Information System is being upgraded to a new version, so it's software installation and data conversion over into that.

***Tacey Ann Rosolowski, PhD***

**01:31:19**

What is the new upgrade allowing?

***Deborah Houston***

**01:31:22**

It's pretty much the same functionality. It is just fixing some things—a new version of software. Software vendors will have products and they do upgrades, some of them every six months, some of them once a year or whatever. At some point, they quit supporting the old versions. This is kind of like we have to move to the new version because what we're on—we haven't upgraded for a while, so what they're on.

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*Tacey Ann Rosolowski, PhD*

**01:31:51**

So it's kind of more of a maintenance thing?

*Deborah Houston*

**01:31:53**

It is, yeah. It's going to take some work, but it's not like they're going to use something that they're not used to using. It's going to have a little bit different look, but it is basically the same functionality they've currently got, and that group has had an IS system for several—many years.

*Tacey Ann Rosolowski, PhD*

**01:32:11**

So they're accustomed to it.

*Deborah Houston*

**01:32:11**

Yeah.

*Tacey Ann Rosolowski, PhD*

**01:32:13**

Anything else that you have ongoing or anything that you are planning that you would like to take on?

*Deborah Houston*

**01:32:22**

My goal—and people laugh at me when I say this. My goal is by the time I retire that I want to see that we have computerized physician order entry and nursing documentation rolled out to the institution. That's my personal goal, and bar coding—the bar coding project finished.

*Tacey Ann Rosolowski, PhD*

**01:32:48**

Why are those your priorities?

*Deborah Houston*

**01:32:51**

Because I think they're key to the institution. I think they're all key to patient safety and staff productivity. It's going to benefit everybody. They're tangible. They are things that I think we can achieve. My staff know that's my goal, and I tell them that regularly. That we're—I am trying to get there. The next three to four years I want those to be done. Then, I can leave, well, I could leave today. I can leave—retire—knowing I feel like I have accomplished something significant for the institution. It is not that I did it, but I helped get it accomplished.

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*Tacey Ann Rosolowski, PhD*

**01:33:38**

Sure. Now looking back here, before you have achieved those goals, what are some things that you've worked on that you are really content with—pleased that you go that done?

*Deborah Houston*

**01:33:52**

Oh, gosh. I think the—well, within IT, you mean or in general?

*Tacey Ann Rosolowski, PhD*

**01:33:58**

Both.

*Deborah Houston*

**01:33:58**

I think the lab—the lab that we started for the hematology patients was a big one. That took a lot of planning—the lab supervisor that worked with me on that. That was a big win.

*Tacey Ann Rosolowski, PhD*

**01:34:16**

What did that do for the institution in your opinion?

*Deborah Houston*

**01:34:18**

Well, I think it decompressed the patients in the Diagnostic Center and got lab drawn and results back on those Hematology patients faster. That was good. That's probably—I think the success of the Perioperative IS Group that we set up and that continues today was a good—a good win.

*Tacey Ann Rosolowski, PhD*

**01:34:47**

Uh-hunh (affirmative). What were some tangible results from that?

*Deborah Houston*

**01:34:55**

I think improved satisfaction of the staff. Consistent desktop—the computers work. There are consistent processes for making sure every day that they're working and that if one breaks, they get it fixed right away or replaced, that kind of thing. Oh, gosh. I don't know. I leave everyday feeling like I've done something. It's hard to—but I know there's a pile left here for me to do when I come back tomorrow.

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*Tacey Ann Rosolowski, PhD*

**01:35:32**

That's not bad—to leave everyday feeling you've done something.

*Deborah Houston*

**01:35:34**

Some days I felt like I've sat in meetings all day, which is most of the days, but I feel like—I like to feel like I've contributed something every day.

*Tacey Ann Rosolowski, PhD*

**01:35:50**

In your view, how quick has MD Anderson been to be experimental with IT and—?

*Deborah Houston*

**01:35:57**

They're very quick to be experimental. They're very quick to want to, again, have the best, newest, greatest, biggest, fastest, strongest—whatever. Once they get it, will they use it? Is it really what they wanted to start with? That's kind of—I think, yes, they are ready to—everybody says they're ready for it. When it comes down to using it is the other part. It's the adoption of the technology, which is the struggle for us.

*Tacey Ann Rosolowski, PhD*

**01:36:47**

I think it's a struggle for everybody—yeah, particularly when people are pressed for time.

*Deborah Houston*

**01:36:50**

And, pressed to do more and make more and—that's what I hear from the faculty, you know.

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## **Chapter 13**

### **B: Institutional Change**

#### ***Perspectives on Changes at MD Anderson Culture and Contributions to the Institution***

#### **Story Codes**

B: Growth and/or Change

B: MD Anderson Culture

A: Career and Accomplishments

A: Personal Background

A: The Administrator

***Tacey Ann Rosolowski, PhD***

**01:36:55**

What kind of change—you talked yesterday a bit about how the institution today is very different from what it was. How do you see that—I think you were talking really from the perspective of the nursing part of your career then? How do you see that from the perspective of your IT career—that change in the institution?

***Deborah Houston***

**01:37:21**

Well, I think the institution is so large now. It's just—it's just huge. You didn't know—you can never know everybody. You could know, when I was in nursing, you knew almost everybody that worked, at least, the shift that you worked because you saw them. You knew who to call or who you could call for what and where your resources were. Today, there are lots of key people you know, but you just don't know people. I guess the personal interaction with people isn't like it used to be. I think IT has helped that because—helped make that the reality. People don't talk to people anymore. They email each other. They instant message each other. We laugh about there's the three email rule. If you're going back and forth and you can't the question answered, stop, pick up the phone, or get up and go talk to the person. People aren't talking to the person in their next cubicle or office. They're emailing. I think—it's like what did we do before that. You called them on the phone or you went and met with them or whatever. I think that is something that IT—technology—has perpetuated. We have lost some of that interpersonal. Yes, people can yell at each other over the email. That's, I think, something that we have perpetuated. Then, I just think the facility, the campus—the spreading out of the facility. I mean, look how far you have to walk to go from---think of our patients. If you happen to park in garage ten because you started out the morning getting a lab test in the Diagnostic Center and some x-ray on that side of that building, and we've scheduled you to have something else over in the Ambulatory Clinic building. Yes, we have, carts, but that's a lot of walking and movement of people and staff. You can spend a day walking between A, C, B in the Faculty Center and the main campus, much less the main hospital. The one MC, administrative building, here at the bank building. There are

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days that I have meetings in all three buildings. It's like I don't know where I left my car at the end of the day. Yes, we have shuttles, but you waste a lot of time.

***Tacey Ann Rosolowski, PhD***

**01:40:29**

Do you think there's a point where MD Anderson can become too big? This kind of goes also to the remote care centers and sister institutions. Do you think it can become too big?

***Deborah Houston***

**01:40:44**

I don't know. That's probably heretical to say that it could become too big, because that's the goal—we want to take care of patients with cancer in the whole world. So, no, I don't think it can get too big. I think the Regional Care Center concept is almost going back to the MD Anderson of old. What we don't have there is the inpatient component of that, but the clinics were you have staff—a smaller group of staff that are working together much more closely.

***Tacey Ann Rosolowski, PhD***

**01:41:22**

What do you think are the challenges of maintaining quality—the MD Anderson brand, if you will, in regional care centers?

***Deborah Houston***

**01:41:34**

Well, I don't think it's the regional care centers that are the issue with that because they're using the same applications, the same—they use ClinicStation just like the clinic here does. It's the exact same systems, the same pharmacy, the same pharmacy system. I think—they go through the same committee process to get orders approved and things like that. I don't think our regional care centers, as we know them here in Houston, is the issue. I think where the struggle with quality and that's what the physicians network group and the global oncology people who work with our sister institutions in Phoenix or in Istanbul or Albuquerque—wherever they're being planned for—and our physicians who are saying they are MD Anderson affiliates or whatever the term is they use out in the community. Are they practicing the way we do? That's something that they measure. I think that would be a struggle. My assumption is the quality is good because I don't hear—I wouldn't hear, but you know. I think that's hard—how do they manage that?

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***Tacey Ann Rosolowski, PhD***

**01:43:06**

In addition to the goals that you have listed that you would like to achieve before you leave—

***Deborah Houston***

**01:43:16**

And win the lottery so I can cruise around the world and all those kind of things, yeah—marry a millionaire—billionaire.

***Tacey Ann Rosolowski, PhD***

**01:43:23**

Yeah, the essentials for retirement. Is there anything else that you really want to do before you leave?

***Deborah Houston***

**01:43:36**

Find somebody to replace me. We need to make a decision on that in the next couple of years. If it is to replace this position, we need to find the right person and, then, get that person here who can suck my brain and follow me around for six months or whatever to learn.

***Tacey Ann Rosolowski, PhD***

**01:43:57**

Right, and get into your networks.

***Deborah Houston***

**01:44:01**

Yeah, yeah. I mean, that's really—we need to figure out a plan for that.

***Tacey Ann Rosolowski, PhD***

**01:44:11**

With all the people that you've worked with and kind of given them a taste of your facilitation skills and leadership skills, what do you hope the people you leave behind will carry on of what you've left?

***Deborah Houston***

**01:44:28**

I hope they foster the—everybody has worth, everybody has something to contribute, everybody needs to be listened to, and everybody should be treated with respect, regardless if you're the nighttime support analyst or you're the director of the department. Everybody needs to listen to what you have to say and go forward.



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***Tacey Ann Rosolowski, PhD***

**01:45:06**

Why is that so important to you?

***Deborah Houston***

**01:45:08**

Because everybody needs to feel valued. If you don't feel valued, you don't like what you do, and you don't enjoy your job. Everybody needs to enjoy what they do. We spend too much time at work not to like what you do. If you're miserable with what you do, you don't do a good job. I have tried to impart that on my employees and the managers that I work with is if you aren't happy or if your staff aren't happy, let's figure out how to make them happy. If they're not happy, if they hate what they do, let's help them find something to do that they like to do to be successful. Everybody should feel successful in their work, whether it's taking care of patients, whether it's programming a computer, whether it's sitting with a physician listening to him complain about the stuff you just built—whatever it is—you need to feel satisfaction and feel like you contribute something.

***Tacey Ann Rosolowski, PhD***

**01:46:03**

I had a few additional questions I wanted to ask you that were kind of a little bit more about private life, but before I go on to that, is there anything more that you wanted to say about your work life at MD Anderson?

***Deborah Houston***

**01:46:16**

No. It's been a good career. It's been a very good career.

***Tacey Ann Rosolowski, PhD***

**01:46:18**

Yeah, yeah. What do you feel—maybe it's a funny question—what do you feel MD Anderson has given you? You've given a lot of your life to MD Anderson. What is it—?

***Deborah Houston***

**01:46:30**

Gray hair? My hair dresser knows how much gray hair I have. I think it has given me a lot of success. I have had a lot of great opportunities from working at MD Anderson, so I appreciate that. A lot of friends. A lot of memories. It's been a good place to work.

***Tacey Ann Rosolowski, PhD***

**01:46:56**

What do you do in your private life when you need to decompress?

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***Deborah Houston***

**01:47:00**

Oh, that's funny. I love to travel. I have dogs that are my children. I read. I do needlework. I try to do things instead of just sitting watching television. I spend a lot of time with family. It's good.

***Tacey Ann Rosolowski, PhD***

**01:47:20**

Among the friends that you have, are your friends pretty much from MD Anderson?

***Deborah Houston***

**01:47:26**

A lot of them are. A lot of them are. Friends that I had years ago that have moved that we've kept up with. My best friend is a nurse. I have lots of best friends, but she worked here for twenty years and then moved back home to take care of her family—her parents. We still travel together and do things. Yeah, and I have friends, lifelong friends, from my husband that—his best friend and his family—I still see regularly. People from his work that I am very close with. Yeah, lots of friends, neighbors.

***Tacey Ann Rosolowski, PhD***

**01:48:04**

Is there a particular place that is really important to you?

***Deborah Houston***

**01:48:11**

Like to travel to?

***Tacey Ann Rosolowski, PhD***

**01:48:12**

Yeah, you know, some place that you feel really a kinship with?

***Deborah Houston***

**01:48:18**

A cruise ship—sitting on the deck of any cruise ship watching the world go by. That's why I want to win the lottery. People laugh at me and say, "Oh, you would never do that." It's like, "If I won the lottery and won millions and millions of dollars, I would quit tomorrow, and I would go get on a world cruise on some cruise ship and just sit there and watch the world go by for 160 days or whatever it is." I would love that.

***Tacey Ann Rosolowski, PhD***

**01:48:46**

Watching the world go by means just—

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*Deborah Houston*

**01:48:50**

Just doing nothing. Reading. Sleeping. Just enjoying life.

*Tacey Ann Rosolowski, PhD*

**01:48:58**

That's a good goal.

*Deborah Houston*

**01:49:00**

That's my goal.

*Tacey Ann Rosolowski, PhD*

**01:49:01**

That's a good goal.

*Deborah Houston*

**01:49:01**

I don't think it'll ever happen, so I go on lots of cruises. I go on at least one—that's the joke—standard joke around here. When I go on vacation, "Where are you cruising to now?" I love to cruise. My husband loved to cruise, so we enjoy that.

*Tacey Ann Rosolowski, PhD*

**01:49:20**

That's great. So that's something you really enjoyed doing together? That's wonderful.

*Deborah Houston*

**01:49:22**

Yeah. So, my next cruise is in October. We're going to the Panama Canal for two weeks with my niece and my best friend. So, it'll be good. We'll have a good time.

*Tacey Ann Rosolowski, PhD*

**01:49:32**

Is there anything else that you would like to add at this point?

*Deborah Houston*

**01:49:35**

No. Thank you for the opportunity.

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*Tacey Ann Rosolowski, PhD*

**01:49:40**

Well, it was really a pleasure talking to you. It was really interesting. It's about quarter of four and I'm turning off the recorder.

*Deborah Houston*

**01:49:44**

Very good.

**01:49:46** (End of Audio Session Two)