

National Burden Reduction Collaborative

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Chair, Association of Medical Directors of Information Systems



Let me tell you a story

- AMDIS 2021 and AMIA-Thank you Natalie!
- Early 2022: Tanya Tolpegin
- Well, why don't you?
- HIMSS 2022: Vimal Mishra
- The Challenge
- Wait, the said what?
- Two (2) days in November → 5 Projects
- Add a 6th

NBRC Pacesetters

- The Association of Medical Directors of Information Systems (AMDIS)
- The American Medical Informatics Association (AMIA)
- The American Medical Association (AMA) - Participant
- The Alliance for Nursing Informatics (ANI)

Participating Organizations

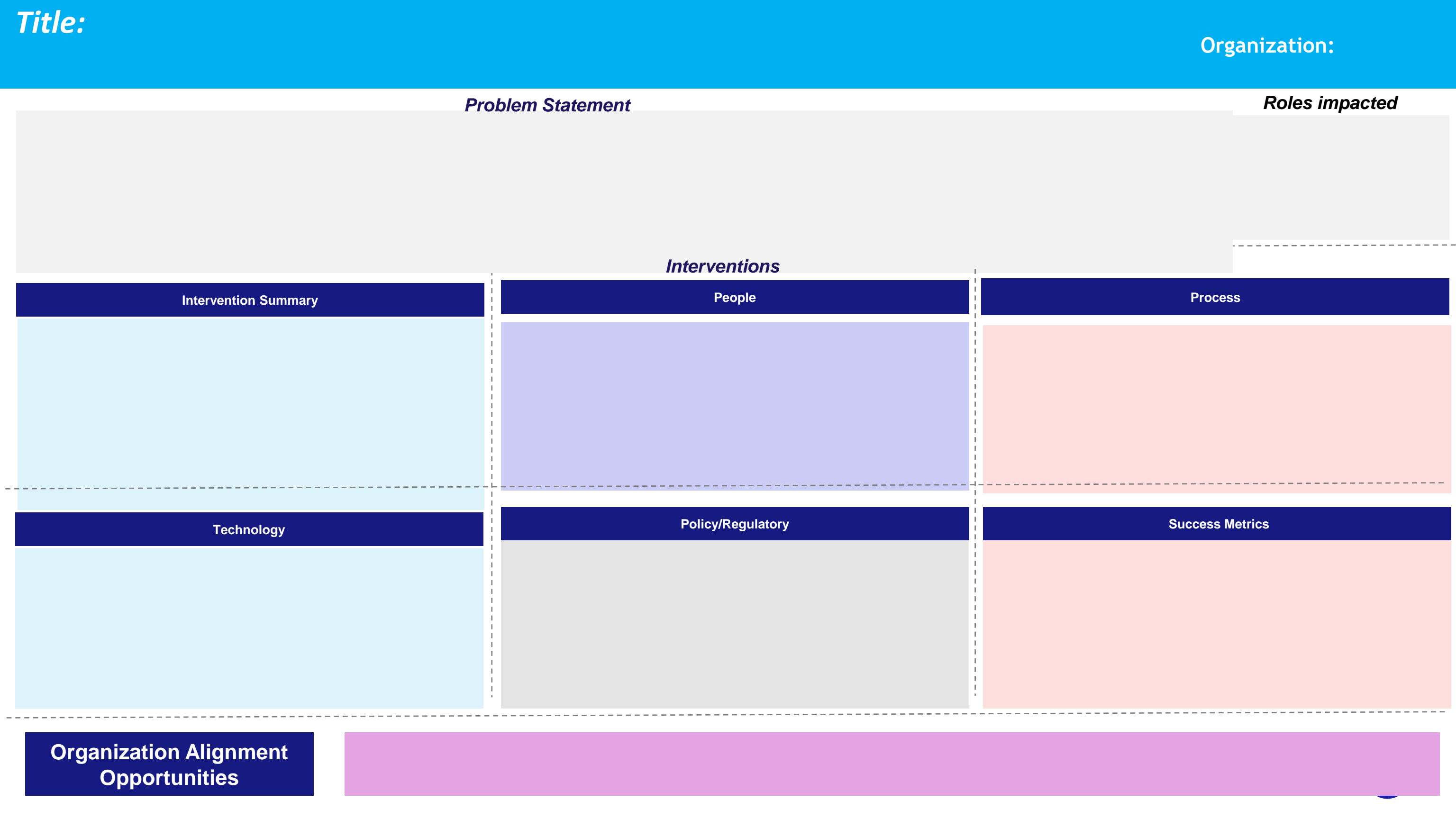
- American College of Medical Informatics (ACMI)
- Arch Collaborative
- Center for Medicare & Medicaid Innovation (CMMI)
- CMS Office of Burden Reduction and Health Informatics (OBRHI)
- DaVinci Project
- Electronic Health Records Associations (EHRA)
- Healthcare Information Systems Society (HIMSS) Physician Community
- Healthcare Information Systems Society (HIMSS) Nursing Community
- HL7
- National Library of Medicine (NLM)
- Office of the National Coordinator (ONC)
- Office of the Surgeon General (OSG)

National Burden Reduction Collaborative Meeting

November 2022 at the AMIA meeting
Washington, DC

Pacesetters





Problem Statement

Clinician burden has been related to burnout, and a significant contributing factor has been related to the electronic health record. While other factors have also been considered as potential causes, or at least contributory to burden, the EHR and its design and use remain significantly involved. Since EHR vendors initially required each hospital or system to create its own user interfaces, often multiple end user experiences were found even within the same health system. There has been a substantial movement to consolidate these interfaces, and standardize them rather than facilitate usability. At preliminary meetings between the HIMSS Physician Committee and the EHRA, a number of issues were discussed as potential issues to address, however after further discussion at the joint meetings one overarching concern was that of the flexibility of the EHR. A series of “As Is” brainstorming sessions with the joint membership were conducted and a number of considerations were entertained. Each of the issues of “flexibility” that were identified represented a vast domain to explore. A series of Blog posts were drawn up to flesh out these issues and to identify potential paths forward. Four specific areas where additional flexibility were felt to be of benefit are listed below in the Intervention summary frame.

Roles impacted

- Physicians
- Nurses
- Health system administrators
- IT professionals
- EHR software developers
- AI developers

- References: Blog posts: <https://www.himss.org/resources/2022-clinical-workflow-flexibility-challenges-ehr-defining-problem-part-one>
- <https://www.himss.org/resources/2022-clinical-workflow-flexibility-challenges-ehr-defining-problem-part-two>
- <https://www.himss.org/resources/2022-clinical-workflow-flexibility-challenges-ehr-defining-problem-part-three>

Interventions

Intervention Summary	People	Process
<ul style="list-style-type: none"> • Flexibility in training for the EHR: learning how to use the EHR should become as easy to do as learning to write a written progress note. The ability of a clinician to learn its use should be adaptable to both the individual’s style of learning as well as their cognitive style and how they will use the technology in their practice • Flexibility in personalizing the EHR for individual use: not every user will work or write a note the same way. • Flexibility in understanding the patient’s story (narrative and pertinent information): reviewing data and reading the story should be as easy and intuitive as having a verbal communication from another provider • Flexibility in providing care- workflows have been shown to be erratic and poorly defined despite attempts to standardize them for the 	<ul style="list-style-type: none"> • Physicians (Specifically front line end users) • Nurses (same as above) • EHR software developers • Health system administrators • IT professionals • Regulators (If mandates or guidelines are necessary) 	<ul style="list-style-type: none"> • Communication • Technology • Human-computer interaction design • User experience and user interface design • Workflow analysis (real world implications) • Interface level design specification
Technology	Policy/Regulatory	Success Metrics
<ul style="list-style-type: none"> • EHR: human factors and safety engineering • EHR: integration into clinical workflow • EHR software development: usability testing systems and processes • EHR certification processes and tools • Communication tools: more rapid and robust communication of usability issues from users to developers and more rapid response 	<p>While some regulatory work has been done to minimize documentation requirements within EHRs, additional work may be necessary. If user interface/usability issues become prominent in potential solutions, policy actions might become important in facilitating the development of the those solutions.</p> <p>Establish a national public usability/safety best practice database</p> <p>Work with EHR software developers to improve user-centered design processes</p> <ul style="list-style-type: none"> • Robust UCD departments which include both experienced clinicians and experts with specific training in user experience design and measurement • More influence of UCD recommendations on development pathways and checkpoints 	<ul style="list-style-type: none"> • Definition of what constitutes the optimal information necessary for the communication which is the purpose of a progress note. • Development of potential use of technology (AI for example) in order to facilitate inclusion of appropriate information while reducing need for active user interactions. • Utilizing known human factor engineering concepts to determine how to create flexibility (Putting guardrails on the cow path rather than paving the cow path) • Creation of crowdsourced libraries of optimal flexible solutions. • Enlistment of stakeholders to develop usable means of creating such notes • Development of metrics for evaluating end user satisfaction and burden reduction. • Identification of financial facilitation for development of these improvements

Organization Alignment Opportunities

- Continue work with EHRA and HIMSS Physician Committees (and Nursing Comm) to develop more flexible interfaces using verifiable UCD processes including end user evaluation and testing
- Work with AMIA, AMDIS, AMA, HL7 and other organizations to facilitate these and other EHR challenges
- Work with health system administrators to arrange financial support (if needed for EHR redesign) as well as for protected time for front line clinicians to participate in usability testing
- Work with Federal partners (e.g. ONC, CMS) to develop new usability-related EHR certification processes and criteria

NBRC Identified Priorities

1. Definition of Burden
2. Training, support, communication, Change Management
3. Streamlined Provider note
4. Reducing Clinician documentation beyond notes
5. Electronic Prior Authorization
6. Patient generated messages

- Project 1: Definition and Measurement of Burden (AMIA)
- Project 2: Streamlined Provider Note (AMIA)
- Project 3: Reducing Health Professionals Documentation beyond Notes (AMIA/ANI)
- Project 4: Training, Support, Communication: Change Management (AMDIS)
- Project 5: Electronic Prior Auth (HL7)
- *Project 6: Inbasket: Patient Generated Messages, e-Visits, and other opportunities (AMDIS)

Project 1: Definition and Measurement of Burden

- AMIA: 25 x 5 program
- Define Documentation Burden
- Refinement and Dissemination of the Logic Model
- Planning:
 - Administration of a national survey on perceived documentation burden
 - Survey hospitals regarding inclusion of documentation burden is strategic plan
- Collaboration opportunities
 - Anyone measuring burden, burnout, wellness, retention
 - TJC as disseminator

Project 2: Streamlined Provider Note

- Policy/Advocacy workstream
 - Regulatory impacts
- Vendor Workstream
 - Education on existing functionality
 - Documentation tools: EHR and Add-ons
 - Incentivize knowledge sharing
- Provider Workstreams
 - Toolkits and education
- Collaboration opportunities
 - Provider organization successes
 - E&M, Note Bloat success, Tool implementation, time reduction, etc.
 - Utilize measurement (Project 1)

Project 3: Reducing Health Professionals Documentation beyond Notes

- Policy/Advocacy workstream
 - Evaluation of existing efforts
 - Reduction/elimination of Prior Authorization
- Vendor Workstream
 - Develop education/best practices aligned to reduce burden
 - Develop HIT Roadmap to reduce burden
 - Engage and incentivize knowledge sharing
- System Workstreams
 - Environmental scan of existing efforts
 - Develop toolkit to guide organization through documentation burden reduction
 - Foster inter-institution coordination
- Collaboration opportunities
 - Sharing of the current 25 x 5 Documentation Burden reduction toolkit
 - Provide input on HIT roadmaps

Project 4: Training, Support, Communication: Change Management

- Policy/Advocacy workstream
 - Opportunities to support education akin to CME
- Vendor Workstream
 - Leverage Arch Collaborative data
 - Education on existing functionality
- Provider Workstreams
 - Identify best practices leveraging education to improve effectiveness and efficiency
 - E.g.: Workflow based, Specialty-specific Trainer, Duration, Initial/Optimization
 - Identify best practices around Technology support
 - Roles, education, delivery mechanism,
- Collaboration opportunities
 - KLAS
 - Healthcare Provider organizations
 - HIT Organizations (HIMSS, AMIA)
 - CMS/ONC

Project 5: Electronic Prior Auth

- Status: Pilot in process
- Policy/Advocacy workstream
 - Public comments on rule making
 - APIs: Patient Access, Provider access, Provider Directory, ePA
 - Standardization/Interoperability
- Vendor Workstream
 - API development
 - Clinical Data exchange
 - Payers/covered plans
- Provider Workstreams
 - Alignment with needs for PA
 - Workflow/Data
 - Documentation needs (manual/automated)
 - Change management
- Collaboration opportunities
 - Provider organizations to expand in-process Pilot

Project 6: Inbasket: Patient Generated Messages, e-Visits, and other opportunities

- Policy/Advocacy workstream
 - Payment reform opportunities
- Vendor Workstream
 - Moving Patient engagement to Patient empowerment
 - Self-help, Education, Collaboration tools
- Provider Workstreams
 - Culture
 - Revenue decisions
 - “Disrupter” collaboration (Content, advice, Telemedicine)
- Collaboration opportunities
 - Healthcare Provider organizations and disruptive providers
 - HIT Organizations (HIMSS, AMIA)
 - CMS/ONC
 - Payers

What is AMDIS going to do

- **Training and Support to Reduce Burden**
 1. Ease ability to obtain CME for EHR training and support
 2. Training and support attestation for CMS incentive payments
 3. Leverage Arch Collaborative data to prove connection of Training/Support on burden reduction
 4. Identify best practices leveraging education to improve effectiveness and efficiency
 - E.g.: Workflow based, Specialty-specific Trainer, Duration, Initial/Optimization
 5. Identify best practices around Technology support
 - Roles, education, delivery mechanism,
- Collaboration with KLAS, HIMSS, AMIA,
 - Goal: NEJM level paper on # 3-5

What is AMDIS going to do

- Inbasket Burden Reduction
 - Payment reform opportunities (
 - Moving Patient engagement to Patient empowerment
 - Self-help, Education, Collaboration tools
 - Culture: Standard of Practice
 - Regulatory standardization
 - Payment standardization
 - “Disrupter” collaboration
 - Content, advice, Telemedicine
 - Generative AI
 - Treatment paradigm
 - Collaboration: Healthcare Provider organizations and disruptive providers, HIMSS, AMIA, CMS/ONC, Payers

How do provider organizations get involved?

We are setting up a “NBRC Community portal” to share documents, news and opportunities.

Please email me at:

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Subject: NBRC participation