Burden/Burnout – What Can WE DO? Discussion points follow...

- David Schlossman MD Presentation – Is There A Standards-Based Approach To Clinician Burnout?

(Slide 22...)

### Policies Allow Usability Burdens to Develop

<table>
<thead>
<tr>
<th>Usability Standards</th>
<th>ONC</th>
<th>FAA</th>
<th>FDA</th>
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<tbody>
<tr>
<td>Rigor of design process used</td>
<td>Required: Apply user-centered design process</td>
<td>Required: Apply human-centered design process</td>
<td>Required: Follow human factors considerations</td>
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<tr>
<td></td>
<td>Compliance: Attestation evaluated by CTB with no requirement for human factors expertise</td>
<td>Compliance: Data-supported internal evaluation including human factors experts</td>
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<tr>
<td>Availability of interface level design specifications</td>
<td>No interface level design specifications</td>
<td>Specific interface level design specifications applied across the industry</td>
<td>Interface level design specifications, some industry wide and some device-specific</td>
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<tr>
<td>Certification and evaluation of the final product</td>
<td>Summative testing not requiring representative end users or a realistic testing environment</td>
<td>Summative testing using representative end users in a realistic testing environment</td>
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</tbody>
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(Slide 23...)

### The Real Discussion Questions

- Is it possible to write a technical standard for user-centered design (UCD) that:
  - encompasses the extremely broad range of developers and systems that may be relevant
  - addresses the deficiencies in ONC’s current UCD standard
  - is not so prescriptive as to be immediately unacceptable to most EHR software developers?
- Would that contribute, even indirectly, to reducing burnout?
- What might the contents of such a standard look like?
  - Data supported internal evaluation and publication of UCD processes
  - Summative testing with representative end users (i.e., experienced clinicians)
  - Specified design level interface paradigms (e.g., Problem Oriented Health Record)
- What other approaches might HL7 take to make a contribution in this area?
- Would anyone be interested in leading or joining a team to work in this area?
• David: EHR System – User Centered Design
  o Cockpit w/virtual reality, simulations
  o Experienced Clinicians
  o Include Patients in UCD (~30% currently accessing their information via PHRs or portals)?

• Reed Gelzer MD: One of the challenges of current EHR design... is that they are not required to conform with longstanding US law with regard to how business records in general and medical records [in particular] are required to function under various circumstances, both scientific, clinical and also [as] business... records support requirements... and there is no entity to make sure that any of that conformance even exists as a baseline.

Compare with Generally Accepted Accounting Principles (GAAP) for managing financial records: [https://fasb.org/standards](https://fasb.org/standards)

• Andrea Borondy Kitts (borondy@msn.com): Are we aware of the US National Academy of Medicine – National Action Collaborative
  o Toolkit + Resource Compendium
  o [https://nam.edu/initiatives/clinician-resilience-and-well-being/](https://nam.edu/initiatives/clinician-resilience-and-well-being/)

• Barry Newman MD: National Burden Reduction Collaborative
  o Howard Landa MD: AMDIS, et al
  o HIMSS Physician Committee
  o HIMSS Nursing Informatics Committee
  o HIMSS Electronic Health Record Association (primarily EHR vendors)
  o HIMSS Burden Reduction Task Force

• Barry: Definition and effective measurement of burden
  o What part is EHR system related?

• Barry: KLAS Stats
  o EHR System Usability – no direct relationship with burden and burnout
  o More accurate correlation – 80% dissatisfaction with administrators

• Barry and others: HITECH Act Outcomes/Challenges
  o Movement away from private practice
  o Clinicians as employees
  o Disconnect between people who design, acquire, implement and use EHR/HIT systems
  o “The administrators have no skin in the game -- patients have the most skin in the game followed by clinicians”
  o Commercialization of healthcare – a major problem
• End-users key to getting it right
  o Can we change business case for EHR systems?

• How might we achieve real systemic change?
  o Involve clinicians from the outset
  o “Let’s focus on initiatives that ground their work on quantitatively measurable objectives that are research-based or based in existing/known requirements.”
  o Greta: “but what about all the regulations that have required all the clicks. case in point is the most recent requirement for the ’no waste’ code required for single-use medications--forces more new work for providers. One of our biggest roadblocks to offloading providers is ’compliance’.”

• Significant challenge of vast quantities of clinical information and clinical knowledge = cognitive burden
  o Lincoln: 7 step process, 6 can be automated

• Reed: “The triumph of CLIA for the purpose of interoperable lab data is a much-ignored pathway to measurable success.”

• Andrea: “CMS and other regulatory agencies are open to discussions on reducing regulatory burden, in fact CMS had an initiative to start that a few years ago, there is much opportunity to do more”

• Andrea: “Medicine is a risk averse discipline in general. Revolutionary change is unlikely, evolutionary change is happening but not as quickly as we need it to. AI is slowly being incorporated into clinical decision support starting in radiology”

• Lincoln Weed: As to the U. Colorado effort that I mentioned, see a new JAMIA Open article, “Problem-oriented documentation: design and widespread adoption of a novel toolkit in a commercial electronic health record” at https://academic.oup.com/jamiaopen/article-pdf/6/1/ooad005/49086795/ooad005.pdf

• Ken Barth: Therapy for burnout = POHR along with problem-knowledge coupler

• George Reigeluth: Consider AkéLex (Steve Datena MD)

• Actions
  o Awareness