**HL7 EHR Work Group – Reducing Clinician Burden Project**

Survey and Responses – August 2019

Survey Questions:

**1)    Do you think the project can be useful and accomplish at least some of its goals? If not, why not?**

**2)    Are there important RCB topic areas or literature resources we have missed?**

**3)    Are there additional RCB success stories or best practices we can highlight?**

**4)    Are there RCB-related software industry activities we should reference and engage with?**

**5)    Is there an RCB topic area you would be excited to work on?**

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**Frank Opelka MD,****Medical Director, American College of Surgeons, Quality and Health Policy**

I applaud all these efforts regarding burden, digital information systems and so forth.

It is difficult to respond simply to your efforts when the problem is so complicated. Our perspective, from the American College of Surgeons, begins with concerns that most burn-out recovery efforts are treatment the "symptoms." For example, EHRs are the symptom when the real issue is the totality of the digital information ecosystem inclusive of the Internet of Things is what is poorly architected. So, our efforts to fix the digital information systems around health care are less about the EHRs and more about building open-standards, patient centric clinical data models upon which anyone can build an API to suit their needs. We are considering proposals right now to launch an open-standards, patient centered clinical data model for just this purpose - and allow others as vendors to have the source code and duplicate the efforts to create scale. Upon this patient cloud, any and all could apply APIs.

Secondly, when we think about all the forces causing burnout, the common theme leads back to transforming healthcare. Several key factors are calling for this transformation - for example, FFS is tearing healthcare apart; also, the amount of knowledge to practice safe and excellent care now calls for AI, machine learning and more - simply because the amount of data and the algorithms in play exceed human capability. So, the concept of caring for a patient by a single physician only applies in very limited and acute conditions - such as acute pharyngitis. Getting beyond the simple conditions, most everything is team-based care.

When you examine the practice of medicine today under FFS - the care model, the business model, the payment models, the compensation models, the data models, the risk models.... all of these are complex models which were once suited for a cottage-industry that is now long gone. Care models are now very complex, longitudinal models with all sorts of data, complex pathways and alternatives and multi-disciplinary teams (not just physicians). And, the business models are now corporatized with how these care models are staffed, resourced, dashboarded, contracted to payment, etc. And the payment models are within ACOs, within bundles, within PCMH, etc... And the compensation models are RVUs - so get on your treadmill and churn, baby, churn.  ---  and all of this is just for one payer. Now add on the complexity of each payer doing it a little differently - and it is no wonder people are burning out. And I have not added in the compensation models, upside-downside risk and quality and cost metrics.

We are retooling an industry without a roadmap, without standards and with complexity like no other. Nothing could be more insane. And we wonder why UNC was highlighted for its failures in NYTs a few weeks ago? No one wants to fail, yet all we do is point out failures.

So, we are grabbing ahold of the various models, breaking them down one-by-one and building them back up. The work you have done on digital information is terrific and in line with our efforts. I am happy to discuss more - for now, we are steeped in this on behalf thesurgical patients. CMS has requested several briefings about our work. The CMS Chief of Staff asked for this [recently]. I have enclosed the deck which I shared with him. [Follow this link: <https://wiki.hl7.org/w/images/wiki.hl7.org/8/8b/ACS-CMS_Mango_v3.0-Opelka-201906.pdf>]

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**John Dalton MD, Chief Quality Officer, PhyMed Healthcare Group**

1) Do you think the project can be useful and accomplish at least some of its goals?

Certainly, but I think it will be difficult to accomplish incremental and meaningful change as an unfunded volunteer organization. If that is the case, collaboration with similar organizations would be key.

2) Are there important RCB topic areas or literature resources we have missed?

The 21st Century Cures Act provides a legislative platform and legal environment conducive to interoperability and true data liquidity. Rules surrounding enforcement of provisions, specifically the definition and enforcement of data blocking provisions have been proposed by the ONC and CMS. The EHR WG would likely benefit from an understanding of the potential impact on and opportunities for digital liquidity provided by the act, and may also be interested in coordinating political and lobbying efforts with other organizations currently involved in the discussion.

3) Are there additional RCB success stories or best practices we can highlight?

At this point in my career, I can enumerate more nightmares created by lack of interoperability and data liquidity between devices and medical software than I can relate success stories

4) Are there RCB-related software industry activities we should reference and engage with?

Personal financial information and the trusted data exchange platforms (SWIFT and FAST) that enable immediate domestic and international transactions from your personal device is a good example of an industry that has solved this problem. The cable industry also was able to collaboratively design and employ a trusted data exchange platform enabling the plug and play capabilities we now take for granted.

5) Is there an RCB topic area you would be excited to work on?

I’m passionate about eliminating Healthcare Acquired Conditions. Hippocrates admonition was "to abstain from doing harm", but current estimates are that there are around 400,000 premature deaths per year associated with preventable harm. The incidence of preventable harm requiring further (expensive) care is estimated to be 10 to 20x that number. (James J: A New, Evidence-based Estimate of Patient Harms Associated with Hospital Care Journal of Patient Safety Volume 9, Number 3, September 2013, pp 122-128). Lack of digital liquidity and true ownership and portability of PHI by the patient is a root cause (if not the root cause) of our inability to meaningfully improve these outcomes and eliminate HACs.

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**Michael Brody DPM, TLD Systems, HL7 EHR WG (Co-Chair)**

Reducing Physician Burden is a broad subject and the RCB project at HL7 has been a broad survey of the environment and the problems that lead to RCB.

To attempt to tackle the problem would be akin to boiling the Ocean. We are an ISO with a focus on interoperability. I believe the best next steps would be to review the body of work done so far, identify each of the problems that can be solved with standards that support interoperability and then develop those standards to fill the gap.

I would rule every aspect of the project that can not be (at least partially) solved by implementation of an IG across the industry out of scope for this group and move forward with that subset. In this manner we as a group can produce artifacts that would be useful in reducing at least some aspects of physician burden with the use of Health Information Technology.

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**Steve Hasley MD, CMIO, American College of Obstetricians and Gynecologists (ACOG)**

I'm so glad you are addressing this issue, and with such thoroughness and professionalism. And I echo Frank [Opelka’s] remarks, serious re-engineering is needed.

I will address your questions below. Please do not construe my thoughts as representing ACOG.

1) Do you think the project can be useful and accomplish at least some of its goals? If not, why not?

While I have not been following this closely, I would beware of scope creep. There are lot's of reasons for burnout, HIT burden is a contributor, but certainly not the only factor. I think focusing on what aspects of HIT are amenable to a technical solution, and defining those solutions, would be a good focus. Using care pathway models to identify points where automation could simplify tasks would be a great example of this.

2) Are there important RCB topic areas or literature resources we have missed?

Again, I'd think about shrinking your area of inquiry, rather than expanding it.

3) Are there additional RCB success stories or best practices we can highlight?

I would be happy to introduce you to the folks at Dorsata, a start-up that ACOG has been working with. Dorsata users seem very satisfied with that product, and it appears that they get out of the office (finish their documentation) much sooner with this app. I believe they can supply additional metrics of user satisfaction, as well as improvement in clinical Outcomes. David Fairbrothers <david@dorsata.com> is the CEO, I'm sure he would be happy to chat with you. Their approach turns 30 clicks into 1 click, by knowing what the "best path" is, so providers don't have to waste time searching for orders that represent the Standard of Care.

4) Are there RCB-related software industry activities we should reference and engage with?

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Core competency for clinical societies is to publish their Standards of Care in a format (BPM+ works for us) that is consumable by a digital platform. This provides the basis for software folks to build in efficiencies. ACOG has close to 100 of these models completed, I anticipate we will be done with Antenatal Care by end of this year.

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**Peter Goldschmidt MD DrPH DMS, World Development Group Inc**

Thank you for the subject update and [Frank Opelka’s] slide deck (which I found to be quite interesting). Also quite interesting were the responses to the survey that you shared. A significant issue is what one considers to be the scope of the problem, At its largest, it seems to be simply change (which is of course inevitable). Regardless, burden has many causes most of which are the context for the burden of HIT/EHR. As a corollary, the chances of reducing HIT/EHR burden are limited unless the context changes. As all commentators point out, the problem is very complex without a clear way forward. As the old saw goes: I didn't know where to start so that I didn't. On the other hand, if something can't go on forever, it will stop (and usually end badly). Good luck going forward.

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