SUPPORTING COMPREHENSIVE PRIMARY CARE IN ALBERTA

DECREASING ADMINISTRATIVE BURDEN

Written in collaboration by Alberta College of Family Physicians and Alberta Medical Association

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EXECUTIVE SUMMARY

The Administrative Burden Project assigned by Alberta Health (AH) to the Alberta College of Family Physicians (ACFP) and Alberta Medical Association (AMA) to co-lead, brought together health care professionals to address the challenges associated with administrative tasks in primary health care. The survey included 766 survey responses, with a balanced gender distribution (54.81% Female, 42.96% Male and 2.23% preferred not to say). Most respondents worked in private office/clinic settings (83.59%) and belonged to Primary Care Networks (PCNs) (92.21%). Practice locations varied, with 60.93% in Urban areas, 23.84% in Rural areas, and 13.82% in Rural-Urban settings.

The project team conducted three focus groups (21 individuals participated) and 14 key informant interviews which served to dig deeper into the root causes, patterns, trends, structures, systems that have contributed and solidified the unmanageable and unreasonable administrative burden that is experienced today in primary care, and we can assume, other parts of the health care system.

SURVEY FINDINGS

- ***Administrative time burden:***

Health care professionals spend an average of 15 to 20 hours per week on administrative tasks, significantly affecting their work-life balance and their ability to see patients. The respondents estimate that 40% of these tasks are unnecessary or could be done by others in the system. This translates into 3,458,000 hours (about 394 and a half years) of physician time spent on administrative tasks per year, most of it unpaid, and 1,383,200 hours (about 158 years) spent on tasks that are unnecessary or could be done by others.

- ***When administrative tasks are done:***

78.13% of respondents said administrative tasks are completed outside clinic time (evenings and/or weekends).

- ***Impacts on patient care:***

Administrative tasks have a significant impact on patient care, with 59.49% of respondents reporting limitations in the time they can spend with existing patients. To cope with the administrative burden, many health care professionals have reduced their patient slots (64.83%) and working hours (51%).

- ***Impacts on Physicians***

Administrative tasks have significant effects on physicians with 96% of respondents finding it is affecting their work-life balance, 97% of respondents finding it is limiting the enjoyment of work and 80.8% find the administrative burden has them looking at retirement and/or leaving the longitudinal care altogether.

KEY PROBLEM AREAS

The focus group sessions, interviews, and survey highlighted a few key problem areas, including challenges related to:

- Forms (Government, Alberta Blue Cross, Non-Insured Health Benefits (NIHB), insurance, program referrals in and outside of health system)
- Work Notes
- Referrals (Centralized referral systems, Facilitated Access to Specialized Treatment (FAST), clinical pathways, follow-up and re-referral)
- ConnectCare (Duplication of results, consults and discharge summaries, having two inboxes, continuous messaging, lack of integration into community care and PCN teams)
- System Integration: Multiple areas of silos of care

- Governance, health systems organizations and regulatory organizations requirements and processes

UNDERLYING INFLUENCES

Administrative burden is influenced by factors such as the need for various forms for basic care, scope creep, the erosion of social safety nets, and top-down bureaucratic direction. Difficulty in referral processes, the launch of ConnectCare, and governing and regulatory requirements are all contributing to the increased administrative burden.

KEY RECOMMENDATIONS

These findings underscore the urgent need to address administrative burdens in primary health care. They impact patient care, work hours, and the overall well-being of health care professionals. Effective solutions and system improvements are essential to alleviate this burden and ensure high-quality patient care.

The working group identified 16 key recommendations for immediate action:

1. Explore options to eliminate work absence notes required by employers.
2. Simplify Alberta Assured Income for the Severely Handicapped (AISH).
3. Allow most responsible and appropriate provider to fill AISH forms.
4. Explore appropriate payment models for physician/primary care provider (PCP) time to complete the AISH form.
5. Consider an opt-in program for common medications requiring special authorizations through Alberta Blue Cross.
6. Consider aligning the Alberta Health Services (AHS) formulary with Alberta Blue Cross preferred medications.
7. Align coverage of medication for common chronic conditions with current evidence based therapeutic guidelines.
8. Use newly approved nationally standardized and simplified short-term and long-term disability forms for third-party insurance and integrate into all electronic medical records (EMRs).
9. Fund added primary care team members that can support administrative burden.
10. Have prescriptions for chronic conditions that are stable, renewed by the appropriate team members in the medical home and medical neighborhood.
11. Develop a “sludge audit” working with the existing Provincial Access to Specialty Leadership group to examine issues and test improvements in the Facilitated Access to Specialty Treatment (FAST) Referral System.
12. Consider increasing the referral coordinators for the FAST programs and have them contact patients to get the appropriate tests done if the investigations required are not available.
13. Increase supports to the existing non-AHS community provider working group working on the issues of duplication of reports and investigations, in ConnectCare which are an issue for family physicians working in multiple locations (Mixed Context providers).
14. Encourage uptake of Community Information Integration and Central Patient Attachment Registry (CII/CPAR) by prioritizing wins that will add short-term value to physicians. For example, using CII/CPAR to address interoperability issues with ConnectCare.
15. Prioritize interoperability projects based on impact to patient care administrative burden, beginning with work already underway with eReferral (see attached paper – Ease of Administrative Burden – Interoperability).

16. Engage Alberta Health (AH), Office of Information and Privacy Commissioner of Alberta (OIPC), and AMA to discuss reasonable next steps to address improving the processes around Privacy Impact Assessment (PIA) submission and review

BACKGROUND

The Commonwealth Foundation Report "*Mirror Reflecting Badly*",[1] from 2021, offered a comparison of high-income countries health systems performance and found four key features that were common to the high performing systems.
These were:

1. Providing for universal coverage and removing cost barriers;
2. Investing in primary care systems to ensure that high-value services are equitably available in all communities to all people;
3. Reducing administrative burdens that divert time, efforts, and spending from health improvement efforts;
4. Investing in social services, especially for children and working-age adults.

In the report, Canada came eighth out of nine countries in system performance. It is time for primary care to be prioritized by all levels of government and health system leadership. We can no longer expect to perform better without investing in primary care.

Alberta has embarked on a series of health system changes. One of the most ambitious is the Modernizing of Alberta's Primary Care System (MAPS). With the recent release of the MAPS advisory panels reports, Alberta's Minister of Health, the Honourable Adrianna LaGrange recently announced that the government was prepared to address the longstanding challenges faced by clinicians in the provision of comprehensive, community-based primary care.

One of the Minister's first actions was to establish the Supporting Comprehensive Primary Care Task Force. The mandate of the Task Force was to develop written recommendations to the Management Committee for consideration in three areas:

i. *<u>Longitudinal Family Physician Practice:</u> The design and implementation of a longitudinal family physician practice compensation model that reflects family physicians' and rural generalists' extensive training, experience, and leadership in primary health care, and with due consideration of the construct, concepts and components informing the "Longitudinal Family Practice Model" specifically proposed by the AMA. The model will build on existing strengths in the primary care sector and would include recommendations on potentially:*

ii. *<u>Strategies to address administrative burden among primary care providers:</u> Additional short and long-term strategies and processes that Alberta Health can implement to reduce the significant administrative burden facing family physicians operating private businesses through which they provide comprehensive primary care; and potentially increasing their time to provide care to patients; and*

iii. *<u>Other short-term actions to further stabilize primary care:</u> Supplementary short-term actions that AH can take to further stabilize comprehensive primary health care.*

The ACFP in collaboration with the AMA were tasked to co-lead a review of administrative burden on family physicians in Alberta. A survey was conducted to identify issues that can best be described as "administrative burden" on family physician practices. Administrative burdens can take many forms and appear to be increasing over time. As the issue is not unique to Alberta family physicians, cross jurisdictional review and research of other Canadian jurisdictions was also considered in the compilation of this report.

Administrative burden, for this document's purpose, is defined as work performed by the physician or another practice team member to support the health care needs of a patient, but only where there is no explicit compensation for the work. Of note, this may include costs that historically may have been implicit in the overhead component of each relevant fee code, but where either the work involved has increased dramatically and/or the frequency of such activities has increased at such a rate that neither revenue nor costs are now appropriately reimbursed. Examples of tasks that have increased and are not compensated for, include completing referrals once specific clinical pathways have been followed which require investigations such as imaging or blood work that cannot be done on the same day as the patient visit, or following up on referrals sent to consultant physicians and finding they are not accepted and having to do a second or even third referral. Activities that may be administrative in nature but are remunerated are excluded from being considered an administrative burden.

The definitions of administrative tasks and administrative burden are varied. Within longitudinal family practice, there are administrative tasks necessary to provide patient care. The tasks become a burden when the volume of tasks is excessive, when the tasks are due to redundancies in the system, when the tasks are of low value to patients, and when tasks are not adequately compensated.[2]

The root causes of these increased burdens can be linked to several areas:

System structures identify the most responsible provider to take on tasks from government agencies, regulatory colleges, administration of health systems and social care, and third parties. This is sometimes done without thought to the uncompensated time that it takes to complete tasks or the impact this can have on patients and the relationship with providers particularly when placed in a gate keeper role. Examples of these tasks include doing sick notes for employees for minor illness or completing forms required for patients to receive social care financial aid.[3][4][5][6][7]

Technology can be helpful but can also lead to the expectation of increased availability, increased data to be reviewed, increased documentation and interference in the complex, difficult to define aspects of long-term patient relationships.[8][9] Technology can be used to decrease burden, for instance AI (Artificial Intelligence) scribes for documentation[10][11] but it also paradoxically can increase the burden with increased messaging, documentation requirements, and quality improvement (QI) processes.[12] Each new technological system also requires time to learn and optimize, which increases the administrative burden in an already stressed system.[13]

There is increasing **risk aversion** in the Canadian health system resulting in increased charting, documentation, and process requirements and increased tasks from multiple parties, including government departments, health administrators, regulatory colleges, and third-party insurers. This work is reducing time that can be spent with patients.[2]

Patient expectations have changed. With increased access to physicians through electronic communication and increased access to health information, the expectations for immediate information

and care are increased.[9] A lack of understanding of the criteria for access to programs and services can lead to strained physician patient relationships when they do not qualify for compensation or benefits.[5]

Physician burnout is an increasing concern in Canadian Physicians. The 2021 Canadian Medical Association National Physician Health Survey revealed 53% of physicians having signs or symptoms of burnout.[14] Burnout is a prolonged response to chronic emotional and interpersonal stressors on the job.[15] Administrative burden has been identified as one of the key contributors to physician burnout.[16] Clerical tasks, such as Increased volume of electronic health record documentation and quality metric entries, inefficiencies in EMRs and EHRs and physician computer order entry have been identified as significant administrative burden for physicians.[17] [18] These tasks contribute to greater numbers of physicians experiencing burnout. Burnout leads to impacts on patients, physicians' health, and the system as a whole. Patients receive lower quality of care, are at risk of more medical errors, have longer recovery times and lower patient satisfaction. Physicians with burnout, leave the profession, or change jobs frequently, have higher incidences of depression, substance use disorders and have poor selfcare. The health system faces poor patient access to providers, increased physician turnover and increased costs.[16] Reduction in the organizational contributors to physician burnout are essential to maintain a high-quality health system.

Other provinces, notably Nova Scotia[19], Manitoba,[20] and Ontario,[21] have started to consider administrative burden reduction as part of retaining and supporting physicians. They note that **the greatest administrative burden is often carried by physicians practicing longitudinal family medicine.** This burden is increasing and affecting patient care, access, and physician well-being.[8][22][16]

APPROACH AND METHODOLOGY

To assess the administrative burden of family physicians and rural generalists working in longitudinal practice in Alberta a multimodal approach was used.

A survey exploring the physicians work hours, time spent on administrative tasks, and identifying areas that lead to the most significant burden was administered through Survey Monkey, with synchronized launches with the ACFP and the AMA's Sections of Family Medicine and Rural Medicine. Frequent reminders were sent by email through regular communication channels, including the ACFP President Message, and promotion through the AMA President's Letters to physicians. The survey results offered quantitative information on administrative tasks and rich commentary on the subject.

The survey also allowed people to volunteer for focus groups to further discuss root causes and potential solutions to the various administrative burden issues identified in the survey.

Key informants including academic health services researchers, College of Physicians and Surgeons of Alberta (CPSA) representatives, AHS primary care leaders, AMA Section presidents, lawyers, physicians involved in the Alberta Surgical Initiative (ASI), and medical students generously gave their time and insights on the root causes and potential solutions to reduce unnecessary administrative tasks and to simplify necessary ones.

The information from the survey, focus groups, and interviews was collated and reviewed by the team. Themes were identified around areas of burden, potential solutions, and recommendations.

Limitations of the survey include self-selection of participants in the survey and focus groups. This may bias the results with respondents interested in the subject or having more difficulty managing administrative burden.

SURVEY RESULTS

The following includes the most significant findings of the survey. The complete survey can be requested by emailing info@acfp.ca.

RESPONDENT DEMOGRAPHICS

According to the AH Statistical Supplement, 2021-22, there were 5,425 family physicians who billed Alberta Health through the Fee-for-Service (FFS) system.[1] Using this number as a reference for the largest number of family physicians active in the province, there were 766 respondents to the survey or 11.5 percent of all family physicians. Further, 71.7 % of all FFS payments to family physicians were for office visits. The survey respondents indicated that 83.59% work in a private office/clinic.

Other characteristics of the respondents included the following:

- 54.81% identified as female
- 42.96% identified as male
- 2.23% preferred not to answer
- 92.21% of respondents belong to a PCN
- 60.93% practice in an urban area
- 23.84% practice in a rural area
- 13.82% practice in both rural and urban

Based on these demographics we are confident that the respondents are representative of active family physicians in Alberta.

HOURS OF WORK

Based on the respondents, approximately 75% of family physicians work more than forty hours each week, with the largest number of respondents working 40-60 hours each week (more than 40%). The work time captures all time related to the operation of the practice, including patient care, administrative tasks associated with patients and the business operations of practice.

Survey respondents indicated that they spend, on average, 15-20 hours a week on administrative work. The three most time-consuming tasks were identified as follows:

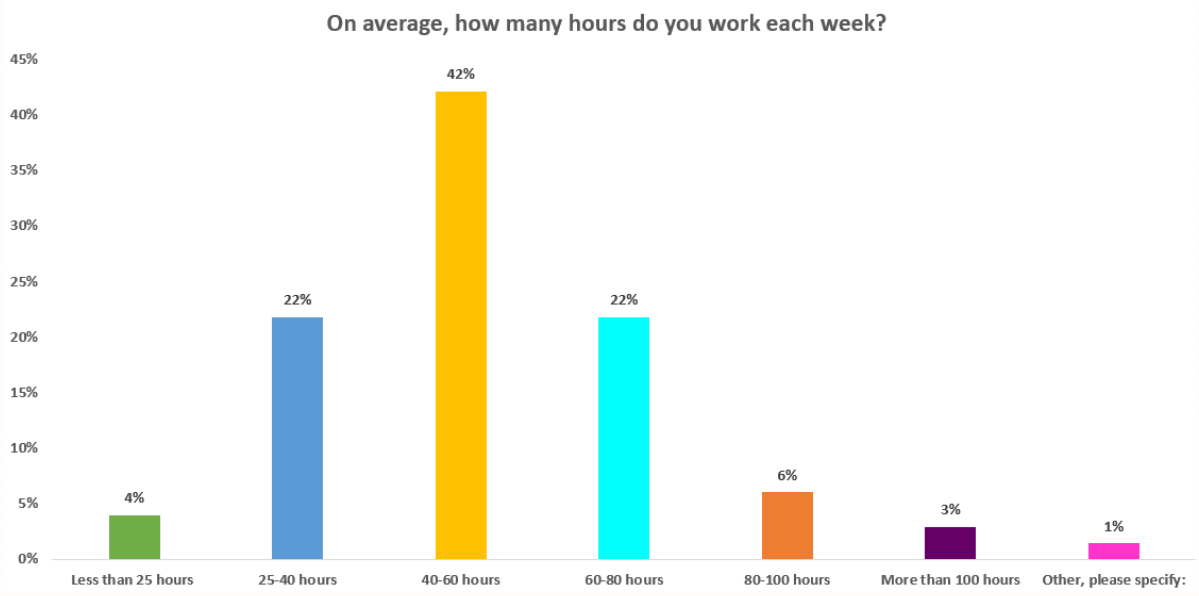
- Managing prescription renewals, patient messages and investigations, with 30 percent indicating they spend four to five hours a week on these tasks and 22% up to 10 or more hours
- Writing notes or completion of forms, with more than 43% indicating they spend between three to five hours and another 11.6 percent spending up to 10 or more hours each week
- Ordering lab/chasing results, with nearly 40% indicating they spend between three to five hours and another 10 percent spending up to 10 or more hours each week

[1] According to the Statistical Supplement, there were 2,049 family physicians who participated in an ARP and another 86 who participated in an AMHSP.

Many of these tasks do not have any remuneration attached to the activity, meaning this is unpaid work. However, if the physician does not do this work, the patient will not have the best care they need. For example, all laboratory tests and diagnostic imaging requests must have forms filled out as part of the request. As well, virtually all newer medications to treat a patient's condition require the physician to either submit a special authorization request to Alberta Blue Cross or the patient's private plan for prior approval, which can take up to 72 hours.

Respondents also reported on how much of these administrative tasks they considered unnecessary and/or could be performed by others. On average respondents reported approximately 40% of these tasks could be eliminated, simplified, or performed by others if resources were available, and policies and regulations changed.

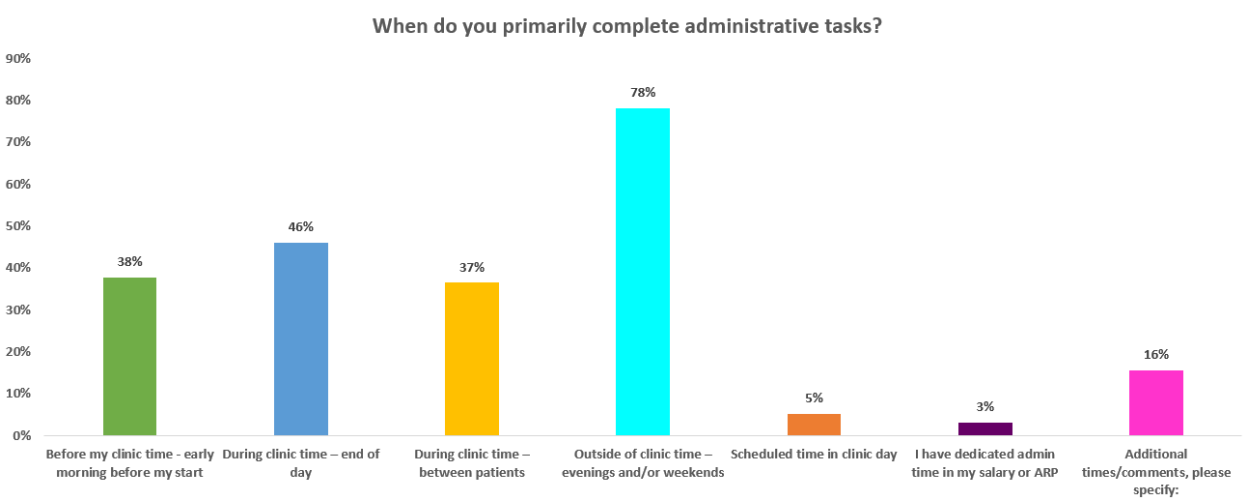
Administrative burden in hourly terms over a year, using the estimated number of family physicians doing longitudinal family medicine, comes to 3,458,000 hours, about 394 years of administrative tasks, 40% of which could be eliminated or done by others. Reducing this burden would first lead to better work life balance for physicians, and then the potential for increased access for patients, and increased system efficiency.



Graph from Q1 from the survey - On average, how many hours do you work each week? Please consider all hours you spend on your practice, including the time you actively see patients, as well as the time you are not seeing patients but conducting tasks related to being a rural generalist and family physician and running the clinic itself, if applicable.

WHEN ADMINISTRATIVE TASKS ARE DONE

Nearly 80% of respondents indicated that they do at least some of these administrative tasks outside of clinic time in the evening or on weekends. Approximately 40%indicated that they do some of these tasks prior to starting their clinical time and more than 40% performed these tasks during clinic time but at the end of the day. It is clear from the responses, that given the amount of time required to perform these tasks, physicians try to make time whenever they can to complete the work while prioritizing direct patient care.



Graph from Q5 from the survey - Presently, when do you primarily complete administrative tasks (select the option that best describes when you spend the most time on administrative tasks)?

IMPACTS TO PATIENT CARE

When asked about the impacts administrative burden has on patient care, 60% indicated that they have had to limit the time they spend with a patient, 66% stated that they have reduced the number of patient slots available for booking, 51% say they have actually reduced the number of hours they work and 30% have reduced the number of hour they are working in community-based comprehensive practice to avoid the administrative burden. All these either impact the quality of care or timely access to care.

IMPACTS TO PHYSICIANS

Administrative burden has significant effects on physicians. Ninety-six per cent of respondents agreed or strongly agreed that they find it affects their work-life balance. Ninety-seven per cent of respondents agreed or strongly agreed that they find it is limiting the enjoyment of their work and 80.8% of respondents agreed or strongly agreed that they find the administrative burden has them looking at retirement and/or leaving comprehensive longitudinal family medicine altogether. Research shows administrative burden is a significant factor in physician burnout.[4,8,23][18]

PRACTICE PAIN POINTS

Respondents were asked to identify practice pain points that are most challenging to them in their daily practice and there was significant agreement. The top four pain points are listed in rank order, from highest to lowest:

1. Other parts of the health care system often place unnecessary and/or inappropriate pressure on me/my practice (95.03%)
2. I am overwhelmed with administrative burden and paperwork related to the care requirements of my patients (89.6%)
3. I spent a burdensome amount of time filling out patient forms (88.62%)
4. It is difficult to manage patient expectations (84.86%)

Family physicians have become overburdened by a system that increasingly requires more administrative work (paperwork) because the system is not connected and/or increasingly requires documentation before resources for patient care can be accessed.

FOCUS GROUP SESSION FEEDBACK

Three focus groups were convened to provide more context and substance to the survey results. These discussions highlighted several issues contributing to the administrative burden in the health care system. Participants frequently mentioned persistent problems, such as excessive paperwork and the absence of standardized questions, which added to the administrative workload of family physicians. Another issue brought up was the complexity of referral pathways, leading to delays and additional administrative work. The shortage of physicians and the ongoing mental health epidemic were also identified as contributing factors.

Many of the observations brought forward ideas that could be considered for short term reduction in administrative burden, meaning they could be implemented with minimum effort. Also, there were others that would require more time and effort. Given this initiative's purpose was to inform the issues regarding the reduction of administrative burden on family physicians, the recommendations encompass both short and long-term strategies. In the short-term, recommendations include investing in a team-based approach, reducing ConnectCare duplicates and improving its functionality, and addressing and eliminating unnecessary forms. These measures can be implemented quickly to provide immediate relief. However, there was also a recognition of the need for long-term changes, such as system integration to streamline processes, a thorough review of the referral process to enhance coordination and increased ministerial coordination to address administrative burdens in a sustained and comprehensive manner. Using modern technology such as Artificial Intelligence (AI) for documentation, closed-loop referral processes, integrated in community EMRs, and prioritizing integration of community clinics with the system will be critical. These long-term recommendations aim to address systemic issues for lasting improvements in the health care system's administrative efficiency.

KEY INFORMANT INTERVIEWS FEEDBACK

Fourteen Key Informant Interviews were conducted. These interviews featured a diverse group of participants, including individuals from AHS, IM/IT (Information Management /Information Technology) working groups, ASI, CPSA, researchers, a legal professional, and a medical student. These interviews provided supplementary perspectives on the administrative burden within the health care system.

Key takeaways from the interviews align with recurring themes identified in the focus groups and survey. These themes include the impact of charting and technological changes on the administrative workload, concerns about excessive testing driven by litigation fears resulting in increased paperwork, and the complexities associated with referral requirements. Additionally, issues related to duplications within ConnectCare and inadequacies in EMR (Electronic Medical Records) systems were identified as contributing factors, alongside the challenges posed by patients' medical conditions.

A key informant from the Surgical Strategic Clinical Network, has a proposal for a pilot that uses AI for documentation in both Connectcare and in primary care EMRs. This could be leveraged to do referrals, forms, and other documentation. Funding a pilot to test proof of concept and then if effective, spread and scale in community clinics would have significant potential to reduce clerical tasks. The proposal could be implemented quickly with appropriate resources.

Based on these insights, the interviewees outlined a set of recommendations to alleviate the administrative burden in health care. These recommendations include exploring team-based care models, reducing redundant and unnecessary forms, standardizing referral processes, eliminating the need for sick notes, enhancing the functionality of tools like ConnectCare, and considering the integration of AI into the health care system. These recommendations aim to improve efficiency within the health care system while reducing administrative burdens on health care professionals.

KEY THEMES

Five broad categories or areas of focus emerged out of the survey, including open-ended comments, the focus groups, and key informant interviews:

1. System and Structural Drivers
2. Forms and Letters
3. Optimize Team Based Care
4. Patient Education, Professionalism, and Regulation
5. Compensation Strategies

SYSTEM AND STRUCTURAL DRIVERS

Family physicians are expected to deal with administrative tasks downloaded from government agencies and ministries, regulatory colleges, private businesses, and the health system. This is seen in third-party forms, work notes, CPSA requirements, PCN QI initiatives, informational continuity and exchange, ConnectCare, centralized referral processes, and other health policies and programs.

ConnectCare challenges were highlighted in the survey and conversations in focus groups. The managing of two inboxes, (ConnectCare and the clinic EMR), receiving multiple copies of results, results going to wrong provider or provider location, and increasingly long documentation (“Note Bloat”) with multiple copies of documents with minor changes that can be pertinent to patient care require increased time by providers to review. The issues with ConnectCare are concerning for physicians that work in multiple locations, like an AHS facility which owns the records and community practice (so-called Mixed Context Providers). This problem was identified in the first launch and has had significant issues with lab results and diagnostic imaging duplication of reports and reports going to the wrong locations. There is an existing non-AHS community provider working group that has been and is looking at solutions for this issue and expects significant improvements by the end of 2024.

The implementation of ConnectCare required multiple training hours, particularly for family physicians and rural generalists that work in hospitals and in longitudinal family practice. The lack of reimbursement for the training time, which was extensive, has been a concern identified by family physicians.

Community Information integration/Central Patient Attachment Registry (CII/CPAR) was discussed with key informants and there has been questions regarding its value in light of ConnectCare and potentially having community providers use the EMR from the EPIC system. This could be helpful, however with well-developed highly functional EMRs already in community practices, switching to a new system that has significant issues and is not ideal. The infrastructure in CPAR could be used to develop interoperability as a solution to the difficulty of integrating into community EMRs.

Finally, Privacy Impact Assessments (PIAs) for integrating to CII/CPAR are also a time-consuming and challenging issue. Increasing incentives to help with PIAs in the community would be a potential solution.

Centralized referral systems require knowledge of pathways, forms, fax numbers, and sometimes the increased requirement of both form and letter. The Alberta pathway hub has 61 individual pathways for primary care providers to follow, and considerable time is spent accessing the appropriate pathway, ensuring the appropriate investigations for a patient are done and the appropriate form and letter are written.

The FAST program, which is streamlining surgical referrals, as part of the work of the ASI, has the added complexity of different pathways for each health zone. Incomplete referrals are sent back to providers to chase patients to get required tests and imaging, and referrals are often rejected without consideration of the context of the patient's clinical situation. Each zone has its own pathway for a particular surgical specialty and single number to fax referrals to. Some specialties require a detailed form and a referral letter which doubles the work for the referring physician. The pathways developed with primary care input, have become increasingly complex and difficult to follow. Forms for referral are not standardized; some surgical colleagues are opting out of the centralized process. It is difficult to keep up with the continuous changes that are occurring with forms, letters, and physicians opting out of the process. Key Informants from the primary care perspective have found that their concerns regarding the process have been acknowledged but no action has been taken to fix them. Presentation of the survey data with the Alberta Health Services Access to specialist care leadership lead to a robust discussion and potential actions to improve the processes in FAST. These will take some increased resources but would use existing engaged leaders from the group working on FAST.

CPSA has been singled out in the survey responses and focus groups regarding the Physician Practice Improvement Program (PPIP) requiring three separate activities. In a time of poor access, physician shortages, and increased burden of administrative tasks, some feel this is an unrealistic expectation. In addition, it was suggested that reviews of the standards of CPSA with regards to third-party forms and requests for information be reviewed. In the current situation with access, requiring third-party forms to be filled out in short time intervals is unrealistic as well.

FORMS AND LETTERS

These are three main categories of forms:

- Government forms (e.g., Alberta Blue Cross, AHS, AISH)
- Private/group insurance long-term, short-term disability, travel insurance, etc.
- Health systems forms: Diagnostic imaging and lab requisitions, forms for programs, homecare, centralized referral forms

The forms and letters add to a significant administrative burden. Continual changes in forms, lack of integration into EMRs, asking for extraneous information, and information others may be better qualified to give were common comments regarding forms.

Accessing social care requires complex forms for programs such as Alberta's AISH, Canada Pension Plan, (CPP) Disability, and Alberta Works. These documents take considerable time to fill out and require patients to pay the physician for the form. As these patients have low or no income, most physicians do not charge for this. Other provinces (Nova Scotia) pay the physicians for the document completion.

Most of these social care forms require physicians to sign off, even when other health professionals may be more qualified to do the forms.

Work note provision is a task with minimal value and takes time away from patients. Family physicians time is not best spent confirming employees sick time, or confirming ergonomic needs to stand up desks, as an example. Visits required for such notes take up valuable time in physicians' schedules. Private businesses should "police" their own employees' adherence to policies and procedures with regards to needed accommodations and sick time.[22][5][7]

Simplifying forms, standardization of forms, integration of forms into the EMRs, and allowing the most qualified provider to do these tasks are potential solutions for addressing unnecessary burden. Considerations to include:

- Collect only the information that needs to be collected.
- Collect information once, reconsider need to re-collect over time.
- Legislation on work notes: Work with private business to remove sick note requirements.
- Third-party providers including government ministries should compensate for physician time spent on the forms necessary for their processes.

OPTIMIZE TEAM-BASED CARE

Primary care would benefit from having teams of health care providers managing the needs of patients.[24][25–28] Ideally, the most appropriate provider on the team can be accessed in a timely way and all administrative and clinical tasks can be completed within a reasonable time and by the most appropriate team member. The mix of team members would depend on the existing clinic staff, and the patient panel needs. One opportunity would be in prescription renewals, a reported increasing administrative task. Using community pharmacists, allied health professionals in the medical home, such as pharmacists and prescribing registered nurses, patients could access a team member for prescriptions for chronic conditions. Team members could ensure appropriate investigations and guidelines are being followed and renew prescriptions, as appropriate. Funding for these individuals would need to be outside the physician compensation models.

Dedicated resources are needed to specifically target some system challenges. Work must happen immediately to address the issues in centralized referral processes with increased referral coordination by the staff doing the triage and acceptance of referrals and the physicians and clinics sending the referrals. Referral coordination using PCN or Zonal resources, use of new or optimized clinic team members to address messages, forms, and letters, and having facilitated optimization of EMR processes would be valuable.

PATIENT EDUCATION, PROFESSIONALISM, AND REGULATION

Patient and public education campaigns could support confidence and clearer expectations around the appropriateness of tests, treatments, and referrals. Family physicians report spending considerable time addressing concerns that patients, families, and caregivers have about standards of care, guidelines, and best practices.

Specialist and generalist relationships were cited as a significant issue in administrative burden. Increasingly family physicians and rural generalists are finding specialist consultations requesting them

to order tests, prescribe medications, and treat conditions that their consultant colleagues have diagnosed and want treated as part of their consultations.

There is further downloading of forms related to the surgical procedures and conditions being managed by the specialist, that family physicians and rural generalists are asked to fill out. The lack of communication regarding the status of referrals, rejection of referrals after months of waiting, difficulty in determining which specialist is accepting referrals were reported as challenges, and compromise and delay patient care.

Maintenance of certification and continuing medical education reporting mechanisms were identified as tasks that could be improved. Automatic uploading of credits, with attendance to events, a thoughtful review of required learning in both AHS and CPSA licensure could reduce some of the burdens currently facing physicians.

COMPENSATION STRATEGIES

While compensation was out of scope for the survey, it was continually raised as a challenge of the current system. The time it takes to carry out many tasks needed for quality patient care is not presently compensated. Payment for indirect patient care, that does not need to be on the same day (i.e.., complex modifier that can be used on another day) would be helpful. Careful consideration of time spent on administrative tasks, reducing unnecessary tasks, and supporting compensation for both physicians and for team members to optimize the administrative burden in practice need to be considered.

OUR RECOMMENDATIONS

The ACFP and AMA believe that the immediate attention and ongoing commitment to the reduction of administrative burden is required of government and health system leadership is critical. Further, all parties must ensure responsibility, accountability, appropriate dedicated human resources, and most importantly, grassroots engagement and empowerment. Unnecessary and unreasonable administrative burden will return if left unmanaged.

GUIDING PRINCIPLES FOR DECREASING ADMINISTRATIVE BURDEN:

The guiding principles for decreasing administrative burden were developed from the literature reviewed, the work done in other jurisdictions, notably Nova Scotia, Ontario and Manitoba, the survey comments, the focus groups, and the key informant interviews. The work in reducing overwhelming administrative tasks must consider the following[4,19–21,29]:

1. Patient care cannot be compromised.
2. Collaboration and codesign in the planning and implementation of solutions that includes primary care providers and the public.
3. Simplification and efficiency in clinical and administrative processes, forms, and requisitions.
4. Consider the reason for collecting data and only collect what is needed.
5. Consider who on the team (or if AI) can and should complete administrative tasks.
6. Third parties requiring the information should pay for the time to complete the form or letter.

The Time for Action is Now…

Primary care in Alberta is by design, fragmented and uncoordinated. With focus, resources, coordination, and commitment, administrative tasks will no longer be considered a burden. Administration is necessary however, it requires attention, measurement, evaluation and planning as part of the day-to-day business of primary care. Careful consideration is needed so that our health system is integrated, efficient, and patient centred. We have work to do and the time for action is now.

The following section outlines the recommended work that will need to be undertaken to reduce the administrative burden in primary care. It provides the rationale behind each recommendation along with key actions and the benefits and impact respectively.

It is expected that a timeline and dedicated human resources will be available to implement the work. This will be key, if we follow the principle of co-design. Family physicians and other stakeholders will need time and resources to participate in co-design. Potential funding and resourcing must be in place including, but not limited to immediate grant fund available through the Canadian Medical Association, the startup and resourcing of the new Primary Care Organization, and a commitment from government and health system leadership across all sectors.

In other jurisdictions, where this has been addressed as a priority for system improvement, decreasing administrative burden took committed resources over two years to make the recommended changes and start seeing significant impacts. However, the measurement of hours saved by each tactic began to be noted within months of implementation.

RECOMMENDATIONS FOR IMMEDIATE ACTION

Notes, Forms, and Insurance				
Recommendation	**Rationale**	**Benefits**	**Key actions**	**Impact**
• **Explore options to eliminate work absence notes required from employers.**	• Relies on patients reporting illness after improved and back at work. • Low value work for physicians • Takes time and potentially appointment slots from other patients. • Using Primary care providers to support third party employment policies. • Estimated one hour per week of time (excludes appointment slots)	• Decreased paperwork • Decreased patient messages, staff time. • Frees appointment slots. • Patients do not have to attend appointment/pay for a note	• Ministry of Health and Ministry of Labour explore options for limiting or eliminating employers' requirements for physician notes for being off work for minor illness. • Other jurisdiction has legislations restricting the requirement for physician notes (Note Nova Scotia legislation)	• Alleviates up to 0.5 hour of week of administrative burden (does not include appointment slots that may be freed) • May free appointment slots for patients • Increased patient satisfaction • Increase provider satisfaction
Alberta's Assured Income for the Severely Handicapped (AISH) • **Simplify Application for both applicants and health professionals** • **Allow the most responsible and appropriate provider to fill in the form** • **Appropriately pay for physician/PCP time to complete form**	• AISH was mentioned in survey comments as one of the most time-consuming forms taking two hours to complete with several redundant questions. • Other health professionals are qualified to fill these forms and may be the most appropriate person for this task. • Payment is up to the applicant, but they are usually lower income due to their health issues and so cannot afford to pay	• Most appropriate health information is collected. • Decreased time spent on forms. • Most appropriate team members fill out the form. • Primary care team members work to top of scope. • Appropriate compensation for the team, consider payment models where Patient does not have to pay	• Propose a working group to assess and simplify the AISH application process including frontline physicians, social workers and administration from AH and social services. • Allow nurse practitioners, social workers optometrists and physiotherapists to fill in the forms as the most appropriate provider. • Explore different payment options for provider time	• Less time spent on form and more appropriate compensation. • More appropriate information obtained and considered. • Administrative burden is lessened for this form by 50% which equals Potentially 0.5 hour per week. • Note physicians working with certain populations would have more significant reduction in administrative burden with this change

Alberta Blue Cross Medication Special Authorizations: • **Consider an opt in program for common medications in family medicine (like the opt in form for Quinolones), which would allow family physicians and other prescribers to agree to follow the criteria for the specific drug in question.** • **Consider aligning the Alberta Health services formulary with the Blue Cross preferred medications.** • **Align coverage of medications for common Chronic conditions with current therapeutic guidelines to ensure best patient outcomes**	• At present there are 87 different Blue Cross special authorization forms, and 15 of them are drugs that are commonly used in family medicine. Agreeing to the criteria for the prescribing of common medications, would eliminate numerous forms daily, and avoid delays in getting important medications to patients in a timely way. • Aligning the AHS formulary with the medications that are covered by Alberta Blue Cross seniors benefit without special authorization would allow for smooth transitions from hospital to home. • Some newer medications most notably in diabetes and asthma treatment, are not covered for first line treatment, and prescribers are required to use medications that are not as effective or worst case may be harmful before being able to get coverage. (Sulfonylureas in diabetes for example)	• Reduces the most common forms for Alberta Blue Cross coverage for seniors and other social programs like Alberta Works and AISH • Patients get medications quickly and efficiently, reduces pharmacy calls and forms. • Hospital transitions to Home are safer, and seamless with medication coverage. • All Albertans have access to the best evidence-based treatments • Cost effectiveness of the medication must be considered • The balance of drug costs with costs to patient and system with using inferior medications that could cause more complications, and /or hospitalizations e.g., dialysis, limb amputations • Aligns with the Diabetes Working group recommendations	• Working group of family physicians, pharmacists Alberta Blue Cross to review the common special authorizations medications used in family medicine and be tasked to develop an opt in program for prescribers. • Working group from Alberta Blue Cross and AHS Pharmacy to align AHS formulary and Blue cross coverage for common medications. • Review the current Diabetes and Asthma guidelines and medications to ensure the medications suggested for first line are covered by Alberta Blue Cross programs • Aligns with the work of the Diabetes Working group and could leverage that work	• At present physicians spend an hour to an hour and half per week filling these types of forms out. With suggested changes, the administrative burden of special authorizations would potentially be reduced by 50% freeing 30-45 minutes per week. • Alignment of AHS pharmacy with Alberta Blue Cross coverage for most programs would eliminate delays in prescriptions for patients in transitions, decreased pharmacy physicians' communications and improve provider and Patient experience. • Allowing coverage of the up to date and most effective medications for chronic diseases like Chronic Obstructive Lung disease, Diabetes and Asthma will improve patient outcomes, reduce or delay complications, and improve quality of life for patients

Insurance Forms: • **Use the newly approved National standardized and simplified short-term and long-term disability forms for third party insurance and integrate into all EMRs** • **Insurance companies should pay for the form**	• Each insurance company had its own forms and they have now agreed to use standardized forms that can be integrated into the EMRs, and basic information can be auto filled • The company requiring the information should pay for the time required to fill out the form • Having to charge a patient to fill out a form required by a third party puts physicians in a difficult position that can adversely affect the therapeutic relationship	• Decreased time to fill out form • Standard information collected with a simplified form • Physician is compensated for the time to fill out the form	• Integrate the standardized short-term and Long-term insurance forms into the EMRs, through vendors • Negotiate appropriate payment for forms with insurance companies • Consider adding other providers to the mix to fill out forms, for example, with a sport injury, having physiotherapy fill out the Insurance form	• Simplified forms will reduce time to fill out form • Compensation for time paid by the third party alleviates the risk to the patient physician relationship • Reduction in time by 30% could save 30 minutes per week/26 hours per year for one doctor in administrative tasks. With 3,800 family physicians practising in community longitudinal family practice, 98,800 hours of administrative tasks reduced. • Most appropriate provider fills out the form

CUMULATIVE IMPACT ASSESSMENT FOR NOTES, FORMS, AND INSURANCE

These four interventions potentially have a reduction 90 minutes in the average time spent per week on notes, forms, special authorizations, and insurance. It is unlikely this would increase access except for appointment slots freed up by patients not requiring sick notes. The access to medications and alignment with guidelines and best evidence would improve patient care. Streamlining the authorization of medications will also minimize inconvenience to patients and ensure smooth transitions of care. Reducing administrative burden is a retention strategy.

Team-based Care				
Recommendation	**Rationale**	**Benefits**	**Key actions**	**Impact/Measurements**
Add team members to support administrative burden: • **Provide additional funding and supported training time, over and above the physician or provider funding models, that supports the addition of team members that are qualified and confident to support administrative work, practice improvement, clinical processes, and flawless patient navigation.**	• Family Physicians and primary care providers work excessive hours of time outside of clinic hours to catch up on administrative tasks compromising their family and personal wellbeing. • Family physicians cut back on clinic hours to compensate for administrative time in order not to compromise personal time. • Many administrative tasks could be delegated or transferred to primary care team members to free up clinical and quality personal time for family physicians currently	• Patient Safety and satisfaction • Provider satisfaction and retention • Employment opportunities for skilled Albertans	• Explore rapid resourcing of team members to help with administrative burden • Consider medical scribes, case coordinators, referral coordinators, AI options, as well as frontline health professionals that could manage both clinical and administrative tasks • Funding would need to be sustained, be directed to physicians' clinics • Team members would be determined by practices need	• Impact would be significant and depend on practice needs • Effectiveness could be measured through survey, practice facilitation
Prescription Renewals: • **Have prescriptions for chronic conditions that are stable, be renewed by the appropriate team members, in the medical home and medical neighbourhood**	• Management of stable chronic conditions is a common family medicine task • Team members in the medical home, and medical neighbourhood have the skills and protocols to renew regular prescriptions and ensure appropriate follow-up visits and investigations are done	• Reduced patient visits to physicians • Team members are practicing to scope • Patients get prescriptions in a timely fashion	• Need support for primary care team members in the medical home (funding outside of physician compensation) • Practice facilitators to maximize scope of practice and design protocols appropriate for the clinic staff, and community providers. This expertise exists in PCNs and AMA ACTT (Accelerating Change Transformation Team). • Some clinics have protocols in place that could be spread and scaled	• Family Physicians spend 4.5 hours on average a week answering messages, filling prescriptions, ordering investigations, and reviewing results. Reducing this by 20% through use of team members would save an hour per week of administrative tasks • Improve Family Physicians work life balance • Health teams are practicing to the top of their scope • Patients get prescriptions in a timely way

Centralized Referral Process				
Recommendation	**Rationale**	**Benefits**	**Key actions**	**Impact/Measurements**
FAST Referral System Audit: • **Develop a "sludge audit" ([30,31])working group to examine existing issues in FAST referral system, using the Provincial Access to Specialty Leadership group and staff from FAST**	• Although some primary care voices were at the table in design of the pathways and referrals for the program, there continues to be issues with rejected referrals, long and complicated pathways, and redundant work. • ASI is an Important system initiative, and the FAST portion is not working as well as expected. It would be critical to implement solutions now	• Simplified pathways will be used by primary care doctors • Less rejected referrals • Better patient access to surgery • Less surgeons will opt out of the centralized referral system • Use of the team that has been working on FAST will ensure efficient use of resource with teams that are familiar with the processes and stakeholders	• Develop a working group, using the team that has been designing and developing the FAST system, to examine pain points in the processes and pathways and simplify the referral processes • Work with the e-Referral review that is already being undertaken and combine work with the prioritization of interoperability for EMR to Netcare and Connectcare • Consider exploring AI resources for documentation and integrating to the referral pathways	• Measure rejected referrals goal reduce by 30% • Family Physicians average about three hours a week, managing referrals and following patients to get referral requirements done. If reduce the rejected referrals by 30% we would have saved one hour of administrative tasks per week and total of 17,160 hours working on referrals per year • Spread and scale the "sludge audit "to other administrative processes
FAST Referral Coordinators: • **Consider increasing the referrals coordinators for the FAST programs and have them contact patients to get the appropriate tests done if the investigations required are not available.**	• Referrals coordinators spend considerable time, putting together lists of investigations and other information needed to complete the referral and send it back to the referring physicians. • Instead, they could contact the patients to ensure those tasks and that information sis completed to get the referral done in a timely way. • Context of the patient referral is sometimes not considered, and unnecessary tests are done due to requirements of a pathway, delaying the referral • Improving FAST will improve access to surgery consults	• Decrease the fax communication regarding incomplete referral requirements • Eliminate multiple steps in getting completed referrals • Adds administrative support to family physicians as well as the surgeons in the system	• Hire referral coordinators with clinical experience to be able to appropriately assess the needed investigations for a referral • Pilot increased coordinators to deal with incomplete referrals forms in one rural one urban zone • Evaluate the referral completion rates, success of getting appropriate investigations, and clinicians' discretion of referral investigations • Require AHS resources and evaluation team through ASI	• Reduce the incomplete referrals by 30%, measure by incomplete referrals being sent back to primary care • Reduce clinicians time spent on phoning and tracking down required tests • Reduce unnecessary diagnostic imaging and lab work • Family Physicians average 3 hours of time on referrals. This would have the potential of saving an hour per week, with total of 197,000 hours of administrative time in a year • If successful, use the same processes and strategies with other centralized referral systems

Information Technology				
Recommendation	**Rationale**	**Benefits**	**Key actions**	**Impact/measurements**
ConnectCare Notifications: • **Increase supports to the existing non-AHS community provider working group working on the issues of duplication of reports and investigations, in ConnectCare which are an issue for family physicians working in multiple locations (Mixed Context providers)**	• Since launch one of ConnectCare, individual physicians that work in both AHS facility that own care records and in community practice have had duplication of results, lost results and results going to the wrong location • The working group has been looking at solutions for this problem for several years and is making progress • As this is a potential risk for patients and providers, it should be a priority of AH, AHS AMA and physician groups to fix and additional resources should be applied as needed	• Reduced duplication of results in the inbox • Less or no lost results • Increased patient safety	• Working group is established and already had some successes in some issues • Review resourcing and add as a priority to improve this situation ASAP	• Impact: Physicians are spending on average 3 hours per week reviewing investigations, and reports in their inbox. By reducing the duplication of reports and ensuring closed loop results, and referrals this could be reduced by 50%. • This would decrease afterhours work on in box management • Improve patient safety/reduce the risk of missed results and investigations
CII/CPAR Uptake: • **Encourage uptake of CII/CPAR by prioritizing wins that will add short term value to physicians. For example, using CII/CPAR to address interoperability issues with ConnectCare**	• Physicians are questioning the value with CII/CPAR given the administrative work required to keep it running. • The focus has been on increasing adoption CII/CPAR in the community. • While work has been ongoing in the background to leverage the functionality, tangible progress has not been made. • CII/CPAR is a key piece of infrastructure needed for interoperability.	• Will offer potential infrastructure to have interoperability with ConnectCare • May help some of the issues of Mixed context users of ConnectCare	• AMA Informatics team and the Informatics Advisory Committee continue work with closely with AH senior leaders on interoperability	

EMR Interoperability: • **Prioritize interoperability projects based on impact to patient care administrative burden, beginning with work already underway with eReferral (see attached paper – Ease of Administrative Burden - Interoperability)**	• Patient informational continuity is complex. Lack of interoperability between the many systems in Alberta makes it difficult and cumbersome to receive and share patient information • Interoperability, including closed loop ordering for referrals, lab, and diagnostic imaging, continues to be the top informatics priority for physicians. • This priority aligns with feedback received during the requirements gathering phase of the eHealth Modernization project. • Leveraging and expanding on existing investments in infrastructure (Netcare, community EMRs, Connect Care, etc.) to enable physicians to order and track without leaving their EMR will help alleviate pain points and pave the way for future integration.	• Optimizes the use of the key systems including Netcare, community EMRs and Connect Care • The improved access and flow of patient data, improves patient care and allows patients to play a more active role in their care • Reduces the number of processes, workflows and access points allowing physicians to spend more time with patients • Reduces duplications and lost results • One In box to manage	• Establish a joint eOrdering project team, including a project manager, IT reps from AH, AHS and AMA, and workgroups with physicians and EMR vendors • Make eReferral a priority and work on next steps to remove roadblocks and move forward with the plan and budget already in place • Create a project in parallel to tackle lab closed loop ordering, including: • Design work and discussions with vendors • Creation of implementation phases to the work to realize quick wins • Work towards implementation of early phases within 6 months • See attached High Level proposal	• Improved flow of information to and from the clinic EMR • Reduced duplication in inbox • Reduced referral rejection • Increased patient safety • Increased time to spend with patients • Measurement if this works with all three areas including referrals, ordering and closed loop lab results, could expect anywhere from 3-5 hours per week in reduction of administrative tasks
PIA Process: **Engage Alberta Health (AH), Office of the Information and privacy Commissioner of Alberta (OIPC) and Alberta Medical Association (AMA) to discuss reasonable next steps to address improving the processes around Privacy Impact Assessment (PIA) submission and review.**	• Challenges include the time and resources needed to create, submit, and keep a PIA current, and vary depending on whether clinics and PCNs have dedicated privacy resources. • See attached paper – Ease of Administrative Burden – PIA Processes	• Simplified process would encourage more participation in CII/CPAR and other interoperability initiatives • Reduced time on doing PIAs	• Reengage the AH, OIPC and AMA to discuss reasonable next steps to address improving the processes around PIA submission and review Including: • Streamlined processes for preparing, submitting, and maintaining PIAs • Reduce the two-year intake-review-acceptance cycle, providing feedback to custodians in a timely manner	• Reduced PIA time and administrative work to integrate EMR with other data systems • Allows interoperability with EMR

(See attached high level proposal)			• Improved transparency in process • Clear guidance on PIA updates • Consider the role of EMR and other information managers in the creation of the PIA. (Is it possible for each vendor to have a standard, reviewed PIA that can be used by all custodians?)	

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