Rapid Decision Support

A product of the Contextualized Health Research Synthesis Program
Newfoundland & Labrador Centre for Applied Health Research

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Reducing Administrative Burden on Physicians

What evidence-based policies, programs, or practices have been shown to reduce the administrative burden on physicians?

This Rapid Decision Support (RDS) includes an evidence synthesis of research into reducing physicians' "administrative burden," which is understood to refer to tasks that are not clinical in nature but that require physicians' time and effort. A range of interventions are identified at the technological level (e.g., voice-to-text software, electronic health records), human-resource level (e.g., employing scribes to document physician notes, transferring some physician administrative tasks to nurse practitioners), and at the organizational level (e.g., policies to limit sick notes, redesigning government medical assistance forms).

The evidence also includes research with a primary focus on physician burnout, where administrative burden has been identified as the main source and variable for intervention. Also included are grey literature and expert opinion from jurisdictions across Canada that are looking into strategies to reduce administrative burden, based mainly on existing research and administrative evidence.

A fundamental issue with physician administrative burden appears to be that, despite a range of interventions to protect physician time for clinical work, for research, and for training, the volume of information being requested from physicians is increasing at a rate that is not sufficiently mitigated by the studied and implemented interventions identified in this report. The Canadian Medical Association addresses this issue in their 2017 publication "Third Party Forms," included below.

Dr. Gerard Farrell, past President of the Newfoundland and Labrador Medical Association comments: “Asking the question, 'are these forms necessary?' is a critical issue for the health system to decide instead of allowing all new forms to be considered legitimate calls on physician time.” (Personal communication).

Review Articles

Baumann LA, Baker J, Elshaug AG. **The impact of electronic health record systems on clinical documentation times: A systematic review**. Health Policy. 2018 Aug;122(8):827-836. LINK

- “The last two decades have seen an increase in the amount of time spent by hospital clinicians on documentation and clerical tasks, decreasing the time available to them to spend on direct patient care and communication with patients and relatives.”
- “The widespread adoption of electronic health record (EHR) systems over recent years held the promise of more efficient information sharing between clinical staff. It was hoped that transitioning from paper to electronic health records would ultimately lead to decreased documentation time for staff and increased time for direct patient care. EHR documentation typically involves use of a bedside terminal, central computer or personal digital assistant (PDA). An advantage of EHR systems is that they can be augmented with computerised physician order entry (CPOE), electronic prescribing and decision support features”
- “This review compares time spent on documentation tasks by hospital staff (physicians, nurses and interns) before and after EHR implementation.”
- “Pooled meta-analysis results indicated that pre-EHR, interns had the largest proportion of total workload spent on documentation tasks (20%, 95% CI 7–32%) followed by physicians (16%, 11–22%), and nurses had the smallest proportion (9%, 6–12%) out of all hospital staff examined. Post-EHR, physicians had the largest proportion of total workload spent on documentation tasks (28%, 19–37%) followed by interns (26%, 10–42%), followed by nurses (23%, 15–32%).”
- Several inefficiencies were noted in work flow. In studies with EHR implementation, use of both paper and electronic documentation was frequently observed, suggesting duplication of work processes. In contrast, full implementation of EHR for documentation appeared to be associated with a decrease in time spent documenting. Thus after an initial transition phase, exclusive utilization of electronic records rather than paper records could potentially lead to a more efficient system allowing improved information flow between different disciplines and medical institutions and more time for direct patient care and communication.

DeChant PF, Acs A, Rhee KB, Boulanger TS, Snowdon JL, Tutty MA, Sinsky CA, Craig KJ. **Effect of organization-directed workplace interventions on physician burnout: a systematic review**. Mayo Clinic Proceedings: Innovations, Quality & Outcomes. 2019 Dec 1;3(4):384-408. LINK

- “Four unique categories of organization-directed workplace interventions were identified. *Teamwork* involved initiatives to incorporate scribes or medical assistants into electronic health record (EHR) processes, expand team responsibilities, and improve communication among physicians. *Time* studies evaluated the impact of schedule adjustments, duty hour restrictions, and time-banking initiatives. *Transitions* referred to workflow changes such as process

improvement initiatives or policy changes within the organization. *Technology* related to the implementation or improvement of EHRs. Of the 50 included studies, 35 (70.0%) reported interventions that successfully improved the 3 measures of physician burnout, job satisfaction, and/or stress."

- "The largest benefits resulted from interventions that improved processes, promoted team-based care, and incorporated the use of scribes/medical assistants to complete EHR documentation and tasks. Implementation of EHR interventions to improve clinical workflows worsened burnout, but EHR improvements had positive effects."
- "There is evidence from a few high-quality studies that (1) the largest benefits result from interventions that improve workplace processes, promote team-based care, and incorporate the use of scribes or medical assistants to complete EHR documentation and tasks; (2) modifications to intensivists' schedules for shift work or interrupted schedules significantly reduces burnout; and (3) duty hour requirements and protected sleep have no significant effect on reducing burnout among residents."
- "Workplace changes promoting *Teamwork* including the use of scribes or medical assistants to reduce the clerical burden of EHR use were the most frequent and successful organization-driven interventions to decrease burnout and improve job satisfaction. Other successful interventions included process improvement for workplace *Transitions*, schedule adjustments and time banking (*Time*), and improvements to *Technology* regarding the EHR."

Ilea P, Ilea I. **Administrative burden for patients in US health care settings Post-Affordable Care Act: A scoping review**. Social Science & Medicine. 2024 Feb 15:116686. LINK

- "In terms of administrative burden subcategories, most patient outcomes reported were learning (22 studies) and compliance costs (26 studies). Psychological costs were the most rarely reported; all four studies describing psychological costs were qualitative in nature. Only twelve studies connected patient demographic data with administrative burden data, despite previous research suggesting an inequitable burden impact. Additionally, twenty-eight studies assessed administrative burden and only three attempted to reduce it via an intervention, resulting in a lack of data on intervention design and efficacy."
- "In the course of our review, it became evident that administrative burden is identified at multiple societal levels, from one-on-one interactions between patients and clinicians to the effects of policy on patients' ability to make decisions about care. We categorized the studies into one of three settings: individual, intraorganizational, or structural, with seven, eight, and 16 studies respectively."
- "Analysis of administrative burden coupled with patient demographics was limited. The inequitable distribution of administrative burden has been established in other settings (Bell et al., 2023; Heinrich et al., 2021; Herd and Moynihan, 2020a; Masood and Azfar Nisar, 2021; Moreno and Mullins, 2017), and studies in this review that did include demographics analyses had similar findings (Barnes et al., 2021; Kyle and Frakt, 2021; Teagarden et al., 2020)."

Sloss EA, Abdul S, Aboagyewah MA, Beebe A, Kendle K, Marshall K, Rosenbloom ST, Rossetti S, Grigg A, Smith KD, Mishuris RG. **Toward Alleviating Clinician Documentation Burden: A Scoping Review of Burden Reduction Efforts**. Applied Clinical Informatics. 2024 May;15(03):446-55.

- "The objective of this review was to identify and comprehensively summarize the state of the science related to documentation burden reduction efforts."
- Not available, but the document has been requested.

Thomas Craig KJ, Willis VC, Gruen D, Rhee K, Jackson GP. **The burden of the digital environment: a systematic review on organization-directed workplace interventions to mitigate physician burnout**. Journal of the American medical informatics association. 2021 May 1;28(5):985-97. LINK

- "Objective: To conduct a systematic review identifying workplace interventions that mitigate physician burnout related to the digital environment including health information technologies (e.g., electronic health records) and decision support systems) with or without the application of advanced analytics for clinical care."
- "Based on the original review, interventions were stratified into teamwork, transitions, time, and/or technology (Table 1). Most interventions were assigned to multiple categories with the exception of 10 studies of exclusively technology-centric interventions. Twenty-six (68%) of the 38 studies provided evidence that burnout and its proxy measures of stress and/or satisfaction were improved by a workplace intervention to address workflow inefficiencies in clinical teams that use a digital environment…"
- "The impact on burnout was similar among time, teamwork, and transitions interventions (Figure 3, range 85%–90% of studies with positive outcomes), and these types of interventions were commonly combined. Technology interventions were least effective with 41% of studies reporting improvement in burnout or its proxy measures (Figure 3)."
- "This systematic review and subgroup analysis summarized the evidence about both successful and ineffective strategies for addressing burnout, factors influencing technology-related burnout, and important scientific gaps in the evidence base. Burnout was decreased by interventions that optimized technology (primarily EHRs), reduced documentation and task time, expanded care teams, and leveraged quality improvement processes to enhance workflows during key transitions in patient care."
- "This review identified several interventions to decrease digital tool use and potentially redirect time for face-to-face patient contact and improvements in work-life balance; many of those studies performed time and motion analyses to understand the impact of workflow modification on physicians' time by proxy of measuring duration of digital tool task completion."
- "Stressors in the workplace, particularly those related to the use of health information technologies (i.e., "technostress"), are major sources of physician dissatisfaction and burnout, but they can often be mitigated by improvements in the quality and timing of training... A few studies identified in this review have used advanced training as a mechanism to improve the skill discrepancies that are essential for technology-user satisfaction. Comprehensive training is a generally applicable strategy for mitigating technology-related stress, and early deployment may offset anxiety that exacerbates burnout."

- "Until the arrival of policy reform, practical and effective workflow interventions should be leveraged to reduce excessive data entry by the physician. For example, documentation efforts can be shifted from physicians to other members of a care team, which could subsequently improve efficiency. A large body of evidence identified from this review leveraged team-based care, primarily where scribes or medical assistants were added to care teams to document patient encounters in real-time under physician supervision."
- "An additional burden of the digital environment is the vast amount of information (e.g., clerical, medical care, and communication) that physicians are required to handle effectively. Studies that leveraged the expansion of the care team, including scribes, could successfully manage and monitor inbox-related communication including patient portals, and refills and results management."
- See also:
    - Kruse CS, Mileski M, Dray G, Johnson Z, Shaw C, Shirodkar H. **Physician burnout and the electronic health record leading up to and during the first year of COVID-19: systematic review. Journal of medical Internet research**. 2022 Mar 31;24(3):e36200. LINK

Primary Research

Ayer M. **Relieving Administrative Burden on Clinical Staff with Streamlined Workflows And Speech-Recognition Software**. Br J Nurs. 2023 Sep 6;32(Sup16b):S1-S9. LINK.

- Position Paper / Narrative Review
- "Successfully integrating speech-recognition software into a hospital's electronic health record (EHR) can improve outcomes for staff, patients and the service as whole."
- "There are many factors that determine the burden of administrative tasks on clinical staff. Addressing each of these factors can allow healthcare organizations to mitigate that burden and thus reduce clinician workload, burnout and attrition (Table 1)."

Factor	Opportunities for improvement
Volume	Minimising how often a task needs to be performed will reduce the overall burden
Time constraints	Allowing more time to complete tasks can avoid stress and minimise errors and omissions
Efficiency	More efficient processes are faster to complete and inspire greater confidence from users
Training	Relevant training can equip staff to perform tasks correctly and efficiently
User-friendliness	Systems that make intuitive sense to new users can improve morale, uptake and results
Reliability	Systems that function properly and as expected can avoid frustration and wasted time and effort
Support	Support from employers, supervisors and colleagues can help staff overcome technical challenges
Control	A system that staff can understand, control and make work for them is likely to provide a better user experience
Responsivity	Systems that provide timely or even immediate results allow for better communication
Interoperability	Standardisation of the language, coding systems and practices used by different healthcare professionals and services supports effective multidisciplinary care and safe transfer

- "Healthcare services can minimize administrative burden by streamlining their workflows for clinical documentation. Existing data-collection practices should be optimized and structured as intelligently as possible. In one example, revising the forms used by clinicians to document pain assessments reduced the time needed to extract and interpret data and had notable benefits in quality, safety and efficiency (Roberts et al, 2022)."

- “Transcription is widely used in clinical documentation, as it is generally faster for clinicians to dictate notes aloud than type or write them down. It can also be more time-efficient for a clinician to dictate notes while they are with a patient, rather than having to return to their computer to type after the consultation, thus increasing the efficiency of clinical workflows. These time savings are partly offset by the time spent checking and correcting the transcription. This checking time is directly tied to the quality of the transcription, and so advanced speech-recognition software can save even more clinician time compared with older software or lower-quality human transcription. This should increase the amount of time clinicians can spend in direct patient care.”

Dymek C, Kim B, Melton GB, Payne TH, Singh H, Hsiao CJ. **Building the evidence-base to reduce electronic health record–related clinician burden**. Journal of the American Medical Informatics Association. 2021 May 1;28(5):1057-61. LINK

- “… we share evidence-based informatics approaches, pragmatic next steps, and future research directions to improve 3 of the highest contributors to EHR burden: (1) documentation, (2) chart review, and (3) inbox tasks.”
- **Documentation**
  - “Speech recognition (SR) software that helps create text from voice commands can enable clinicians to spend less time on documentation and more time interacting with patients.[16] Use of voice for EHR documentation is growing,[17] and its acceptance depends greatly on how well it is integrated with the EHR and fits into workflow…”
  - “Ambient virtual scribes that use devices such as Amazon Alexa or Google Assistant and combine artificial intelligence to parse dictated information and detect structured data are also gaining interest…”
- **Chart Review**
  - “The use of [Natural Language Processing (NLP)] and machine learning (ML) provides a newer approach to reduce chart review burden by quickly identifying new or relevant information in the chart.[29] For example, Goss[30] developed a novel way to automatically compile clinically and contextually relevant information using NLP and ML…”
  - “The use of note visualization tools and graphical representations that better synthesize patient information and improve navigation to new, clinically important details can accompany the NLP and ML approach mentioned previously…”
- **Inbox Tasks**
  - “Team-based staffing models and better EHR inbox designs might assist with inbox burden.[41,42] One team-based care model reduced burnout rates from 53% to 13% within 6 months after launch.[43] There is also evidence to support other types of care redesign interventions as potential solutions to reduce inbox burden, including expanding roles and responsibilities for nurses and medical assistants under physician-written standing orders.”

- “Approaches garnering preliminary success for better inbox design include involving practicing clinicians in inbox redesign and utilizing quality improvement methodologies…”

Ebbers T, Takes RP, Smeele LE, Kool RB, van den Broek GB, Dirven R. **The implementation of a multidisciplinary, electronic health record embedded care pathway to improve structured data recording and decrease electronic health record burden**. Int J Med Inform. 2024 Apr;184:105344. LINK.

- “Reusable data capture in EHRs could lead to major improvements in quality measurement, scientific research, and decision support. To achieve these goals, structured and standardized recording of healthcare data is a prerequisite. However, time spent on EHRs by physicians is already high. This study evaluated the effect of implementing an EHR embedded care pathway with structured data recording on the EHR burden of physicians.”
- “Before and six months after implementation, consultations were recorded and analyzed with video-analytic software. Main outcome measures were time spent on specific tasks within the EHR, total consultation duration, and usability indicators such as required mouse clicks and keystrokes. Additionally, a validated questionnaire was completed twice to evaluate changes in physician perception of EHR system factors and documentation process factors.”

Table 1. Categories and tasks used in measurement app.

Category	Task	Explanation
1. EHR	Chart review	When the physician is looking for or reading information from the patient record.
1. EHR	Input	When the physician is entering informationinto the patient record.
1. EHR	Ordering	The physician orders tests, e.g.imaging, laboratory or medication.
1. EHR	Other (documentation)	Used when the observer cannot discern whether the task falls in one of the four other (more specialized) EHR tasks.
2. Communication	Physician-patient communication	All communication between physician and a patient.
2. Communication	Discussion with colleague	All communication between the physician and a colleague.
3. Other	Other computer tasks	All tasks on computer that are not in the EHR program (e.g. reading mail).
3. Other	Other activities	All tasks that do not fit in one of the other categories.

- “Total EHR time in initial oncology consultations was significantly reduced by 3.7 min, a 27 % decrease. In contrast, although a decrease of 13 % in consultation duration was observed, no significant effect on EHR time was found in follow-up consultations. Additionally, perceptions of physicians regarding the EHR and documentation improved significantly.”

- “As can be seen from the data in Table 2, the highest reduction in EHR time is found in the task placing orders. The mean time required per order decreased from 59.79 to 37.89 s ($p < 0.000$), a 36 % reduction. Additionally, the total number of orders per consultation increased from 6.94 to 10.08 after implementation ($p < 0.001$).”
- “his study showed that reducing administrative burden while enabling structured, reusable data capture at the point of care is feasible. Our results show that in IOC, the period after implementation was significantly associated with a 3.69-minute reduction ($p = 0.003$) total EHR time per consultation, a 26.7 % decrease. These objective findings are corroborated by significant increases in the perceptions of HNC care providers on perceived ease of use of the EHR and facilitating conditions for proper documentation.”

Joukes E, Abu-Hanna A, Cornet R, de Keizer NF. **Time Spent on Dedicated Patient Care and Documentation Tasks Before and After the Introduction of a Structured and Standardized Electronic Health Record**. Appl Clin Inform. 2018 Jan;9(1):46-53. LINK.

- Type: Primary Research
- “Background: Physicians spend around 35% of their time documenting patient data. They are concerned that adopting a structured and standardized electronic health record (EHR) will lead to more time documenting and less time for patient care, especially during consultations.”
- “Objective: This study measures the effect of the introduction of a structured and standardized EHR on documentation time and time for dedicated patient care during outpatient consultations.”
- “Highlighting the most important results, we see that the EHR implementation was significantly associated with an 8.5% decrease in time for patient care in center 1 (using legacy-EHR previously). This means 8.5 percentage points less time is devoted to patient care relative to the total time of the consultation. We did not find a significant difference in time for patient care at baseline or a significant difference in effect of the EHR implementation between the two centers. For dedicated documentation time as outcome, the EHR implementation was significantly associated with an 8.3% increase in center 2 (previously using paper-based records).”
- “We measured a total mean documentation time (with and without combining it with patient care) of 31% for center 1 and 26% for center 2 before implementation and 33% for both centers after implementation.”

Murphy DR, Satterly T, Giardina TD, Sittig DF, Singh H. **Practicing clinicians’ recommendations to reduce burden from the electronic health record inbox: a mixed-methods study**. Journal of general internal medicine. 2019 Sep 15;34:1825-32. LINK

- “Workload from electronic health record (EHR) inbox notifications leads to information overload and contributes to job dissatisfaction and physician burnout. Better understanding of physicians’ inbox requirements and workflows could optimize inbox designs, enhance efficiency, and reduce safety risks from information overload.”

- “Feedback from practicing end-user clinicians provides robust evidence to improve content and design of the EHR inbox and related clinical workflows and organizational policies. Several strategies we identified could improve clinicians’ EHR efficiency and satisfaction as well as empower them to work with their local administrators, health IT personnel, and EHR developers to improve these systems.”
- Recommended Changes and Associated Strategy by Theme (see Results):
    - Inbox Content Should Be Actionable for Patient Care and Relevant to Recipient Clinician
    - Inboxes Should Reduce Risk of Losing of Messages
    - Inbox Functionality Should Be Optimized to Improve Efficiency of Processing Notifications
    - Team Support Should Be Leveraged to Help with EHR Inbox Notification Burden
    - Sufficient Time Should Be Provided to All Clinicians to Process EHR Inbox Notifications
- “High-priority themes included adjusting message content to make it more actionable for patient care and relevant to recipient clinician, designing EHR inboxes to reduce risk of losing message information, optimizing inbox functionality to improve processing efficiency, increasing integration of non-clinician staff in message processing workflows, and providing sufficient time and resources for clinicians to process messages. In subsequent interviews, clinicians validated the importance of these themes by describing current strategies to improve efficiency and SA related to each one.”
- “Of the strategies identified during interviews, most involved efficiency. This is not unexpected given clinicians’ focus on reducing their workloads. Two impacted [Situational Awareness (SA)] level 1 (perception of information): making key clinical information more salient by eliminating clutter unrelated to patient care and allowing a focus on more urgent messages and adding comments to messages to allow them to discern urgent from non-urgent messages on subsequent review.”

Nguyen OT, Jenkins NJ, Khanna N, Shah S, Gartland AJ, Turner K, Merlo LJ. **A systematic review of contributing factors of and solutions to electronic health record–related impacts on physician well-being**. Journal of the American Medical Informatics Association. 2021 May 1;28(5):974-84. LINK

- “Physicians often describe the electronic health record (EHR) as a cumbersome impediment to meaningful work, which has important implications for physician well-being. This systematic review (1) assesses organizational, physician, and information technology factors associated with EHR-related impacts on physician well-being; and (2) highlights potential improvements to EHR form and function, as recommended by frontline physicians.”
- “Twelve studies assessed the association between organizational factors and well-being. Supplementary Appendix 4 summarizes these findings.”
- “Sixteen studies focused on the association between physicians’ attitudes and behaviors involving the EHR and their well-being. Supplementary Appendix 6 summarizes these findings.”
- “Eleven studies looked at EHR functionality and its effect on well-being. Supplementary Appendix 7 summarizes these findings.”

- "Twelve studies presented physicians' recommendations on how to improve well-being and EHR-related burden. All recommendations primarily focused on improvements in the "efficiency of practice" domain. As seen in Table 2, physician recommendations spanned across 3 themes: federal policy, organizational policy, and IT."

Waldren S, Billings E. **A Guide to Relieving Administrative Burden: Essential Innovations for Documentation Burden**. Family Practice Management. 2023 Jul;30(4):17-22. LINK

- "*A Guide to Relieving Administrative Burden* is a series of supplements developed by the American Academy of Family Physicians (AAFP) to provide information about innovations proven to relieve administrative burden and optimize your family medicine experience."
- "The primary battlegrounds of administrative simplification are advocacy and innovation.
    - **"Advocacy** involves driving policy to relieve administrative burden, develop and promote better payment models, and protect your scope of practice. The AAFP advocates with the federal government, larger payers, employers, and health information technology (IT) vendors. You can find examples of the AAFP's advocacy efforts and wins on administrative simplification at aafp.org/simplification.
    - **"Innovation** is focused on helping you relieve your daily burdens with necessary changes that you can implement as soon as you are ready."
- "The literature shows that a significant percentage of the time family physicians spend on administrative and EHR tasks is devoted to chart review (32.1%), billing and coding (3.9%), and other clerical tasks (e.g., order entry) (16.6%), in addition to visit documentation (23.7%).[1] Throw in the burden of managing the EHR inbox, which accounts for 23.7% of physicians' time in the EHR, and you have a core set of common administrative challenges (*Table 1*)."
- "In *Tables 2*, *3*, *and 4*, you will find a list of techniques, technologies, and transformations for addressing documentation burden that have been identified in the literature and by family physicians working with the AAFP Innovation Lab. A relative estimate of potential burden reduction and probable cost range for each innovation is also shown. Actual impact will vary based on the practice environment and the baseline level of documentation burden. More information about these innovations and others is available at aafp.org/simplification."

Grey Literature and Expert Opinion

CMA Admin Burden Working Group (2023). **Improving Physician Wellness by Reducing Physician Admin Burden**. Canadian Medical Association. LINK

- This report is a "detailed description of the ABWG's recommendations, which outline the main solution areas in which the CMA should focus its efforts to tackle physician admin burden."
- Five root causes:
    - **Health care system**: Working with disparate system partners, each with their own objectives, metrics and processes, increases physicians' administrative workload.
    - **Health care workforce**: An aging population, compressed workforce and lack of specialized administrative support can cause admin burden.

    - **Technology**: Improperly developed and implemented technological infrastructure, processes and policies can contribute to administrative workload.
    - **Patient expectations**: Uninformed expectations of the health system can lead patients to access physicians for unnecessary tasks and increase admin burden.
    - **Human factors**: A physician's individual preferences, competencies and available supports can variably contribute to admin burden.
- Strategic Recommendations:
    - **Champion interoperability through legislation**: Promote the passage of legislation that mandates interoperability of health data and information technology, leading to a more interconnected health care system.
    - **Eliminate sick notes once and for all**: Eliminate unnecessary sick notes and the requirement for a physician to complete them, streamlining health care procedures.
    - **Address federal and national forms**: Examine and simplify existing government forms, reducing the role of physicians where unnecessary, and establish best practices for creating new forms.
    - **Build a position on AI and admin burden**: Develop a clear and concise position for the ethical, responsible and effective use of AI in health care, with a specific focus on minimizing administrative burden and safeguarding patient data.
- See References section for additional evidence and resources

Canadian Medical Association (2024). **Regarding Bill 68: An Act mainly to reduce the administrative burden of physicians**. Parliamentary (QC) submission prepared by the Canadian Medical Association and presented to the Committee on Labour and the Economy Aug. 19, 2024. LINK

- "As stated in the introduction, the CMA is in favour of Bill 68 and any efforts to reduce physicians' administrative burden. The CMA is submitting recommendations to the members of the committee to help drive progress and improve the effectiveness of the health system."
- "**Recommendation 1: Add qualitative standards for physicians' physical and mental health to future performance indicators**"
    - "The CMA recommends adding qualitative standards for physicians' physical and mental health to the performance indicators that will be used to evaluate the success of the provisions put in place. If requested by the members of the parliamentary committee, the CMA would be happy to use its 2021 National Physician Health Survey1 to help define the performance indicators for this area. A survey is scheduled for 2025 that includes questions on administrative burden"
- "**Recommendation 2: Innovate to reduce administrative burden**"
    - "The CMA recommends creating a government investment fund to implement innovative solutions to reduce the administrative burden in health care practices"
- "**Recommendation 3: Promote technology interoperability**"
    - "The CMA recommends that the government improve the interoperability of current and future computer systems used for health care in Quebec"
- "**Recommendation 4: Make physicians' lives easier by simplifying the administrative form process**"

- “The CMA recommends that Quebec draw on best practices like those implemented in British Columbia and Nova Scotia, which have significantly simplified the forms to be filled out by physicians.”

Canadian Medical Association (2017). **Third Party Forms**. CMA Policy. LINK

- “Scope: This document provides guidance for physicians, patients and organizations that request third-party forms subject to federal/provincial/territorial legislation and regulations. Several strategies aimed at reducing the administrative burden of third-party forms are recommended to allow more time for direct patient care.”
- “… the steady rise of third-party form requests (see Appendix A) and the cumulative time that form completion takes away from direct patient care necessitates a more reasonable approach to form requests and fair remuneration for the physicians’ time and expertise.”
- “Several strategies aimed at reducing the administrative burden of third-party forms are recommended to allow more time for direct patient care.”
- “Third parties should only request medical forms when there is a need for medical information about a patient (i.e., information that could not be provided by a non- physician) to be used for employment/education purposes or the evaluation of a medically related benefit for the patient.”
- “Increasing administrative workload/paperwork has been identified by physicians as one of the biggest contributors increasing the demand for their time at work.”
    - This means that paperwork demands are both excessive and continuing to increase.
- “Office policies and strategies can be instituted by physicians to better manage third-party requests. These strategies include:
    - having an office policy or standardized method to manage third-party form requests;
    - having clear communication and posted signage on patient and physician
    - responsibilities regarding forms and fees;
    - using a standard form template (e.g., for sick notes and organizing time to complete forms.”

College of Family Physicians of Canada, Canadian Nurses Association, Canadian Medical Association. (2022). **Health Human Resource Policy Recommendations: Summary**. LINK

- “Announcement: *A new health worker support fund to improve the well-being of our healthcare providers and support retention*
- “Recommendation: Commit $300 million over three years through a federal fund that P/Ts can access to improve the well-being of healthcare workers through access to administrative and mental health supports in primary and secondary care settings.”
- “Rationale: Workload is often a gateway to provider burnout and worsening mental health across Canada. 59% of physicians indicate their mental health has worsened since the onset of the pandemic with 56% attributing to increased workload and lack of work-life integration.1In Ontario alone, more than 50% of RPNs coped poorly or extremely poorly during the pandemic, while 80% reported a significantly increased workload.”
- “Examples of use of funds:

- Funding for a rapid assessment of drivers of administrative burden, work, workload, and working conditions to understand pain points and develop actions from the evaluation for P/Ts to implement to mitigate workload challenges (i.e., scaling the assessment out of Nova Scotia)
- Support the advancement of staffing ratios in secondary care settings
- Support an increase in administrative/clerical and cleaning staff in nursing settings and family practices to unlock more time for direct patient care (e.g., nurse orderlies, reduced paperwork)
- Support for immediate no-cost, on-site, accessible mental health supports for healthcare workers."

Council on Health Economics and Policy, Doctors BC (2022). **Creating Space for Doctors to be Doctors: A Cumulative Impact Lens on Physician Demands**. LINK

- "They are concerned that the time spent on certain tasks is duplicative, unnecessary, and not based in evidence. Tasks such as paperwork, charting, and EMR management take away from valuable time spent tending to patients, teaching medical students, researching, and other meaningful work activities."
- "A key recommendation to secure the future stability of our health care system, is for all organizations involved in the sector to examine tasks they assign to clinicians using a cumulative impact lens. No single task is the ultimate cause of a problem, but when many tasks accumulate over time, significant stress is often the result. Viewing through this lens, tasks can be examined across organizations, to avoid adding duplicative, unnecessary, or burdensome tasks to a clinician's plate."
- "Along with a more fulsome look at our policy recommendations and organizational commitments, the policy paper introduces the Burdens Solutions Tool—a framework or pathway designed to identify solutions to any new or changing demands that may be perceived as a burden by doctors and other health care professionals."
- **Recommendations**:
  - "That the Ministry of Health (MOH), Ministry of Children and Family Development (MCFD), health authorities, regulatory bodies, insurance companies, and other stakeholders who create demands on physicians use the Burdens Solution Tool—and consistently engage physicians in this process—when considering new/changing demands and evaluating existing demands."
  - "The development of an accountability structure, approval requirement, or legislated limitations on the ability of third parties who are not involved in the delivery of health care or social services to unilaterally impose administrative burdens, such as assessment, signature, or form completion requirements on physicians without seeking input from physicians on their medical necessity."
  - "That physicians be meaningfully engaged in the development of BC's digital health ecosystem governance, and the ongoing development of standards, planning, design, implementation, evaluation, and training associated with electronic record-keeping systems."

- “That the Ministry of Health, Ministry of Advanced Education, Skills & Training (MOAEST), and health authorities consider options to support the training and expansion of clinical and administrative support staff, in all health care settings.”
    - “That the BC College of Physicians and Surgeons (CPSBC) continues its commitment to apply and communicate how the principles of right-touch regulation are being used in the development of proposed standards, guidelines, and policies (or revision thereof).”
- See also:
    - Doctors of BC (2022). **Addressing Physician Burdens: Burden Solutions Tool** LINK

Doctors Nova Scotia (2024). **Reducing physician administrative burden**. LINK

- Project Status Report: Reducing Physician Administrative Burden (2020)
- Pilot Project: Reducing Unnecessary Physician Administrative Burden
    - Physician Administrative Burden Survey – Key Findings
- Forms and processes: Following is a round-up of changes to forms (and where to find them) and process through red tape reduction work. Links have been added to help physicians find forms quickly online and whether the form is available within their EMR.

Doctors Manitoba. (2024). **Joint Task Force to Reduce Administrative Burdens For Physicians: Progress Report**. LINK

- Initiative website: LINK
- “Adopt a burden reduction lens to any administrative task involving a physician. This means if a process or task involving a physician is being changed, the administrative burden for the physician should be, at best decreased or, at worst neutral. If a change results in an increase in physicians’ administrative time, there must be a compelling reason for this (i.e. a measurable improvement to patient outcomes or safety), and a corresponding decrease in administrative burden should be identified elsewhere to ensure a net reduction overall.”
- “Consult physicians when a change will affect their administrative tasks, including initiatives specifically targeting reductions in administrative burden. When redesigning an administrative task involving a physician, the best practice is to seek feedback from physicians to ensure the change will result in a measurable burden reduction for them.”
- “The Task has created resources to support both recommendations, including an administrative burden measurement tool and a playbook with suggestions for physician engagement.” Please see:
    - **Reducing Administrative Burdens for Physicians A Measurement Guide**. Joint Task Force to Reduce Administrative Burdens for Physicians, August 4, 2023 LINK
    - **Reducing Administrative Burdens for Physicians Process Improvement Playbook.** Joint Task Force to Reduce Administrative Burdens for Physicians, August 4, 2023 LINK
- Has summaries from projects that are complete, or underway and at a point where an interim measurement of hours saved is available:
    - Simplifying Virtual Visit Documentation
    - Addressing the Login Burden

    - Improvements to EIA Disability Medical Assessments
    - Eliminating Vaccine Reporting Requirements
    - Eliminating Discharge Face Sheets
- See also:
    - Doctors Manitoba (2024). **Reducing Administrative Burdens for Physicians**. LINK
        - Report 2: Progress on Reducing Administrative Burdens (February 2024)
        - Report 1: Measuring the Burden, Opportunities for Improvement (May 2023)

Erickson SM, Rockwern B, Koltov M, McLean RM, Medical Practice and Quality Committee of the American College of Physicians*. **Putting patients first by reducing administrative tasks in health care: a position paper of the American College of Physicians**. Annals of internal medicine. 2017 May 2;166(9):659-61. LINK

- "The paper outlines a cohesive framework for analyzing administrative tasks through several lenses to better understand any given task that a clinician and his or her staff may be required to perform. In addition, a scoping literature review and environ- mental scan were done to assess the effects on physician time, practice and system cost, and patient care due to the increase in administrative tasks. The findings from the scoping review, in addition to the framework, provide the backbone of detailed policy recommendations from the ACP to external stakeholders (such as payers, governmental oversight organizations, and vendors) regarding how any given administrative requirement, regulation, or program should be assessed, then potentially revised or removed entirely."
- "This executive summary provides a synopsis of the full position paper (**Appendix**)."
- **ACP Policy Recommendations** (all quoted)
    1. The ACP calls on stakeholders external to the physician practice or health care clinician environment who develop or implement administrative tasks (such as payers, governmental and other oversight organizations, vendors and suppliers, and others) to provide financial, time, and quality-of-care impact statements for public review and comment. This activity should occur for existing and new administrative tasks. Tasks that are determined to have a negative effect on quality and patient care, unnecessarily question physician and other clinician judgment, or increase costs should be challenged, revised, or removed entirely. (See Appendix Figures 1 and 2 for examples.)
    2. Administrative tasks that cannot be eliminated from the health care system must be regularly reviewed, revised, aligned, and/or streamlined in a transparent manner, with the goal of minimizing burden, by all stakeholders involved.
    3. Stakeholders, including public and private payers, must collaborate with professional societies, frontline clinicians, patients, and electronic health record vendors to aim for performance measures that minimize unnecessary clinician burden, maximize patient and family centeredness, and integrate the measurement of and reporting on performance with quality improvement and care delivery.
    4. To facilitate the elimination, reduction, alignment, and streamlining of administrative tasks, all key stakeholders should collaborate in making better use of existing health information technologies, as well as developing more innovative approaches.

5. As the U.S. health care system evolves to focus on value, stakeholders should review and consider streamlining or eliminating duplicative administrative requirements.
6. The ACP calls for rigorous research on the effect of administrative tasks on our health care system in terms of quality, time, and cost; physicians, other clinicians, their staff, and health care provider organizations; patient and family experience; and, most important, patient outcomes.
7. The ACP calls for research on best practices to help physicians and other clinicians reduce administrative burden within their practices and organizations. All key stakeholders, including clinician societies, payers, oversight entities, vendors and suppliers, and others, should actively be involved in the dissemination of these evidence-based best practices.

Government of New Brunswick. (2024). **Initiatives to reduce administrative burden for physicians, improve collaborative care model**. LINK

- "Changes to forms requiring physician involvement were made following work involving the New Brunswick Medical Society and the departments of Social Development and Health. The changes include:
  - Removing physician involvement in three instances.
  - Expanding authorization to medical professionals other than a physician in nine instances.
  - Streamlining forms and processes in 15 instances.
  - Reducing or removing renewal requirements in 13 instances"

Government of Nova Scotia. (2023) **Patients Before Paperwork: Reducing Red Tape for Physicians**. Slide deck. LINK

- Comprehensive list of actions to "reduce red tape"
  - Includes action descriptions, degree of implementation, and estimated number of hours saved.
- See also:
  - Canadian Federation of Independent Business (2024). **Patients before paperwork, Jurisdictional update: Canadian progress on reducing the physician administrative burden**. LINK
  - Canadian Federation of Independent Business (2023). **Patients before paperwork: Nova Scotia's approach to improving patient care by reducing physician red tape**. LINK

Ontario Health. (2024) **Patients Before Paperwork**. LINK

- "Implementation of Pb4P: The Pb4P initiative is currently assessing a variety of different digital health tools and clinical workflows. This work is being informed by engagement with clinicians, health system partners and patients through a multi-phased and clinically led approach. Engagement is a key component of this initiative and will help to guide change and identify new

opportunities to improve health system coordination, as well as enhance the experiences of patients and health care providers."

- "Phase one of Pb4P is focused on improving utilization of digital health tools such as eConsult, eReferral, the Ontario Laboratories Information System (OLIS) and Health Report Manager (HRM). These digital health tools support regular, day-to-day processes like patient care referrals, patient care consultation requests between clinicians and specialists, the secure sending of patient reports and access to and delivery of patients' laboratory orders and test results."
- Includes:
  - "e-Consult: a secure digital health tool which provides family physicians, nurse practitioners and midwives with timely access specialist advice they may need to deliver care to their patients, often eliminating the need for an in-person specialist visit entirely."
  - e-Referral: a platform that enables a "quick and secure referrals between primary care clinicians, specialists and organizations province-wide, reducing administrative burden and supporting clinicians to spend more time delivering patient care."
  - Ontario Laboratories Information System Opens in a new window (OLIS): "a secure digital health tool that provides authorized health care providers with access to patients' laboratory test orders and results, both past and present, from hospitals and public health and community labs through one platform."
- "Each Ontario Health region is equipped with a Regional Digital Health team that can:
  - answer your questions or requests for information about digital health tools
  - provide guidance around digital health tools
  - facilitate connections to enable digital health tool sign-up and onboarding"

Registered Nurses' Association of Ontario (no date). **Toolkit to Support Employers Working to Maximize Full Scope of Practice Utilization for Primary Care RNs and RPNs: Factors to consider: Barriers and enablers**. LINK

- "A summary of factors that influence the implementation of maximizing nurses' full scope utilization in primary care settings is presented below. Based on a literature review to inform this project, validation with key members of the project team, and the results of a survey of 199 professionals and administrators of primary care teams across Ontario, the following barriers and enablers have been outlined and discussed."
- "The most important enablers to maximizing nurses' full scope of practice utilization are listed below in order of priority: 1. Team communication; 2. Team trust; 3. Resources for education; 4. Staff readiness; 5. Organizational culture; 6. Understanding rationale for full scope; 7. Role clarity; 8. Patient population; 9. Change management; 10. Funding models; 11. Time available; 12. Liability considerations"
- "The most critical barriers in maximizing nurses' full scope of practice utilization are listed below in order of priority: 1. Staff readiness; 2. Time Available; 3. Resources for education and mentoring; 4. Organizational culture; 5. Understanding rationale for full scope; 6. Funding models; 7. Team trust; 8. Role clarity; 9. Change management; 10. Team communication; 11. Liability considerations; 12. Patient population"

- See also: 10 Steps to Maximizing Nurses' Full Scope of Practice Utilization in Primary Care Settings

Related On-going Activities in Newfoundland and Labrador

Farrell, G. (2023). **Administrative Burden Survey Results; NLMA seeking Expressions of Interest for Administrative Burden Committee**. President's Letter, NLMA. LINK

- "On average, physicians spend 42 per cent of their time on administrative tasks outside of clinic time, either in the evenings or on weekends."
- "Survey respondents estimate that more than one-third of inefficient administrative tasks could be streamlined through better processes or technology, while one-third could be completed by another role or individual. Respondents felt that just under one-third of these tasks could be eliminated altogether without any negative impact."
- "The NLMA recognizes that reducing administrative burden is an important factor in addressing persistent recruitment and retention challenges."
- "The NLMA and the Department of Health and Community Services have agreed to establish a committee to guide, design and oversee the implementation of initiatives to reduce physician administrative inefficiencies. It will initially focus on NLPDP special authorization forms and EMR duplication. The NLMA has also proposed that the Department hire a full-time project coordinator to assist the committee in achieving its mandate."
- See also: **NLMA Receives Funding to Help Reduce Administrative Burden** (2024) LINK
    - "We are thrilled to announce that the NLMA is one of 11 organizations to receive [a Health Care Unburdened Grant] funding."