Joint Task Force to Reduce Administrative Burdens on Physicians

PROGRESS REPORT #1
Measuring the Burden
Opportunities for Improvement

May 30, 2023
Executive Summary

This first report offers a look at the extensive administrative burden physicians in Manitoba face in their daily work. We identify opportunities to reduce the burden based on physician feedback, with a challenge to organizations to help us achieve a meaningful reduction this year.

We estimate:

- **Physicians spend 10.1 hours per week on administrative tasks on average**, which adds up to 1.4 million hours per year.

- 44% of this time is unnecessary, equivalent to 633,000 hours per year or 1.9 million patient visits.

Opportunities for Improvement

Through physician consultation, we have identified the most significant unnecessary administrative burdens facing doctors. We will work with the organizations identified as responsible for these burdens, along with the physicians impacted, to review, prioritize, and support improvement.

Our Initial Goal

Our recommended goal is to start by reducing the time physicians spend on unnecessary administrative tasks by 10%. This would free up the equivalent of 63,000 hours of physician time per year, equivalent to 190,000 patient visits. With the support of the organizations responsible for unnecessary administrative burdens, we believe this could be achievable by December 2023.

Challenge to “Burden Owners”

We are challenging the organizations identified as “owning” the unnecessary administrative tasks outlined in this report to validate and assess the burden and where beneficial, make improvements to reduce or eliminate unnecessary burdens by December 2023. This work should be informed by physician experience and feedback, and it should be undertaken in partnership with the Task Force.
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About the Joint Task Force
Joint Task Force

Objectives and Deliverables

Our Purpose: To reduce excessive and unnecessary administrative burden faced by physicians, recognizing this is a diversion from patient care and a leading cause of physician burnout.

The objectives and deliverables assigned to us include:

a) Measure the administrative burden and the portion that could be reduced or eliminated
b) Adopt a measurable goal
c) Develop and implement actions plans to reduce the burden and measure the progress
d) Provide recommendations on how to avoid creating excessive new burdens
e) Report on progress, including an interim report in May
The Joint Task Force is a partnership between the Manitoba Government and Doctors Manitoba. It was established by the Minister of Health and Doctors Manitoba President in February 2023, just days after the Canadian Federation of Independent Business issued a national report and challenged provinces to improve.

The members of the Joint Task Force were appointed in April 2023.
Joint Task Force Membership

Dr. Randy Guzman MD, FRCSC, FACS, RVT, RPVI, ICD.D
Hospital-based specialist, vascular surgeon, Professor, and Head of Vascular Surgery Section, and President-Elect with Doctors Manitoba

Dr. Alexis Botkin MD FRCPC
Community-based specialist, dermatologist, and a Board Director with Doctors Manitoba representing the Victoria Hospital Medical District

Dr. Ian Alexander MD CCFP
Rural family physician, Assistant Professor, and Regional Family Medicine Specialty Lead for Interlake-Eastern Regional Health Authority

Dr. Shawn Thomas MD, CCFP, FCFP
Urban family physician and WRHA Medical Specialty Lead for Primary Care

Dan Skwarchuk, B. Comm (Hons), CHE, CPA, CGA
Winnipeg Regional Health Authority Lead, Corporate Services and Chief Financial Officer

Laura Jones
Executive VP and Chief Strategic Officer with Canadian Federation of Independent Business

Keir Johnson (Co-Chair) MPA
Director of Strategy & Communications with Doctors Manitoba

Paul Pierlot (Co-Chair) MA
Director of Policy and Planning Manitoba Government
Measuring Administrative Burden on Physicians
Methods

Our baseline measure of administrative burden is based primarily on a survey of physicians conducted by Doctors Manitoba. A series of questions were modeled after similar questions used in surveys by the government of Nova Scotia and the Canadian Medical Association.

The survey asked physicians to estimate:

- The hours they spend weekly on administrative tasks
- The % of time spent on administrative tasks that are considered unnecessary
- Whether or not the time spent on administrative tasks has changed
- The top contributors to unnecessary administrative burden

In Manitoba, the survey was conducted in February 2023 with 1,053 responses, representing a strong response rate of 33%. A follow up survey was conducted in April 2023 to collect supplemental information with 447 responses.

Definition

**Administrative tasks** include forms, administrative processes, IT/EMR inefficiencies, and procedures which physicians are required to complete as part of providing medical care services.

- It WOULD include the completion of paperwork or forms, the processes related to certification, licensing, privileging, billing and audits, practice or group management, including scheduling, administrative meetings, etc.
- It WOULD NOT include direct patient care, including consultations or the interpretation of a test or examination of a specimen and its documentation.

**Unnecessary administrative burden** includes physician administrative tasks that could be eliminated completely, reduced or streamlined in some way, or delegated to another individual (e.g. clerical or administrative staff or clinical colleagues).
Manitoba physicians estimate they spend an average of 10.1 hours per week on administrative tasks, which equals 1.44 million hours per year.

This is very similar to other estimates, including 10.6 hours per week in Nova Scotia and 10.0 hours per week across Canada.
A burden for all, but not shared equally

The estimated time spent weekly on administrative tasks varies, suggesting the burden is not shared equitably.

Different physician groups appear to spend more time on administrative tasks than others:

- Family physicians & Rural physicians
- Younger physicians
- Black, Indigenous and Physicians of Colour (BIPOC) and women physicians

While this disparity requires further investigation, it is important to keep in mind during any assessment, prioritization and improvement work to reduce administrative burden.
Two thirds of physicians reported that the time they spend on administrative tasks has increased over the last five years.

N=960
Question: How has the number of hours you spend on administrative tasks changed over the last five years?
Time Spent on **Unnecessary** Administrative Tasks

44% of time spent on administrative tasks is **unnecessary**

633,000 hours per year on unnecessary tasks. This is equivalent to 1.9 million patient visits.

Administrative tasks are unnecessary if they could be eliminated completely, reduced or streamlined in some way, or delegated to another individual (e.g. clerical or administrative staff or clinical colleagues).

N=447
Question: Of the total time you spend on administrative tasks each week, what percentage of that time is spent on administrative tasks that are unnecessary for you as a physician to complete?
Physicians identified the organizations most responsible for the unnecessary administrative tasks they face, referred to in this report as the “burden owners.” Multiple organizations could be identified.

These organizations may not be aware they have created unnecessary administrative burdens on physicians.

Over half of physicians (52%) identified private insurance companies, and some other organizations outside of the health care system were also identified, such as WCB, MPI, and employers.

Several organizations inside the health care system were also identified.

N=957

Question: Which of the following organizations are the biggest sources of your unnecessary administrative burden?
Goal for Improvement
Initial Goal

Our initial goal is a challenge to reduce the time physicians spend on unnecessary administrative burdens by 10%.

This would free up 63,000 hours per year of physician time, equivalent to 190,000 more patient visits.

The Task Force believes this goal could be achievable by December 2023, provided the organizations that “own” administrative burdens commit to making the necessary improvements within this timeframe.
Opportunities for Improvement
Opportunities to Reduce Administrative Burdens

Physicians submitted over 1,400 comments about unnecessary administrative burdens through the survey and subsequent feedback via an email suggestion box.

These comments have been carefully analyzed to identify themes and, ultimately, opportunities to reduce unnecessary administrative burdens on physicians.
Many Burdens, Common Themes

Our analysis of over 1,400 suggestions from physicians about unnecessary administrative tasks revealed some common underlying themes.

- **Excessive Duplication**: Physicians are burdened with excessive duplication and repeat tasks.
- **Delegate**: Some tasks should not require a physician and could be delegated to other personnel and/or providers in part or in whole.
- **Physicians as “Gatekeepers”**: Physicians are often asked to approve access to benefits for other organizations.
- **Electronic Records Have Added to the Burden**: Physicians cited inefficiencies in how EMRs work, the burden of multiple log-ins, and fragmentation of records.
- **Overly Complicated, Manual or Paper-Based**: Many forms were described as overly complicated, manual and paper-based.
- **Forms are not Standardized or Harmonized**: The same information is asked for in different formats from different organizations, or even from the same organization.
Opportunities for Improvement

Based on physician input, the following have been identified as the most common unnecessary administrative burdens. This is not a complete or exhaustive list. Each requires further exploration to understand the impact on physicians and the effort required to address the issue. The burdens are not listed in any order or priority.

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<th>Administrative Burden</th>
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<tr>
<td>1. Orders &amp; Requisitions</td>
<td>Shared Health, RHAs, Private Labs</td>
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<td>Orders and requisitions for bloodwork, imaging (MRIs, CTs, etc.) and endoscopies were the most common examples cited. Physicians reported that there are different forms for each test or procedure, within and across the different organizations responsible for processing and delivering the service.</td>
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<td>2. Sick Notes</td>
<td>Nearly All Employers</td>
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<td>Many employers require employees to obtain a sick note from a physician when away from work due to illness. Policies vary about how many days away require a sick note. Often, patients make an appointment to see their physician just to get a sick note, as their medical issue is minor and would otherwise resolve with self-care and time.</td>
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### Opportunities for Improvement Continued

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<td><strong>3. Referrals</strong></td>
<td>RHAs, Shared Health, Physicians</td>
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<td>Physicians on either end of referrals or requests for consultation expressed some frustration with inefficiencies. For physicians sending referrals, they often find it challenging to navigate different specialty areas, finding a specialist that focuses on the specific medical issue, whether or not they are accepting referrals, and how long the wait is. There are a multitude of forms for different areas, each using different formats and asking for similar information in different ways. There was sometimes a lack of clarity about tests to pre-order and why this was the responsibility of the referrer. On the receiving end, some specialists expressed frustration that some information was missing or not easily accessible in the patient’s electronic records.</td>
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| **4. Private Insurance Forms/Requests**       | Private Insurers                           |
| Physicians expressed concern about several issues related to private insurance requests and forms, including frustration with: a) the lack of standardization of forms from different companies, b) physicians being asked to “approve” benefits such as massage or physiotherapy for some plans, and c) the process for some prescription drug requests. |
Opportunities for Improvement Continued

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<td><strong>5. IT, Technology, EMRs</strong></td>
<td><strong>Shared Health, EMR Vendors</strong></td>
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<td>There were no shortage of IT-related concerns raised by physicians. This included the “log-in burden” requiring some physicians to sign on to 5+ different apps to function, the lack of interoperability between electronic medical records (EMRs) and other systems, inefficiencies in EMR design, and concerns about computer hardware and WiFi access.</td>
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<th>6. Dictation / Admin Support</th>
<th><strong>Shared Health, RHAs, University</strong></th>
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<td>Physicians had differing views about voice recognition dictation, with some wanting this feature in their service area or EMR. Meanwhile, some who have expressed frustration with inaccuracies and preferred the previous transcriptionist model. Many physicians recognize and value strong administrative support when they have it, but many working in hospitals noted there is a high vacancy and turnover rate in some areas that have eroded the value of administrative support, leaving some physicians doing these tasks themselves.</td>
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Opportunities for Improvement Continued

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<td>7. Pharmacare</td>
<td>Manitoba Health</td>
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<td>Many physicians were frustrated with the exceptional drug status (EDS) form and process with provincial Pharmacare. To some, it feels that there is a growing list of medications that aren’t officially part of Pharmacare but are routinely approved through EDS, raising the question about why the lengthy special application process is requested repeatedly for the same medication.</td>
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| 8. Prescription Refills     | EMRs, Pharmacies            |
|                            | Physicians expressed frustration with the prescription refill process. Examples cited suggest pharmacies sometimes call a physician for a refill when one is already on file, and about the inefficiency in writing, printing and sending a refill in EMRs. |

| 9. Pre-Op Assessments      | Shared Health, RHAs, Physicians |
|                            | Similar to referrals, there was some frustration on both the sending and receiving end of pre-operative assessments. Lengthy wait times can result in pre-ops that are out-of-date, or in some cases pre-op assessments “expire” because of long wait times and operation rescheduling. Information is sometimes requested that already exists in the initial referral or in the patient’s record. |
Opportunities for Improvement Continued

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<td><strong>10. Discharge Summaries</strong></td>
<td>Shared Health / RHAs</td>
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<td>Like referrals, physicians on both the sending and receiving end expressed some frustration with discharge summaries, or short reports that are written by a hospital physician at time of discharge and shared with a community-based physician, such as a family doctor.</td>
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<td><strong>11. Physician Claims &amp; Billing</strong></td>
<td>Manitoba Health</td>
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<td>Physicians expressed frustration with excessive or duplicative requests for information to justify physician billing claims, both in the initial submission as well as occasional follow-ups from Manitoba Health staff.</td>
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<td><strong>12. EIA Disability Medical Assessments</strong></td>
<td>Manitoba Families</td>
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<td>Physicians play a role in providing an assessment of medical and functional issues that could qualify individuals for extended disability support payments through Employment and Income Assistance (EIA) in the provincial Department of Families. Physicians raised concerns about the form itself being unclear and including unnecessary questions, and about the frequency of reassessments to reconfirm eligibility.</td>
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<td><strong>13. WCB Processes</strong></td>
<td><strong>Workers Compensation Board</strong></td>
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<td>Physicians who have managed the care for workers insured by WCB reported unnecessarily frequent and excessive levels of reporting and duplication.</td>
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<td><strong>14. MPI Processes</strong></td>
<td><strong>Manitoba Public Insurance</strong></td>
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<td>Physicians who have provided the care for patients related to an MPI claim reported unnecessarily frequent and excessive levels of reporting and duplication.</td>
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<td><strong>15. Return to Work</strong></td>
<td><strong>Employers / Insurers</strong></td>
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<td>Whether through employers or private insurers, physicians are asked to validate their patient’s functional status and ability to return to work. This is a task many physicians are frustrated with because they have a lack of context about the job demands, and they are not equipped to assess functioning in the office (i.e. weights to assess how much can be lifted). This is likely better done, in most cases, by a different health professional.</td>
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Other Opportunities for Improvement

16. **Regulatory Forms & Reviews**
   College of Physicians and Surgeons of Manitoba
   Some physicians suggested the initial application and annual renewal process could be streamlined, and the quality review process could be simplified.

17. **Research Review and Approval**
   University and Shared Health
   For physician researchers, the university and Shared Health research review processes were described as overly complicated with an opportunity to reduce duplication and streamline.

18. **Medical Learner Supervision Reporting**
   University - College of Medicine
   Some physicians who supervise medical learners (students and residents) described the reporting requirements as excessive and could not understand why so much detail was needed.

19. **FNIHB Processes and Forms**
   Federal Government
   Physicians raised concerns that some of the processes within the federal First Nations and Inuit Health Branch designed to get services and benefits for First Nations Peoples are overly complex and could be a barrier to getting the service approved, including Jordan’s Principle approvals.

20. **Disability Tax Credit Form**
   Federal Government
   The federal disability tax credit form is viewed by many physicians as overly onerous and unnecessary for a doctor to complete. Most of the information is functional, not medical, in nature. They often see patients sent to them from accountants or other third parties suggesting they talk to their doctor and “give it a shot” but patients are often clearly ineligible. This not only creates an unnecessary administrative task for the physician, but also creates unnecessary friction in the physician-patient relationship.
Next Steps

Reaching our Goal: A Challenge to Burden Owners
Reaching and Maintaining Our Goal: A Challenge to “Burden Owners”

While the Joint Task Force has been tasked with identifying excessive and unnecessary burdens, setting a goal, and measuring progress, it is the organizations who “own” the unnecessary administrative tasks who must agree to lead the actual improvement work to reduce or eliminate the unnecessary administrative burdens.

Our challenge to these organizations is to work with us to assess and validate the tasks identified as unnecessary by physicians, and to commit to a short-term improvement to reduce the portion of administrative burden that is deemed to be unnecessary. In other jurisdictions and sectors, the experience of reducing administrative burdens or red tape for end-users often results in internal efficiencies as well, creating a win-win scenario that benefits all involved.

The Task Force will support this assessment and improvement work in the following ways:

► Facilitating physician involvement to better understand the nature of the burden and ideas to improve.
► Deploying a common measurement method.
► Offering coaching, guidance and expertise on approaches for making improvements.
► Monitoring and tracking progress.

The following page provides an overview of the process.
Next Steps:
Engagement → Prioritization → Improvement

Identify Opportunities for Improvement

Engage "Burden Owners"
- Validate Burden
  - Yes
  - Assess Effort to Improve
  - No
  - Obtain Commitment to Improve
  - No
  - Yes

Engage Physicians
- Validate Burden
  - Yes
  - Assess Impact on Practice
  - No

Prioritize Opportunities for Improvement
Initiate & Support Improvement Projects
Monitor, Measure and Report Progress

PARK for future review
Monitoring & Measuring Progress

With a baseline in place, an initial goal set, and opportunities for improvement identified, the Task Force will shift its focus to working with the “burden owners” and supporting, monitoring and measuring progress to reduce unnecessary administrative burdens on physicians.

To ensure a consistent approach is used to measure reductions, a model for measurement, based on administrative burden reduction work in Nova Scotia and Manitoba, will be deployed to all “burden owners” who commit to an improvement. This model leverages time measurements before and after the improvement work to determine the resulting time savings.

In some more complex cases, such as a variable step process involving multiple roles, a combination of methods may be used in conjunction with measuring before-and-after time, such as surveys, experiments, interviews and focus groups with physicians and others who play a role in the process being streamlined or improved.

In some cases, regulatory requirements - steps and actions within a process, and pieces of information needing to be entered in a form - will also be considered as these are tangible elements that can be identified, measured and tracked through the course of process improvement initiatives.

In determining the overall impact, time savings per physician will take into account the number of times the form, task or process needs to be completed in a year, and savings will be extrapolated across the number of physicians that need to complete the given form, task or process each year.

The Task Force will track the progress each “burden owner” makes and combine results to determine the overall progress towards the initial 10% reduction goal.
Please send administrative burden concerns and ideas to adminburden@doctorsmanitoba.ca