EZMSA

EDMONTON ZONE MEDICAL STAFF ASSOCIATION

PHYSICIANS ADVOCATING FOR HEALTH

Dear Members,

Over these last few weeks I have engaged with other physician leaders in our zone regarding how to improve physicians' lives. We see distress and moral injury from working in a system that is overstretched, often unable to meet the standards of patient care and access we would like, while increasingly drowning in administrative tasks. Often it feels our ideas and concerns are not being heard by those who can make changes. Thank you to all those physicians who care so tremendously about their patients and about their colleagues. Please know there are wonderful physicians in leadership who care deeply for physician health, and acknowledge often the system is the issue, not the physician or their lack of resiliency.

While we have seen incremental progress, we are certainly far from a sustainable level of work or acceptable waits for many areas of patient care.

From a Globe and Mail article by Wency Leung, released January 30, 2023, it was "found that each doctor in Nova Scotia spent an average of 10.6 hours, or more than a full work day, per week on administrative tasks, 38 per cent of which was unnecessary – work that could have either been completed by someone else, or eliminated completely." "The Canadian Federation of Independent Business report… estimated doctors spend 18.5 million hours a year nationally on needless administrative activity – the equivalent of 55.6 million patient visits. And **if governments across the country were to reduce that burden by 10 per cent, it would translate to the equivalent of 5.5 million more patient visits per year**..." Like many of you, 10 hours would be an underestimate of time spent on administrative tasks in a week, and it has a direct negative impact on enjoyment of my clinical work. Referrals, re-referrals, and rejected referrals due to process issues, contribute significantly to the load.

Below is a letter from the EZMSA on referral process design. The initial concepts were presented in November 2022 at the AHS Zone Medical Administrative Committee, with refinements made over the last several months. The EZMSA will do our best to spread this document to key stakeholders. We have also attached a PDF version of the document so you can distribute it as you wish. My hope is that we can work toward comprehensive referral systems built with more physician input, and ultimately requiring less physician administrative work, with resulting improved patient access and care.

Please continue bringing your ideas to AHS, the Alberta Medical Association, and to the EZMSA. As always, feel free to contact me directly with any concerns. Let's continue to build a community of physicians that support each other and improve the lives of our patients.

Letter: Referral Issues – Mend the Gaps

Physicians and their health care teams are collapsing under ever-increasing administrative burden. New and developing referral systems, some – including Connect Care – that were designed for the US health care system, were put forward partly on the premise of reducing care gaps and delays in the system. Unfortunately, the reverse is happening. Delays in care and gaps in the system are increasing. These effects have been amplified by physicians leaving practice and those remaining becoming increasingly burnout.

Remember the 'Greg Price story', widely publicised within AHS. Greg was a young man who found a testicular lump. His care over the following year or so was a catalogue of system gaps and delays that ultimately led to his death. There were numerous points at which, had system communication and safeguards been stronger, this young man would be alive today. It is clear that the increasing administrative burden physicians now face is having an even greater impact on patient safety, because of care gaps and physician burnout.

What can we do? Both referring and consultant physicians are being failed by the current system. It is time to strip down the referral processes to the basics, then build them up again, using principles of co-design and interest-based negotiations. **Physicians and staff, on both sides of the process, need meaningful input into referral system development**. Change in processes is essential to combat our current challenges with physician capacity and patient care and access.

INITIATION OF REFERRAL: Referring physicians should carefully consider referrals, ensuring the referral is necessary. Have a clear ask of the consultant service. Include a brief medical and surgical history, updated medication list and allergies. Optimized referrals make triage easier and faster and reduce repeat communications and rejected referrals.

STANDARDIZED FORMS: Referral forms should be standardized where possible, with one access point per area (i.e. truly centralized referral systems). NetCare referrals are a recipe for disaster, as that system does not communicate with community Electronic Medical Records (EMRs). Most community-based physicians do not use Connect Care in their community practice nor is it feasible for them to do so, even if that physician works on Connect Care in another capacity. Consistency between forms would greatly improve efficiency for the referring physician.

Any new forms should be prepared for the major community EMRs by the consultant physicians' staff and/or centralized referral staff. Uploading, importing and formatting these forms is very time intensive. Careful communication between teams will be essential to ensure the form is correct and easily available.

PATHWAYS SHOULD BE CO-DESIGNED, BRIEF, RELEVANT AND USEABLE AT POINT OF CARE. New Zealand's Canterbury Health Pathways is an excellent example of how to design helpful pathways, and recommends regular monitoring, evaluation and feedback on the pathways. Pathways should not be decrees to community physicians, but rather co-designed, thoughtful ways to improve patient care, that are refined over time through rigorous processes. In the Edmonton Zone, there are several specialties with multiple pathways, some of which are 16+ pages in length. There is insufficient time at point-of-care to navigate long referral pathways and both family doctors and other specialties struggle to keep up with lengthy and proliferating pathways. Data on actual use of the pathways and feedback on refining them is essential. There also needs to be leeway for patients who do not fit into any given pathway.

REJECTED REFERRALS: Referrals may be rejected due to minor omissions, including missing investigations (which may not be obtainable by primary care) and even minor form changes. **Consultants should authorise staff to contact the patient directly to complete referral work ups if the referral received is nearly complete**. Additional preparation or items required before an appointment should be arranged by the consultant's office. When referral forms are changed, the previous form

should be accepted if there is adequate information, with communication back to the referring team enclosing the new form to be used next time (that has already been added to the major EMRs, as previously discussed).

The EZMSA have asked that AHS undertake a Quality Assurance Project to look further at the referral systems under its purview. Consultant physicians should consider accepting a referral request even if the ask is not exactly within their subspecialised area of expertise or redirect to an alternate provider where possible. It is important that in this time of crisis, physicians in all areas cover more general issues in their specialties, to improve patient access and support our colleagues.

ADDITIONAL ISSUES, DUE TO LENGTHY WAIT LISTS: When wait time from referral to appointment is so long that the initial imaging or investigations become out of date, consider changing criteria for investigations like imaging. Imagine how frustrating it is for a patient to be told tests are outdated and must be done again or, even worse, that they need to make an appointment with their family doctor to arrange to do the tests again? Any work that is redirected to the referring physician decreases access for other patients. If it is not safe to extend the intervals of investigations, the consultant's office should contact the patient to arrange the required updated tests.

These process changes will reduce repeat communications between clinics and share the administrative workload more equally between referring and receiving services.

MONITORING REFERRAL PROGRESS: For patient safety it is essential that the progress of a referral, from time sent to patient appointment, is closely monitored. This is both for process improvement, and to make sure that patients aren't 'lost.' For now, this monitoring should be shared equally by referring physician and consultant specialists' staff. In an ideal state, referral status would be monitored by centralized program staff (funded by Alberta Health (AH) for larger initiatives like Alberta Surgical Initiative), in association with a portal for both patients and physicians to enable them to directly check on progress of the referral. The College of Physicians & Surgeons of Alberta standards must be adhered to; for example, the consultant has 14 days to acknowledge receipt of a referral. As a quality improvement initiative, monitoring the referral process at each step will help identify issues and lead to process improvements. Given the significant administrative burden on referring physicians (and their staff) resulting from rejected referrals, the reasons for declining referrals should be tracked and analyzed to see if process changes can reduce this metric.

As a general reminder, most community physicians do not have access to Connect Care and NetCare does not directly communicate with community clinic EMRs.

CONSULT LETTERS: Clarity in the consult letter is helpful for both parties. Diagnosis/impression should be noted prominently, with a clear plan detailing what the consultant physician will do, as well as any suggestions to the referring physician for further management or monitoring. Many examples of such letters already abound within the Edmonton Zone. If simple follow-up of the patient by the consultant physician is needed within a year or less, the consultant physician's staff should arrange these appointments directly with the patient. Patients and referring physicians greatly appreciate the time this service saves.

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FUNDING: Most importantly, AH and AHS must work with both referring and consultant physicians to identify system issues and possible solutions, and then allocate appropriate funding to allow for success. Please listen when physicians say that a process is not working or needs to be improved. With the current crushing administrative burden facing physicians, it is essential to recognize that most of the work in the referral process is NOT physician work. Funding must support the staff and systems necessary to build and operate robust referral systems.

Physicians need to lead in system change and participate in designing processes that impact them and the clinical care they provide. Innovation must happen and be concretely supported. In this time of overwhelmed doctors and an increasing number of patients without a primary care physician, it is essential that we improve capacity within the system, without increasing burnout. Let's work together to improve physicians' lives AND patient care. Let's mend the gaps.

Warmest regards,

Katherine Kasha, MD CCFP FCFP
President 2023

Mission: **Physicians Advocating for Health**
Vision: **Engaged Physicians; Sustainable Healthcare; Health Community**
Values: **Advocacy; Integrity; Growth and Learning; Community Connection**

Click here to contact the EZMSA Physician Advisor