AMA | STEPSforward®

Saving Time Playbook

from the AMA STEPS Forward® Playbook Series

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This playbook is part of the AMA STEPS Forward® practice innovation program. Each playbook curates the best content AMA STEPS Forward has to offer—toolkits, videos, podcasts and ready-to-use tools, templates, and resources—into practical, actionable strategies and tactics to help you create positive change in your practice today.

For the optimal experience—GO DIGITAL!

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AMA STEPS Forward® also acknowledges the following additional authors of the toolkits referenced in the Saving Time Playbook for their contributions: Melinda Ashton, MD (Getting Rid of Stupid Stuff); Kevin Hopkins, MD (Patient Portal Optimization); James Jerzak, MD (EHR Inbox Management); Margaret Lozovatsky, MD (Patient Portal Optimization); James Rice, MD, MHA (Patient Portal Optimization).

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Introduction

> While burnout manifests in individuals, it originates in systems.

Christine Sinsky, MD

The Burnout Problem Is Organizational, Not Personal

Physician burnout is an epidemic in the US health care system, with 44% of physicians reporting signs of burnout such as emotional exhaustion and depersonalization.[1] The significant time spent on non-patient-facing tasks in the clinician's workday contributes heavily to burnout. Saving time for physicians and other team members is crucial—but this cannot be accomplished by simply telling physicians to become more efficient during patient visits or when writing notes. Physicians are already trained to be efficient and practice good time management skills. Therefore, timesaving efforts need to come from the top down: from the level of practice or organizational leaders who can effect large-scale change.

Who is this Playbook for?

This *Saving Time Playbook* is for:

- Practicing physicians who are aspiring change agents
- Medical directors
- Practice managers
- Operations leaders
- C-suite executives

Anyone interested in process improvement, timesaving workflows, efficiency of practice, and physician well-being can benefit from the content outlined and linked to within this Playbook.

This Playbook contains opportunities to **EXPLORE MORE!** through 9 AMA STEPS Forward® toolkits.

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Scan this QR code to fully engage with the Playbook and access all relevant links on your computer or mobile device.

Strategy 1: Stop the Unnecessary Work

Unnecessary tasks have introduced a heavy burden into the daily workload of physicians and other clinicians and contribute to physician burnout. The idea of getting rid of unnecessary work can feel so simple yet so daunting at the same time. Many physicians, especially those already experiencing burnout, feel resigned to whatever unnecessary work they are given. However, with visible leadership commitment, concrete examples to work from, and mechanisms in place to evaluate and implement effective changes, unnecessary work does not have to be "just how it is."

This section will help you *save time* by:

- Identifying opportunities to de-implement unnecessary processes and protocols at the practice or organizational level
- Soliciting ideas from practicing physicians for eliminating unnecessary tasks and duplicative work

De-Implement, De-Implement, De-Implement

The AMA STEPS Forward de-implementation checklist (PDF) is a great place to start. Many of these de-implementation tactics can be accomplished within weeks or even days (Table 1).

Table 1. Potential De-Implementation Opportunities

COMPLIANCE

OPPORTUNITY TO ACT	DE-IMPLEMENTATION ACTION
Allow verbal orders in low-risk and in crisis situations as legally permitted	–
Reduce signature requirements	• Eliminate signature requirements for forms that do not legally require a physician signature • Eliminate order requirements for low-risk activities that do not legally require a physician signature (ear wash, fingerstick glucose, oximetry) • Consider eliminating "challenge questions" to electronically sign orders when the user already logged in and actively using the EHR
Evaluate annual trainings and attestations	• Review current compliance training modules and consider removal of those that aren't required by a regulatory agency or for which evidence of benefit is lacking
Reduce attestations required daily or every time one logs in	• Eliminate requirements as allowed by state or federal requirements (i.e., for privacy protection attestation) that occur on a daily or every-time-one-logs-in basis (i.e., consider whether an annual attestation is sufficient)

QUALITY ASSURANCE/IMPROVEMENT

OPPORTUNITY TO ACT	DE-IMPLEMENTATION ACTION
Eliminate the rote ascertainment of learning style preference	–
Perform condition screens no more frequently than recommended	• Include a "grace period" of at least 30–50% of the guideline recommended time interval when constructing a performance measure from a clinical practice guideline Example: If clinical practice guideline recommends annual screening for depression, then set performance measurement with an interval of performing this task within 18 months; otherwise, team members will waste limited clinical resources screening more often than is required to meet the 365-day annual interval

EHR

OPPORTUNITY TO ACT	DE-IMPLEMENTATION ACTION
Minimize alerts	• Retain only those alerts with evidence of a favorable cost–benefit ratio
Simplify login	• Simplify and streamline login process, leveraging options like single sign-on, RFID proximity identification, bioidentification (fingerprint, facial recognition, etc)
Extend time before auto-logout	• Consider extending time for workstation auto-logout • Consider customizing workstation location and the security level to use patterns of the specific user
Decrease password-related burdens	• Consider extending the intervals for password reset requirements • Help users create passwords that are both strong and easy to remember (ie, by allowing special characters and spaces and by allowing longer passwords that can be passphrases) • Consider use of password-keeper programs
Reduce clicks and hard-stops in ordering	• Reduce requirements for input of excessive clinical data prior to ordering a test • Eliminate requirements to fill fields attesting to possible pregnancy in males or women over 60 years old
Eliminate requirements for password revalidation	• Identify ways to reduce unnecessary requirements for users to re-enter username and password when already signed in to EHR, to send prescriptions Note: Organizations may choose to keep this requirement in place for opioid prescriptions)
Reduce note-bloat	• Reduce links embedded in visit note documentation templates that automatically pull in data from other parts of EHR contributing to "note bloat," but adding little if any true clinical value
Reduce inbox notifications	• Stop sending notifications for tests ordered that do not yet have results or have test results not ordered by the physician in question • Stop sending notifications for reports generated by the recipient of the notification • Eliminate multiple notifications of the same test result or consultation note • Consider auto-release of normal and abnormal test results to the patient-facing portal with embedded or linked patient-friendly explanations
Simplify order entry processes	• Optimize technology to auto-populate necessary discreet data fields if the information already exists in EHR (e.g., if medical assistant has completed a discreet field for "last menstrual period," optimize your technology so no one has to reenter that data into the order for a pap smear)

Getting Rid of Stupid Stuff

For additional ideas, a simple program throughout your practice to solicit suggestions for change can be a powerful timesaving tool. Physicians themselves are often in the best position to recognize the "stupid stuff" in their day-to-day but may not feel empowered to speak up unless asked. The Getting Rid of Stupid Stuff toolkit offers details on creating a comprehensive Getting Rid of Stupid Stuff (GROSS) program for your practice or organization.[2]

Key STEPS are:

1. Appoint a high-level champion to lead the GROSS initiative
2. Engage appropriate departments to support the cause (Table 2)
3. Engage teams and clinicians in gathering information
4. Triage suggestions for appropriate next steps (Figure 1)
5. Celebrate success

While some of this unnecessary work may require investigation, time, and resources to eliminate, many things end up being "pebble in shoe" fixes that are easy to accomplish with dramatic effects, such as:

- Changing the automatic logout time for the EHR from 5 minutes to 15 minutes
- Turning off automatic inbox notifications for copied test results ordered by another physician
- Turning off automatic inbox notifications for test order and scheduling confirmations
- Allowing prescriptions for non-controlled substances to be electronically sent in without reentering the EHR password each time

A successful GROSS program does not need to be complicated. The essential elements include a visible leadership commitment, concrete examples to work from, and an IT and governance structure to evaluate the feasibility of requests and implement effective changes. Early and regular communication about the program and its successes will help to generate interest and increase confidence in the program.

EXPLORE MORE!

Getting Rid of Stupid Stuff toolkit

Reduce Pajama Time and Work Outside of Work (WOW) podcast
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Small Interventions Matter podcast
Listen on Spotify | Listen on Apple Podcasts

Electronic Health Record Optimization podcast
Listen on Spotify | Listen on Apple Podcasts

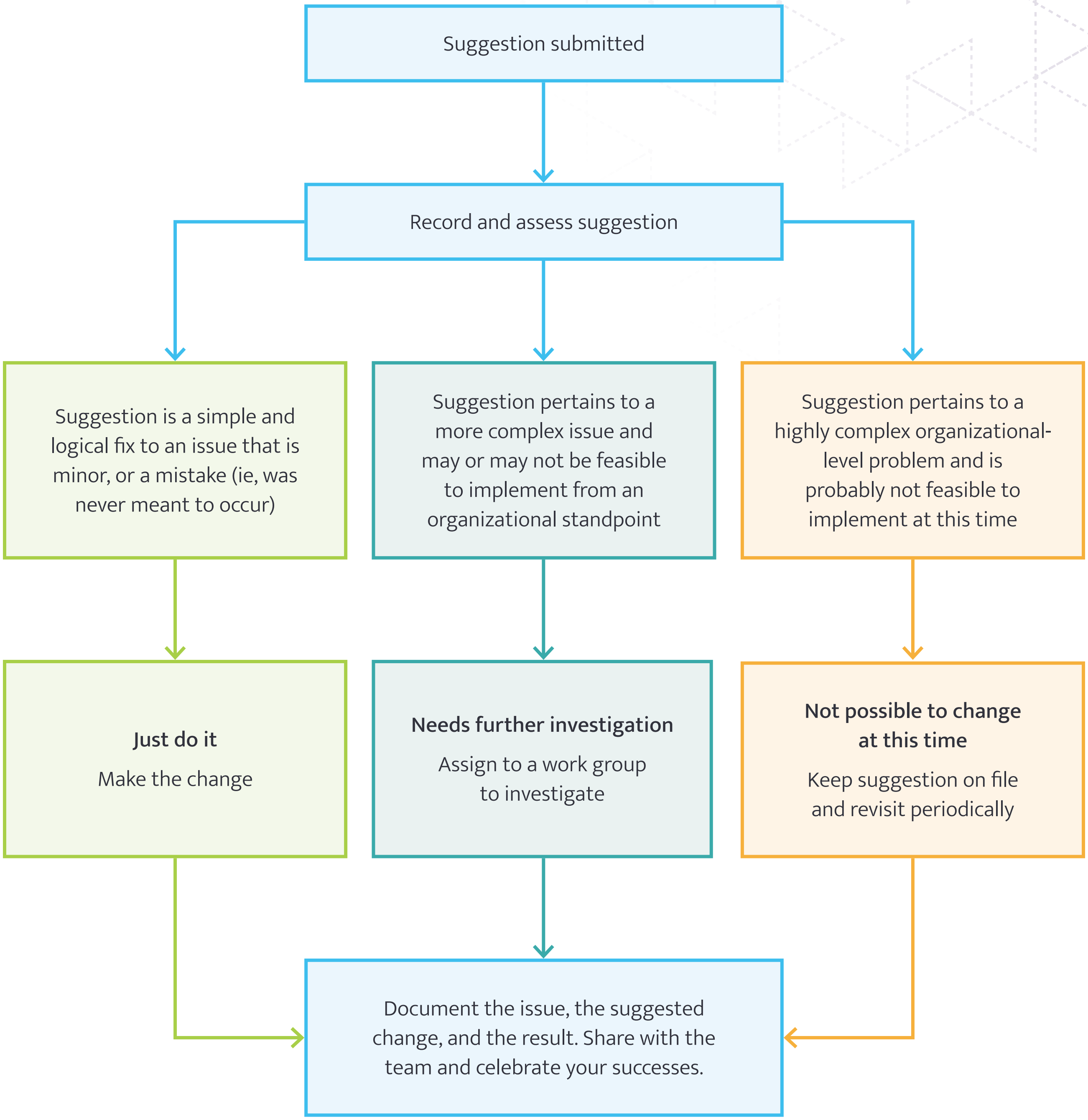
Table 2. Key Players in a GROSS Initiative

DEPARTMENT	ROLE	POTENTIAL "STUPID STUFF" THAT CAN BE ADDRESSED
Information Technology (IT)	Design, build, and maintain/improve the EHR	The record-keeping system for a practice's financial data, with debit and credit account records validated by a trial balance
Risk Management	Advocate for liability reduction	Processes implemented to mitigate risk that may be well-intentioned but not useful
Legal	Oversee compliance and risk management activity	Processes implemented to mitigate risk that may be well-intentioned but not useful
Compliance	Interpret regulatory requirements	Misunderstandings about regulatory requirements
Quality	Provide expertise on process improvement and understanding regulatory requirements	Misunderstandings about regulatory requirements
Health Information Management (HIM)	Provide information on documentation, coding requirements, and coding	Overinterpretation of requirements (especially HIPAA rules)
Revenue Cycle	Provide information on payer requirements	Misunderstandings about requirements for accurate billing
Mandatory education	Provide mandatory physician (and other clinician) training	Irrelevant training requirements
Nursing leadership	Represent nurses and provide expertise on nursing workflow	Documentation requirements that are variably determined by managers, rather than standardized. Documentation of nurse activities, rather than patient care provided
Physician executive leadership	Represent physicians and provide expertise on physician workflow	Medical executive committee requirements that create extra work
Specific departmental leadership*	Provide expertise on specialty-specific workflow	Specialty-specific requirements that create extra work (often thought to be necessary for that specialty, but may not actually be)
Laboratory services	Provide expertise on appropriate lab ordering practices	Unnecessary clicks to accomplish appropriate ordering

*eg, radiology, ER, hospitalist, OB/GYN, pediatrics, surgery, pharmacy

Figure 1. Getting Rid of "Stupid Stuff" Decision Tree

Triage suggestions to determine appropriate next steps



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Getting Rid of Stupid Stuff

- Start getting rid of stupid stuff with the help of a de-implementation checklist (PDF).
- Record and revisit "unsolvable" problems periodically.

Strategy 2: Share the Necessary Work

Of course, even with optimal reduction of unnecessary work, at the end of the day, there is still much necessary work to be done. The key here is involving the entire care team to share the workload—this is essential for maintaining efficient patient care workflows and freeing up time for physicians to give their undivided attention to patients.

This section will help you *save time* by utilizing core team-based care workflows that include:

- Pre-visit planning and pre-visit laboratory testing
- Advanced rooming and discharge
- Team documentation
- Annual prescription renewals and medication management
- EHR inbox and patient portal management

Pre-Visit Planning and Pre-Visit Laboratory Testing

Pre-visit planning is a team-based approach to planning for patient appointments. Pre-visit planning communicates to patients that the practice is planning ahead in order to make their next visit as meaningful and productive as possible. Pre-visit planning saves time, reduces practice costs, and improves patient care. It can mean the difference between a clinic where physicians and team members are floundering and frustrated versus one where things run smoothly with the capacity to handle any unanticipated issues that arise.[3-6]

The Pre-Visit Planning toolkit describes STEPS for implementing a comprehensive workflow, including scheduling patients for future appointments at the conclusion of the current visit, arranging for pre-visit labs and other testing, identifying care gaps and pending/entering orders before the visit, and spending a few minutes to huddle as a team before the visit (Figure 2).

The Pre-Visit Laboratory Testing toolkit hones in on the process of pre-ordering laboratory tests before the patient's next visit, delegating order entry, and empowering team members to act appropriately when lab results are returned to the inbox.

How much time and money will pre-visit laboratory testing save my practice?

Consider a hypothetical scenario of an internal medicine practice that has not implemented pre-visit laboratory testing. This practice has 1,000 patients with medical conditions or prescription medications that call for regular laboratory testing. Every day, physicians and staff spend at least half an hour each reviewing results after a patient's visit has concluded and reaching out to patients to help coordinate follow-up care. These factors result in more than 200 hours of physician and staff time spent on post-visit laboratory tasks per year.

The Pre-Visit Laboratory Testing Time and Cost Savings Calculator (Figure 6) generates the estimated amount of time saved per day and the estimated annual savings that could be gained by implementing pre-visit laboratory testing. See the Calculators for Cost and Time Savings section for more information.

EXPLORE MORE!

Pre-Visit Planning toolkit

Pre-Visit Laboratory Testing toolkit

Improve Patient Care with Collaborative Care Team Models podcast
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Team-Based Care Model podcast
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Pre-Visit Planning

- Empower care team members to close potential care gaps before the physician sees the patient.
- Use a pre-appointment questionnaire to avoid being caught off guard by unexpected patient agenda items.
- Take a long view: schedule several future routine appointments at once.

Figure 2. STEPS of Pre-Visit Planning

At the End of the Current Visit	Between the Current and the Next Visit	On the Morning of the Next Visit
1 Use a Visit Planner Checklist to Preorder Labs and Other Needed Tests for the Next Visit	4 Use a Checklist to Review Pre-Visit Tasks	6 Hold a Pre-Clinic Team Huddle
2 Schedule the Next Follow-Up Appointment	5 Send Patient Appointment Reminders	7 Use a Pre-Appointment Questionnaire to Gather Patient Updates
3 Arrange for Tests to Be Completed Before the Next Visit		8 Perform a Handoff of the Patient to the Physician

?

QUESTION:

Which team members can enter orders during pre-visit planning?

According to the Joint Commission, any licensed, certified, or unlicensed team member, including registered nurses, licensed practical nurses, medical assistants, and clerical personnel, may enter orders at the direction of a physician. This includes orders based on standard office protocols or standing order sets that have been approved by the practice or organization.

Team members who are not authorized to "submit" orders should leave the order as "pending" for a certified or licensed team member to activate or submit after verification. The authority to pend vs activate or submit orders varies based on state, local, and professional regulations.

While the Centers for Medicare & Medicaid Services (CMS) is silent on who may enter orders, in general, CMS considers diagnostic test order requirements met if there is an authenticated medical record by a physician supporting their intent to order the tests. Again, this may vary by state, local, and professional regulations.

Advanced Rooming and Discharge

Physicians alone cannot do all the work needed for most office visits.[7] Advanced rooming and discharge protocols are standardized workflows that enable nonphysician team members to take on additional responsibilities to save physician time and reduce costs for practices. Additional tasks include identifying screening tests and immunizations due, updating certain history components in the chart, and helping with patient education and follow up planning, among other things (Table 3).

Conducting advanced activities during patient rooming will enable the physician to spend more time directly interacting with the patient, rather than focusing on these elements of the visit. The augmented patient discharge process will ensure that patients understand and remember their discharge instructions, leading to improved treatment adherence.

EXPLORE MORE!

Advanced Rooming and Discharge toolkit

Improve Patient Care with Collaborative Care Team Models podcast
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Training Medical Assistants as "Encounter Specialists" podcast
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Table 3. Tasks Medical Assistants or Other Team Members Can Complete Under Advanced Protocols

During Rooming	During Discharge
• Identify the reason for the visit and help the patient set the visit agenda • Perform medication reconciliation • Screen for conditions based on protocols • Update past medical, family, and social history • Administer immunizations based on standing orders • Pend or order preventive services based on standing orders • Assemble medical equipment, if needed, before the physician enters the exam room	• Print and review an updated medication list and visit summary • Review other after-visit instructions, such as home blood pressure monitoring or referrals to subspecialists • Coordinate the next steps of care, such as scheduling future appointments and labs

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Advanced Rooming and Discharge

- Prioritize "the list". For patients with several concerns, ask them, "What are the 3 issues that are most important to you today?"
- If possible, place a printer in every room.

Team Documentation

Team documentation, or multiple contributor documentation, is a process where nonphysician team members assist with documenting visit notes, entering orders and referrals, reconciling medications, and preparing prescriptions during a patient visit. Clinical team members, such as medical assistants or nurses, or nonclinical team members, such as students or dedicated scribes, can support team documentation (Figure 3). The degree of task-sharing varies according to state and local scope of practice regulations.

Decreasing physician time spent on documentation tasks that other team members can handle is also an important cost-saving tool for organizations.

Sometimes, physicians express concern that another person in the room interferes with the patient–physician relationship. However, most physicians who have transitioned to team documentation find that the extra person actually improves the patient–physician relationship by allowing them to focus on the patient rather than be distracted by the EHR. Patients also voice this benefit of increased attention from their physician, and in general view the extra person in the room as another advocate for their health.

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Team Documentation toolkit

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Figure 3. Sample Team Documentation Workflow

Patient check-in

Patient rooming

Take vital signs, determine chief complaint, update past family and/or social history, update immunizations, etc.

Areas where others could assist in the team documentation process while they are with the physician and patient in the exam room

Patient interview and examination

During the physician's discussion with the patient, the documentation assistant records the history and exam as directed by the physician.

Plan of care and clinical documentation

While the physician and the patient discuss the plan of care and next steps, the documentation assistant records the plan and fills in the details for the after-visit summary.

Prescription, order, and referral processing

Throughout the visit, the documentation assistant can place orders, ensuring that any orders are prepared for the physician's signature as appropriate.

Patient education and care coordination

Reinforce next steps of care as well as provide immunizations, patient education and health coaching, order and schedule laboratory tests, screenings, etc.

Patient check-out

Annual Prescription Renewals and Medication Management

Managing the care of patients who take multiple medications creates a conundrum for the already overburdened clinician: during a brief visit, how do you fill or refill medications efficiently, reconcile all medications, and ensure that patients are taking them as prescribed?

Adopt annual prescription renewals for medications for chronic illnesses

The Annual Prescription Renewals toolkit is devoted to synchronizing all prescription refills to the same day, and providing enough refills on this day to last patients for 12 to 15 months. You could save up to **5 hours a week** by writing prescriptions for certain medications that treat chronic conditions so that all patients receive a 90-day supply with 4 refills.[8] The shorthand for this is "90 x 4." Choose one visit, such as the annual checkup or wellness visit, to renew all medications, even if there are still a few refills left on some of the older prescriptions. This may seem intuitive, but many practices don't have standard processes for synchronizing and standardizing recurring patient prescriptions. Eliminating frequent prescription renewals is the first step to improving how you and your team manage medications for your patients.

How much time and money per year will an annual prescription renewal process save my practice?

Consider a hypothetical scenario of an internal medicine practice that has not implemented an annual prescription renewal process. This practice has 1,000 patients with chronic illness with an average of 5 medications per patient. Every year, each patient makes an average of 2 calls per prescription. Each call lasts about 2 minutes. These factors result in more than 300 hours or 8 weeks of physician and staff time spent on prescription renewals per year. The Annual Prescription Renewal Time and Cost Savings Calculator (Figure 5) generates the estimated amount of time saved per year and the estimated annual savings that could be gained by implementing an annual prescription renewal process. See the "Calculators" section of this playbook for more information.

Adapt how your practice manages medications

Building on the Annual Prescription Renewal toolkit, the Medication Management toolkit details the STEPS you can take to further optimize processes for managing medications, including tips for medication reconciliation, prior authorization, medication de-escalation, and medication adherence.

EXPLORE MORE!

Annual Prescription Renewals toolkit

Medication Management toolkit

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Medication Management

- 90×4 is one of the easiest, most impactful ways to change how you manage medications.
- Incorporate medication reconciliation into existing workflows.
- When you see your patient is not at goal, investigate medication nonadherence.
- Develop standing orders for refills that require lab evaluation (eg, thyroid stimulating hormone [TSH], HbA1c, or International Normalized Ratio [INR] for patients on warfarin).

EHR Inbox and Patient Portal Management

A key time sink for physicians in the EHR is the physician EHR inbox, or in-basket. As the physician's workload grows, so does the volume of the inbox, creating a burden that is impossible to manage alone.

The reality is that (1) many inbox messages do not need to enter the inbox in the first place, and (2) of those messages that should enter the inbox, the majority do not need to be routed to the physician (Figure 4).

The EHR Inbox Management toolkit will help you keep unnecessary messages from being routed to the inbox, guide you through establishing a centralized team inbox, and provide workflows to empower team members to contribute in a meaningful way to inbox management (Table 4).

Key STEPS are:

1. Engage the IT department
2. Group different types of messages into common buckets
3. Create team pools corresponding to each bucket of messages
4. Assign team members to cover team pools
5. Develop workflows and train team members to manage team pools

The Patient Portal Optimization toolkit provides further detail on how to effectively manage the patient portal component of the EHR.

EXPLORE MORE!

EHR Inbox Management toolkit

Patient Portal Optimization toolkit

Electronic Health Record Optimization podcast
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Improve Practice Efficiency with EHR "Quick Wins" podcast
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Taming the EHR podcast
Listen on Spotify | Listen on Apple Podcasts

Sharing Clinical Notes With Patients podcast
Listen on Spotify | Listen on Apple Podcasts

Figure 4. Recommendations to Tame Your EHR Inbox

Bucket	What	Routes to	First pass by
BUCKET 1	Information or questions about clinical care from patients or clinicians outside the practice →	Clinical pool →	MA, escalate to triage RN or physician as needed
BUCKET 2	Nonclinical questions from patients or others (eg, scheduling questions, billing questions) →	Administrative pool →	Patient liaison or PSR, escalate to MA or billing staff as needed
BUCKET 3	Medication refill requests from patients or phramacies →	Refill pool →	Refill nurse (RN or LPN)
BUCKET 4	Requests for forms or letters →	Administrative pool, then may need to be forwarded to the clinical pool →	Administrative pool, then MA or RN for any clinical information, lastly by a physician for signature is needed

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EHR Inbox and Patient Portal Management

- The majority of inbox messages do not require "physician eyes", and the ones that do should be triaged prior to being sent to the physician.
- Physical colocation or brief huddles between team members and physicians can eliminate unnecessary back-and-forth message exchanges.
- Instead of setting aside time, encourage team members to use any free moments to check the EHR inbox. For example, longer appointments may give team members who aren't part of the visit a 10- to 15-minute window to check the EHR inbox throughout the day.

Table 4. Things That Should Not Enter the EHR Inbox

THE PHYSICIAN INBOX	
WHAT	**HOW TO SOLVE THE PROBLEM**
• Results of tests not ordered by the physician • Notifications of canceled orders or overdue (expiring) orders • Notifications of scheduled appointments • Patient Event Notifications which are not federally required (eg, admissions to hospital outpatient departments, colonoscopies, pharmacy visits, other ambulatory visits)	Turn off automatic notifications for physicians. Can also consider batched notifications.
• Notifications of canceled appointments or no shows for appointments with specialists	Institute system-wide patient outreach protocol for canceled/missed appointments originating from the department where the appointment was scheduled to take place.
• Any untriaged patient portal messages	Use a patient portal protocol for triaging messages.
• Refill requests for medications that treat chronic conditions	Implement a refill protocol with standing orders (as allowed by state regulation).
• Scanned copies of documents that are already signed • Automated (non personalized) specialist correspondence for specialist visits • Progress notes on hospitalized patients	Turn off automatic carbon copy (cc) function.

THE CARE TEAM INBOX	
WHAT	**HOW TO SOLVE THE PROBLEM**
• Logistical questions regarding tests, procedures, or appointments	Reroute to clerical or administrative inbox.
• Clarifying questions regarding a recent visit without first being directed to review their visit note	Optimize communication with patients via after visit summaries and shared visit notes with patients. Make the note easily accessible to patients on the patient portal.
• Billing questions	Reroute to billing department.
• Questions about routine lab results	Implement pre-visit planning with pre-visit labs. Consider adding FAQs about routine results as a smart phrase.

Strategy 3: Make the Case to Leadership

It has been said time and again: saving time saves money. With the support of organization leadership, the timesaving measures described in this Playbook have the potential to:

- Reduce the number of physicians who decrease their clinical effort to part time, which may result in increased burnout for their colleagues
- Improve overall patient volume and access, thereby increasing patient satisfaction and quality of care
- Increase team engagement using team-based care approaches, which translates into improved team morale, better continuity of care, higher performance on quality metrics, and decreased turnover for staff members
- Improve organizational culture, which may lead to easier recruitment of new physicians and team staff members when needed
- Reduce physician turnover within the organization (replacing a physician who leaves can cost 2 to 3 times their salary)

This section will help you *save time* by:

- Identifying key messages to convey to organizational leaders to help them understand the value of physicians' time
- Providing simple calculators to make your case

Calculators for Cost and Time Savings

Sample calculators from the AMA STEPS Forward® toolkits provide excellent starting points for communicating the financial benefits of saving time to organizational leadership. In addition to estimating the time and money saved (Figures 5 and 6), calculators can also estimate the cost of burnout and physician turnover to the organization and cost savings from implementing burnout interventions (Figure 7).

Click anywhere on each figure to access the interactive online calculator and toolkit.

Figure 5. Calculate savings from annual prescription renewals*

1,000 patients x 5 Meds/patient x 2 calls/year x 2 minutes per call

= 20,000 minutes/year

Time spent on medication renewal calls
(equivalent 6 hours per week or 8 weeks per year)

Estimated Savings from Annual Prescription Renewals

~1 hour/day = **$26,400/year**

Estimated time saved
(equivalent to up to 8 weeks per year)

Estimated savings per year*

*Based on $120/hour average cost of physician and clinical team member time, and 220 clinic days/year.

Figure 6. Calculate savings from pre-visit laboratory testing*

$3	$1	220
Dollars per minute of physician time	Dollars per minute of staff time	Clinic days per year

Estimated Savings from Previsit Labs

1 hour/day

Time saved per day
(equivalent to 27 days per year)

$26,400/year

Money saved per year
with previsit labs

*Based on equal task involvement between physician and team member.

Figure 7. The cost of physician burnout for your organization*

500	44%
Number of physicians in your organization	Rate of physician burnout in your organization
$500,000	7%
Cost of turnover in your organization per physician	Current physician turnover rate (all causes) in your organization

Impact of Physician Burnout in Your Organization

11	**$5,347,222**
Number of physicians in your organization turning over due to burnout per year	Estimated cost of physician turnover per year due to physician burnout

$1,000,000	20%
Cost of interventions per year	Projected reduction in burnout

Estimated Savings from Burnout Intervention

4.86%	**$1,069,444**	**6.94%**
Turnover with burnout interventions	Estimated savings due to reduced burnout	Return on investment (ROI), per year

*For details regarding calculator formulas, please see Figure 2 of the source article from JAMA Internal Medicine. Other costs of burnout, in terms of medical errors, malpractice liability, patient satisfaction, productivity and organizational reputation, are not included. See more at Shanafelt T, Goh J, Sinsky C. The Business Case for Investing in Physician Well-being. *JAMA Intern Med.*2017;177(12):1826–1832. doi:10.1001/jamainternmed.2017.4340r

Conclusion

Getting rid of unnecessary work and improving practice efficiency are cornerstones for preventing physician burnout and creating a culture of wellness at the organizational level.

This work requires commitment by senior leadership as well as concrete strategies to create change, which are outlined in this Playbook.

By guiding practices and organizations on how to identify and reduce unnecessary tasks, avoid overinterpretation of regulations, and implement more efficient workflows, this Playbook helps physicians get back to their true calling—taking care of patients.

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Resources and Further Information

For the optimal experience—GO DIGITAL!

Scan this QR code to fully engage with the Playbook and access all relevant links on your computer or mobile device.

Practical Tools

The selected practical tools listed here are to get you started on several of the new or adapted processes outlined in this Playbook right away. The individual toolkits on the AMA STEPS Forward® website include these and additional resources. Click on the following links for immediate access to the listed resources.

Getting Rid of Stupid Stuff

- De-implementation checklist (PDF)

Pre-Visit Planning

- Pre-appointment questionnaire (Word Doc)

Pre-Visit Laboratory Testing

- Visit planner checklist (Word Doc)

Advanced Rooming and Discharge

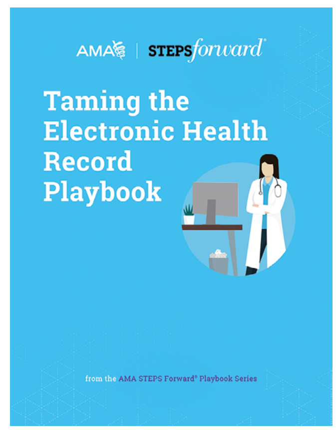
- Rooming checklist (Word Doc)
- Discharge checklist (Word Doc)

Annual Prescription Renewals

- Synchronized prescription renewal checklist (Word Doc)

Related Playbook

For additional timesaving and efficiency-boosting tips, check out the companion STEPS Forward Taming the Electronic Health Record Playbook (PDF).



Key Journal Articles

- Sinsky CA, Daugherty Biddison L, Mallick A, et al. Organizational evidence-based and promising practices for improving clinician well-being. *NAM Perspectives.* November 2, 2020. doi:10.31478/202011a
- Shanafelt T, Goh J, Sinsky C. The business case for investing in physician well-being. *JAMA Intern Med.* 2017;177(12):1826-1832. doi:10.1001/jamainternmed.2017.4340
- Sinsky CA, Rule A, Cohen G, et al. Metrics for assessing physician activity using electronic health record log data. *J Am Med Inform Assoc.* 2020;27(4):639-643. doi:10.1093/jamia/ocz223
- Sinsky CA, Bodenheimer T. Powering-up primary care teams: advanced team care with in-room support. *Ann Fam Med.* 2019;17(4):367-371. doi:10.1370/afm.2422
- Porter J, Boyd C, Skandari MR, et al. Revisiting the time needed to provide adult primary care. *J Gen Intern Med* (2022). doi:10.1007/s11606-022-07707-x

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Learn More About Practice Innovation

Take the next steps on the journey with the AMA STEPS Forward® practice innovation resources and assets.

Use the 5-pronged approach (Act, Recognize, Measure, Convene, Research) as your guide. Employ the evidence-based, field-tested, and targeted solutions described below to optimize practice efficiencies, reduce burnout, and improve professional well-being.

Act

- View the comprehensive portfolio of AMA STEPS Forward® resources at stepsforward.org, including toolkits, playbooks, videos, webinars, podcasts and calculators.
- The AMA's Mentoring for Impact program provides virtual meetings with a Professional Satisfaction and Practice Sustainability Group physician who can help develop a customized approach to remove obstacles that interfere with patient care. For more information, email stepsforward@ama-assn.org (include "Mentoring for Impact" in the subject line).

Recognize

- Participate in the AMA STEPS Forward® Recognition of Participation certificate program and find new ways to engage with your team
- Use the AMA Joy in Medicine™ Health System Recognition Program as a road map to support your organization's strategic efforts

Measure

- Take our practice assessment to identify and prioritize your workflow intervention efforts
- Encourage your organization to measure professional well-being on an annual basis

Convene

- Join us at the AMA STEPS Forward® Innovation Academy for timely and relevant webinars and more
- Attend the International Conference on Physician Health™ (ICPH), the American Conference on Physician Health (ACPH), and other upcoming conferences, summits, and events as they are announced

Research

- Stay abreast of meaningful research to guide your professional well-being strategies and interventions

Watch the video to learn more about AMA Professional Satisfaction and Practice Sustainability efforts, or visit stepsforward.org.

About the AMA Professional Satisfaction and Practice Sustainability Group

The AMA Professional Satisfaction and Practice Sustainability group is committed to making the patient–physician relationship more valued than paperwork, technology an asset and not a burden, and physician burnout a thing of the past. We are focused on improving—and setting a positive future path for—the operational, financial, and technological aspects of a physician's practice.

Learn more.

Disclaimer

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