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CENTRALIZED SCHEDULING: BENEFITS AND RISKS

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INTRODUCTION

Employed provider networks invariably consider the option of implementing a centralized scheduling process. Proponents cite benefits such as:

- Promoting scheduling consistency and reliably "filling" provider schedules.
- "Forcing" standardization of appointment types and other scheduling templates issues across the network.
- Wresting control of the schedule from providers and their practices, giving management more control of template management across practices.
- Maximizing staff utilization by consolidating the scheduling functions across practices.
- Avoiding "constant" interruptions at the front desk and allowing staff to more consistently devote undivided attention to the patients and to their assigned tasks – which should result in better customer service and more reliable, comprehensive capture of patient information, co-payment collection, and other tasks associated with successful revenue cycle function.

When done well, creating an efficient centralized scheduling process can achieve these benefits – but there is a risk of huge costs with few benefits if not done well.

Just as centralized scheduling has many supporters (usually administrators), it also has many detractors (usually providers and their clinical support staff). Some detractors cite actual previous adverse experiences but most just fear the unknown possibilities associated with a different paradigm, a loss of control, and a perception that no one can do scheduling as well as they and their office staff can. As a result, the mere mention of the topic often ruffles feathers and rankles the troops.

ESTABLISHING A CENTRALIZED SCHEDULING PROCESS

So how can an organization best proceed through the mine field that is centralized scheduling planning, design, implementation, and execution? Considering these suggestions should help:

Define the Intent

Is the organization creating a call center or a centralized scheduling process? A call center provides a single point of contact for all practice issues and a "remote" interface through call transfer or voice/electronic mail messages. A centralized scheduling process can be embedded within the practice structure and deals solely with requests for patient appointments. Determining and communicating the intent of vision for the undertaking is a crucial starting point for the endeavor.

Get Staff Involved

Involve physicians, APPs, practice managers, and administrative and clinical support staff from the beginning of the planning process to be aware of and address their multiple perspectives. Involving key stakeholders allows the organization to anticipate issues and create processes to mitigate them (Failure Modes and Effects Analysis). Involving stakeholders early permits the development of shared expectations – such as defining a culture or expectations of "full schedules" across the network as well as how the network is ultimately affected.

Adopt Template Parameters

Involve the stakeholders with defining standard appointment types and durations – and the criteria for variances. These might include longer appointment durations for providers joining the group immediately out of a training program or longer appointment times based on patient complexity/risk stratification. Ensure that the template parameters are specialty-specific and are uniformly and equitably applied – and reinforced.

Adopt Scheduling Parameters

Develop the "rules of the road" for the patient scheduling process. When should appointment requests be "elevated" to another level? What types of patients merit special consideration? When can "same day" appointments be utilized? These are all questions that are important to consider.

Define Any Exceptions

Some organizations adopt the tenet that 100% of all practices' appointments will be scheduled through the centralized scheduling process. This type of rigid approach invites dissension and conflict. Rather, consider the centralized scheduling process within the 80-20 or 90-10 rules – the process is appropriate for scheduling 80 to 90% of all appointments … but not likely 100%. Define the exceptions, such as all requests that cannot be fulfilled within the availabilities of the published schedule or requests that require clinical critical thinking, and define the processes to accommodate those requests. Outlining identified circumstances in advance predicts a more smoothly operating system.

Risk Stratification for Patients

Undertaking the process of risk stratifying established patients will pay dividends for chronic care management and population health management initiatives. In the scheduling process, having patients risk stratified can assist schedulers with ensuring that patient complexity matches appointment lengths and assigned provider type while acting within the scheduling parameters. Various stratification systems exist but simple ones[1] can be accomplished fairly readily, can be annotated on the patients' profiles, and can be referenced when appointment requests are made.

Staff Appropriately

Ensure that an appropriate number of adequately trained, experienced individuals who possess excellent customer service skills staff the process. An "adequate number" will depend on the call history – volume of calls received, number of calls historically abandoned, average length and type of call – and the complexity of practices covered. A general rule of thumb is a ratio of one (1) scheduler for every five (5) providers. "Adequate training" involves intimate knowledge of processes, policies, procedures, and practice operations combined with defined customer service expectations. The impact of adequate training should never be underestimated and sufficient time and effort should be expended prior to inserting staff into the process.

Open Communication

Communication is always important – but especially important in high stakes undertakings fraught with peril as well as personal opinions. Communicate early and often through the planning, design, and implementation phases. Use provider leadership structures, provider champions, and all-provider meetings to effectively augment written communications about plans and results. Information about initiating a centralized scheduling process is one topic that cannot be overcommunicated.

Rapid Cycle Change

Initiate the new processes in a small pilot project utilizing a "champion" stakeholder practice and principles associated with rapid cycle change to identify and address "bugs" in the system within short time frames. This minimizes adverse global impact and generates a critical mass of providers and practices over time with progressive satisfaction in the evolving system. Ensure that scheduler support is able to expand as the numbers of supported providers expands. Anticipate the expected growth and train schedulers before they are absolutely needed.

Continue Monitoring

Once fully implemented, continue to actively monitor the program to solicit feedback and continually improve. Entropy can gain momentum in any system and the process may drift to be no longer executed as designed. Discovered early, interventions can stay the course. In addition, ongoing monitoring can identify design improvements to enhance function and outcomes. Employing ongoing continuous process improvement methodologies should not only keep the program on track, but should also permit it to get better with age.

CONCLUSION

While nothing is fool proof, utilizing this framework offers a roadmap to successful planning, design, and implementation of a centralized scheduling program. For organizations that desire external resources to augment their intrinsic resources for new undertakings, or trouble shoot existing programs, HSG has the expertise and experience to help. Call us at (502) 814-1180 or visit HSGadvisors.com.

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CITED REFERENCE

1. J. Dom Dera, Risk Stratification: A Two-Step Process for Identifying Your Sickest Patients. Family Practice Management, May/June 2019.