The concept's founder explains how to do "today's work today" and improve patient access to your practice.

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Answers to Your Questions About Same-Day Scheduling

Same-day scheduling, also known as "advanced access" or "open access" scheduling, allows medical practices to dramatically decrease patients' waiting times for appointments. Very simply, it requires that practices do today's work today by offering a same-day appointment to all patients who call. The result is more timely care, increased patient satisfaction and improved practice efficiency.

While the concept has great potential and has garnered much interest, it is often misunderstood. The key mistake practices make is thinking of same-day scheduling as a ready-made product or a specific solution guaranteed to reduce a practice's waiting time. In reality, there is no such product or solution; however, there is a proven process and a set of proven principles, which if applied in a customized fashion to each environment, will result in improved access to care. The course of action is similar to any quality-improvement process and involves four steps:

1) Assemble a team to address the problem;
2) Set an aim or a goal;
3) Make changes;
4) Measure to see whether your changes have resulted in an improvement.

The principles to apply throughout this process are fairly simple:

1) Understand, measure and achieve a balance between supply and demand;
2) Recalibrate the system (or reduce the backlog);
3) Reduce the number of queues by reducing the variety of appointment types or lengths (queuing theory);
4) Create contingency plans for times of heightened demand or lessened capacity;
5) Influence the demand (e.g., by matching patients with their own physicians, making the most of current visits and rethinking return-visit intervals);
6) Manage the constraints or bottlenecks (e.g., remove

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ILLUSTRATION BY GERARD DUBOIS

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Same-day scheduling results in more timely care, increased patient satisfaction and improved practice efficiency.

For same-day scheduling to work, a practice must first achieve a balance between supply and demand.

To estimate your demand, track the number of appointment requests you encounter on a daily basis for several weeks.

Next, figure how many appointments your practice can deliver on a daily basis.

from the physicians any work that can be done by someone else).

Same-day scheduling, then, is really all about the process and the principles, not about a specific product or solution. It will require some thought, customization and experimentation to apply these principles to your specific environment. If you're ready to embark on that, read on. What follows are commonly asked questions about open-access scheduling submitted by *FPM*'s readers.

Getting started

Q I practice within a large group that is looking into advanced-access scheduling. How should we start?

A The best way for your team to begin is to measure the supply and demand in your practice and make sure they are balanced. Advanced access will not be sustainable if patient demand for appointments is consistently greater than physician capacity to offer appointments. In fact, there is no system that will solve a demand-supply mismatch.

Your practice's demand can be derived by measuring the number of appointment requests it encounters on a daily basis and tracking the data over a period of time using statistical process control graphs. There will be variation, but a pattern or range should begin to emerge (e.g., 22 to 28 appointment requests per physician per day). You will probably find that demand is heavier on certain days of the week.

Next, you need to make sure your supply is adequate to meet the daily demand. To figure your supply, ask how many appointments your practice can deliver on a daily basis (e.g., 28 appointments per physician per day). Ideally, your supply rate should equal 80 percent of the range of daily demand. For example, if your range of demand is 22 to 28 appointment requests per day, 80 percent of that range would be 27. This is the amount of appointment slots that you would need to have in order to eliminate waiting time. In addition, you need to factor in any internally generated demand, such as return or follow-up appointments directed by the physician. You can use the internal demand as a load-leveler; that is, you can bring patients back at times when external demand is predictably lower – early morning or late in the week.

Once your supply and demand are well matched, you can begin to apply the remaining principles, mentioned earlier.

KEY POINTS

- Under advanced access, practices do "today's work today" by offering a same-day visit to all patients requesting an appointment.
- Advanced access is not a specific product or solution, but it involves a proven set of principles, which can be applied to individual practice environments.
- To begin eliminating waits, practices must ensure that the physician's supply of appointments is balanced with patient demand for appointments.

An appropriate panel size

Q What do we do if our patient demand is too great because we have a physician with too many patients on her panel?

A To eliminate waiting times or delays, supply and demand need to be balanced at the practice level and at the individual physician level. If a physician is over-paneled – that is, if she has more work than she can do – then the consequences are grave. Because she can't manage all of her patients, the work spills over to her colleagues or out of the practice, and patient satisfaction, quality and revenue cascade downward. On the other hand, matching patients with their personal physician is strongly correlated with improved clinical outcomes (compliance with prevention guidelines, management of patients with chronic illness and early detection of serious illness) and higher patient satisfaction. Hence, an over-paneled doctor produces tremendous adverse effects within a system. Over-paneled doctors are often blind to this because they are isolated from many of these consequences.

Physicians are usually reluctant to deal with this problem, in part because it seems to be patient driven. Some doctors are popular, and we let them become over-popular because we hate to say "no" to our patients. However, an over-paneled doctor is essentially saying "no" to her patients every day because she cannot do the work and is sending it elsewhere. It is her action that says "no."

There is a limit to what a physician can do. This limit can be mathematically derived. By trying to extend the limit beyond what is

practical, you are putting your practice in a position where it cannot be successful.

Standardized appointment lengths

Q Under open access, physicians are supposed to handle any issues that arise that day for any patient. To do this, wouldn't physicians need to be liberated from seeing patients every 15 minutes?

A The best systems have a single appointment length, whether it's 15 minutes or 20 minutes, because this allows greater flexibility for patients and is simpler for your staff. With standard appointment lengths, any patient can have any appointment slot at any time. If you create appointment slots of varying lengths that are locked into the schedule, then only certain slots are available for certain kinds of patients, which will create a waiting time. In addition, it is difficult to predict what kinds of slots you will actually need.

When practices use a single appointment length, as opposed to multiple appointment lengths, physicians are far more likely to develop a rhythm and stay on time. My recommendation would be to pick an appointment length that fits with the physician's style and patients' needs but allows the practice to complete all the work every day. At the same time, if there are some issues that you know will take more time (e.g., a physical), then permit the schedulers to merge two or more appointments slots. This can be done anywhere on the schedule, permitting maximum patient flexibility.

The trouble with carve-outs

Q I am one family doctor in a 50-physician multispecialty group, and I have been interested in open access for a long time. To that end, I have carved out six to eight "same-day" slots in my daily schedule for patients with urgent needs. However, I have not had the courage to switch completely to open access. Is a carve-out approach OK?

A Carve-out models have problems. First, the more time that you carve out of your schedule, the longer the waiting time extends for non-carved-out appointments. In addition, the more you carve out, the more accurate your predictions need to be. If you over-predict and carve out too many appointments for same-day visits, you could end up with unused capacity; if you under-predict, you could end up with an overbooked schedule.

In addition, carve-out models can waste a lot of time and energy on scheduling and triage. For example, what do you do with a patient who meets the criteria for a same-day appointment but can't get to your office today, or a patient who doesn't quite meet the criteria for a same-day appointment but can't wait until the end of the queue? Do you ask these patients to call back tomorrow, increasing your phone volume, or do you pre-book them? If you pre-book them, do you use a carved-out slot or a regular slot? These issues will rapidly deteriorate your carve-out model. The simpler approach is to offer all patients a same-day appointment, regardless of their problem. It requires no triage and no predictions.

Reducing backlog

Q How do we begin to reduce our backlog of already scheduled appointments so that we can begin advanced access?

When practices use a single appointment length, physicians are far more likely to develop a rhythm and stay on time.

A You will have to do extra work until the backlog disappears. This may mean working through the lunch hour, seeing more patients per hour or working late for several weeks. It will also require that you make the most of current visits, resist pushing work into the future and rethink your return-visit intervals.

As your backlog shrinks, mark a target date on the calendar and agree as a group that you will not pre-schedule any visits beyond that date unless there is a clinical reason for doing so (i.e., physician-driven returns) or the

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If a physician has too many patients on his or her panel, supply and demand will be mismatched, with work spilling over to colleagues or out of the practice.

The best systems use a single appointment length (e.g., 15 minutes or 20 minutes) because this allows greater flexibility for patients and is simpler for staff.

To prepare for same-day appointments, practices will need to work down their backlog of previously scheduled appointments.

As your backlog shrinks, mark a target date on the calendar and agree as a group that you will not pre-schedule visits beyond that date unless the physician or patient deliberately chooses a future appointment.

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Even under same-day scheduling, patients who need a pre-scheduled or follow-up appointment should be given one.

Whenever possible, schedule return visits late in the week or early in the day, when demand out of the population is naturally lower.

Same-day scheduling can be a shock to patients who are used to waiting days or weeks for an appointment, so educate them about the new system.

Practices with multiple part-time physicians may need to choose patient continuity with a team over continuity with a single physician in order to avoid waiting times.

patient wants a visit in the future.

Also, make sure you protect the physicians after they have reduced their backlog. Don't penalize them by making them absorb their colleague's work. To help motivate the physicians, display their data showing reduced waiting times. Backlog reduction is a necessary step to recalibrate the system, not a conspiracy to make physicians see more patients in perpetuity.

Scheduling patients in advance

Q A good proportion of my patient appointments need to be scheduled in advance because they involve procedures, prenatal visits, chronic care follow up, etc. Is open access feasible given my patient population?

A In the best systems, when a patient needs a pre-scheduled or follow-up appointment, that appointment is given. This is true even under advanced access. For example, if you know that a patient is going to return for a follow-up visit, the best approach is not to ignore that demand and lose control of it but to negotiate with the patient about when the return visit should occur. Whenever possible, you should schedule return visits late in the week or early in the day, when demand out of the population is naturally lower.

Pre-scheduling patients with certain clinical needs ensures you will not lose them to follow-up. In some practices, such as an obstetrical practice or one with a high component of newborns, the amount of pre-booked appointments is going to be higher than in typical practices. But the underlying dynamic remains the same: The demand, whether externally or internally generated, needs to equal the amount of appointments available. If practices can achieve this balance, then they can eliminate waiting time. Of course, patients with prescribed follow-up will still have a waiting time, but it is clinically justified.

While pre-booking is appropriate in some clinical situations, it is not appropriate in many cases, such as annual exams. If a practice has completed all of Monday's work on Monday, then it should have enough space on Tuesday even for an annual exam, if the patient chooses a same-day visit.

Patient preference

Q How should we handle patients who can't agree to a same-day appointment because they need to arrange time off from work before their appointments?

A Same-day scheduling can be a shock to patients who are used to waiting days or weeks for an appointment. You'll need to educate them about the new system, and most will welcome it. A small number of patients won't want an appointment on the day that they call. In these cases, do not tell the patient to call back on the day he or she wants to be seen, as this will increase your phone traffic. Instead, simply pre-book those appointments on the day the patient prefers, using slots in the early morning or late in the week if possible.

If a practice has completed all of Monday's work on Monday, then it should have enough space on Tuesday even for an annual exam.

Part-time physicians

Q I work in a family medicine residency practice, with multiple part-time physicians working varied hours. Is open access possible in this setting?

A An academic environment is no different from any other kind of environment where supply is sporadic but demand comes in unabated on a daily basis. What you need to do is match that demand with the correct supply and with as little time lapse as possible. In an environment where the physicians are not always present, you have to make a choice about continuity: Do you want patients to have continuity with a single physician, or can they gain continuity from a team of providers? If you choose continuity with an individual physician, you are going to create a waiting time. If you choose continuity with a team, you can avoid waiting time.

Either way, you still have to match the

supply with the demand. In an environment where the supply is steady, it can be balanced with demand on a daily basis. But in an environment where the supply, for whatever reason, is sporadic, you may need to pick a bigger balance box. For example, if you have three physicians on Wednesday but five physicians on Thursday, your supply and demand may balance each other over two days, instead of a single day. Be aware that as your balance box grows beyond a day, you're treading dangerously close to a carve-out model.

Preparing for visits

Q I prefer to see my patient list the day before so that I can research patients' concerns and organize what I need (e.g., patient education hand-outs, pre-printed encounter forms, algorithms). Would it work to modify open access and set appointments for the next day, rather than today?

A The preparation work for tomorrow's patients takes the same amount of time as the preparation work for today's patients. The challenge, then, is to do this work "just in time" rather than with a 24-hour lead time. "Just in time" processes are key to building a system with a smoother patient flow. The solutions for this will vary for each practice. Perhaps, instead of batching this work and handling it at the end of the day, you can address it in smaller blocks of time between patients. Or you may be able to handle it at the point of care if you organize the materials in your exam room or computerize the information so that you can access it quickly. Just-in-time solutions should work for the majority of your patients. Patients who require extensive preparation will probably have a pre-booked appointment, and that work can be done in advance.

Keep your appointment book

Q If open access is so great, why bother making appointments at all? You could potentially save time and money, and avoid many phone calls, by throwing out your appointment book and letting patients walk in on an as-needed basis.

A It would be unwise to solve the waiting time *for* an appointment and at the same time create a waiting time *at* the appointment. Your goal should be to reduce all waiting, both for the appointment (the access issue) and at the appointment (the office efficiency issue). Under open access, you create the dignity and respect of an appointment time while doing today's work today.

Going it alone

Q I am a new physician in an established office. Could I use open access even if the other physicians don't?

A It's very difficult to run two systems in a single practice. It could confuse patients and would certainly frustrate the staff, who would have to follow multiple rules. In addition, there is great value in working together in a practice. For example, when one physician is absent, the others can provide coverage. If the physicians have different waiting times, it may affect their willingness to support one another.

Dealing with vacations

Q How do you deal with physician absences or vacations under open access?

A Contingency plans are the key to managing absences, vacations or any other situations where demand temporarily exceeds supply. In a group practice, it's usually best to give patients a choice: Wait for your primary physician's return or be seen today by another physician in the group. About half of the patients will choose to be seen today, and you should divide those added visits equally among all physicians. When the physician returns, you could implement a contingency plan that temporarily allows half of his or her appointment slots to be carved out for same-day visits, while the other half are pre-booked. To get back on track, the physician may also need to work through lunch, see patients more

Your goal should be to reduce all waiting, both for the appointment and at the appointment.

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With same-day scheduling, practices must learn to do the prep work for patients' visits "just in time" rather than with a 24-hour lead time.

Same-day scheduling is part of a strategy to reduce all waiting times, both for and at the appointment.

To manage physician absences, vacations or other situations where demand temporarily exceeds supply, practices will need to develop contingency plans.

In a group practice when a physician is on vacation, it's usually best to give patients a choice: Wait for your primary physician's return, or be seen today by another physician in the group.

quickly or stay late for a day or two.

In a solo practice, patients will have no choice but to wait for the physician's return, and the office should develop a contingency plan similar to that described above.

A team approach

Q My staff seem skeptical of open access. Should I force them to do it anyway?

A In my experience, the people who do the work need to transform the work. The likelihood of change being accomplished by directive or mandate is extremely low. While leadership is crucial in setting the tone, the direction and the parameters, the key change vehicle is the team of people actually doing the work. This can be both frightening and empowering.

Start by educating your staff about the principles behind advanced access and the potential benefits. If you find a few individuals who seem interested in the concepts, support them and let them experiment with it.

Ready, aim, fire

Q Our practice is beginning to experiment with open access. What should our aim be?

A An access problem is a delay problem. In order to improve the flow of work, you should aim for reduced delay. This aim is the glue that will hold all of your efforts together. When the waiting time is reduced, you'll accomplish additional goals. Patient satisfaction will improve, physician satisfaction will improve, staff satisfaction will improve, the cost of care will be reduced, revenues will be enhanced, and clinical care will finally be optimized. You could focus on improving any of those other results in isolation, but if you focus on reducing the delay, you can achieve optimal results in all of those arenas. Thus, setting an aim around the reduction of waiting time – an aim that's both quantifiable and measurable – is crucial. To improve your work, you need to know what you are trying to achieve.

A sample aim would be "to reduce the time until the third next available appointment from seven days to one day." We use the third next appointment as a measure because it gives a more accurate picture of a practice's access. The first available appointment is often an anomaly (e.g., due to a last-minute cancellation) and not indicative of the true availability of appointments.

The secret to failure

Q In cases where open access has failed, what were the reasons?

A Failures are usually related to a lack of one of the following major success factors in reducing waiting times both for and at an appointment. The first success factor has to do with leadership. The leadership of an organization has to recognize that all waiting times are wasteful and that there is a proven process and set of principles to virtually eliminate waiting times in health care.

The second success factor has to do with measurement. In order to reduce waiting times, we have to achieve a balance between the demand for work and the supply of work. If there is a mismatch, and there's more demand than there is supply, then no system in the world will ever work. We need to measure demand, supply, panel size variation and current delays.

The third success factor is physician involvement. If the physicians are engaged and involved, success is not guaranteed, but if they are not engaged and involved, failure is almost certain.

The fourth success factor is the engagement of the entire team. Health care is a team sport, and to successfully reduce waiting times, we need the engagement of all the people who work together on this team.

Note: For more information on advanced access, read Dr. Murray's previous article, "Same-Day Appointments: Exploding the Access Paradigm," FPM, *September 2000, page 45; http://www.aafp.org/fpm/20000900/45same.html. Send comments to fpmedit@aafp.org.*

If the physicians are not engaged and involved, failure is almost certain.

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Staff members need to be involved early in the transition to open access, as change is rarely accomplished by directive or mandate.

Start by educating your staff about the principles behind advanced access and the potential benefits.

When practices aim to reduce the waste of waiting for appointments, additional benefits will follow, such as improved patient satisfaction, physician satisfaction, staff satisfaction, revenue and quality.

The leadership of an organization has to recognize that all waiting times are wasteful and that there is a proven process and set of principles to virtually eliminate waiting times in health care.