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Open Access Scheduling: A Medical Director's View from the Trenches

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Open Access Scheduling: A Medical Director's View from the Trenches

Most patients who make a traditionally scheduled appointment with their primary care doctor can expect a wait of weeks or months. Indeed, the hallmark of a successful practice has been to have a long waiting list of booked appointments. For patients who are ill or who need to be seen urgently, the wait is usually less but at the expense of other patients' appointments or the doctor's time, i.e., they are "squeezed" into an already busy schedule.

Now imagine that a patient can call for any type of appointment, routine or urgent, and be told to come in that same day or the next, without overloading the schedule or the doctor. This is the premise and promise of open access scheduling: A patient may be seen when he wants for what he wants and by his own doctor. Developed by the Institute of Healthcare Improvement (IHI) in Boston, open access scheduling follows the motto, "Do today's work today" and not next week or next month. It is a major change in the way patients are scheduled for appointments in that almost all appointments are kept open until that day or the day before. Instead of a patient leaving the office and being told that he has a return appointment in three months, he is told to call in three months for an appointment on the day he wants it. Instead of telling a patient who calls for an appointment that the next available one is in six weeks, he is told to come in that day or the next. Instead of the doctor having an empty visit slot because a patient forgot or cancelled his appointment, all the slots are full with patients who showed for their appointment because it was made within one day. Instead of staff wasting time scheduling and rescheduling patients who forgot or cancelled their appointments, or the schedules of doctors who had to cancel, they can be used for other duties.

The Department of Family Medicine of Jefferson Medical College decided to implement open access scheduling in July 2002 after months of debate and planning. Many reasons led to this decision, such as the need to improve patient satisfaction with access to the clinical office and the need to decrease the rate of patients who do not show for or cancel their appointments. There was also a need to increase clinical productivity and income while maintaining the ability of the faculty to pursue their academic mission of teaching and research.

By analyzing patient visit data over the last five years, it was apparent that both of these reasons were intertwined. For example, for regular patient hours, only 57% of patients who were scheduled for a visit on a certain day actually arrived for that visit, despite a costly phone reminder system. Contrasted to this were the 85% of patients who arrived for sick or urgent visits. A 10% increase in arrived patients for regular office hours would mean a large increase in productivity. Also, about one-third of the approximately 1,500 phone calls per day were from patients who requested relatively soon appointments, so the patient volume was thought to be available.

Numerous obstacles were confronted both during planning and initial implementation. Chief among those obstacles was that of all the practices in the country that were using open access scheduling, none was an academic department with essentially all full-time equivalent physicians, so there was no blueprint to

follow. Requiring every physician to use the open access model rather than piloting the program with a few adventurous faculty members solved this problem. Obtaining agreement from busy physicians and requiring them to make such a drastic change was the next biggest obstacle. This was overcome through education and compromise in that the new scheduling system was initiated with 50% open access slots and 50% traditionally scheduled appointment times. Education of staff and patients in the open access scheduling system was also a key in overcoming the reluctance to change. Another modification is that patients may call up to one business day before they want an appointment to allow for some planning of their schedule.

Now, eight months later, open access scheduling has come close to being an unqualified success. The no-show rate has decreased from 19% to 14% overall despite not having an appointment reminder system. Two-thirds of all no-shows are patients who were booked into the prescheduled appointment times. The arrival rate for scheduled patients has increased from 57% to 67%, the 10% improvement first imagined. The success is across the board for faculty and residents alike. Total visits have increased 10% despite decreased clinical hours due to physician attrition and without having to increase individual physician clinical time. Charges and income have also increased and are over budget as a direct result of the improved clinical productivity. The statistics have improved every month and are improving even more since the open access appointment times were increased to 75% and the prescheduled slots were decreased to 25%. The physicians are unanimous in their support as the financial performance speaks for itself.

While no formal analysis of patient satisfaction has been done, clearly the majority of patients are pleased and sometimes amazed at their ability to see their own doctor within a day of calling. Some patients express frustration that when they call at peak times in the morning to schedule an appointment, the phones are busy, and they are unable to make an appointment for that day. The move to 75% open access slots has helped alleviate this problem since more appointments are now available the next day. Another common complaint is from patients who cannot make the transition to the open access system and demand a prescheduled appointment. These patients are educated individually by the staff but may also be given appointments in the prescheduled slots; if those slots are full and a physician allows it, the prescheduled slots are double-booked. Under no circumstances are open access slots opened until one business day before the physician's office day. After eight months of open access scheduling, the learning curve for both patients and physicians has improved.

In summary, open access scheduling is a major change in the way patients are scheduled for a doctor's visit. For the Department of Family Medicine, the change to open access scheduling has been successful both in patient satisfaction and clinical performance. It has also brought a large measure of notoriety in that other academic departments, both locally and nationally, are asking for our expertise and help to establish an open access scheduling system.

About the Author

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