

**A REVIEW OF CENTRALIZED SCHEDULING IMPLEMENTATION IN PEDIATRIC  
AMBULATORY CARE**

by

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**ABSTRACT**

Without fundamental care, children do not have the opportunity to reach their greatest potential. This is even more true for those whom require subspecialty care but are unable to obtain it. The absence of accessible and timely healthcare for children is of public health significance. This essay will highlight one of Children's Hospital of Pittsburgh of UPMC's efforts to address access to care experienced by patients seeking outpatient services. Specifically, the project of focus, the implementation of a virtual contact center outpost, was aimed at streamlining the patient scheduling experience so that patients are able to secure visits to receive the care that they need. This essay will cover the project implementation and development between January 2017 and December 2017 of the pediatric contact center outpost at Children's Hospital of Pittsburgh of UPMC.

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## **1.0 INTRODUCTION**

As an administrative resident at the Children's Hospital of Pittsburgh of UPMC (CHP), the majority of the author's project work within ambulatory services involved the shared goal of improving patient access to care. Starting in January 2017, the author joined CHP as an administrative resident and began working on a significant project to create a centralized scheduling outpost onsite at CHP's main campus, one of the many initiatives aimed at improving access to care and meeting trends in improving the consumer experience. This essay will discuss the aspects of bringing a centralized contact center to CHP, including the primary issues it aimed to solve, best practices for implementation, and the various components of implementation, including the author's role, of bringing a centralized contact center to CHP.

## **1.1 ACCESS TO CARE**

The United States healthcare market is experiencing barriers to care as a result of access problems, specifically due to shortages in pediatric subspecialists. Access to care is a critical issue throughout the United States due to availability of affordable services and/or geographic limitations. The lack of pediatric subspecialists has caused delays in care through limited appointment availability, oftentimes resulting in wait times as long as six months to a year for certain subspecialty appointments. To make up for the provider shortage and to meet patient

demand, subspecialists are often working beyond their contracted relative value unit (RVU) requirements, leading to physician burnout and job dissatisfaction. The limited access to pediatric care has forced many patients and families to travel significant distances to receive the care that they need. Additionally, the generally used decentralized model of scheduling further complicates the access issue for patients, as it is generally designed to meet the needs of the organization, staff, and providers. It is the combination of these factors that creates barriers to care and ultimately patient dissatisfaction.

## **2.0 ACCESS TO CARE AT CHILDREN’S HOSPITAL OF PITTSBURGH OF UPMC (CHP)**

Children’s Hospital of Pittsburgh of UPMC (CHP) is a leader in the pediatric healthcare industry and is known for innovation in the care of childhood conditions and disease. Consistent with the reputation in standard of care, CHP has been ranked in the *U.S. News & World Report* annual Honor Roll of America’s Best Children’s Hospitals consistently for eight years, most recently ranking No. 9 for 2017-2018. It is a member of the UPMC hospital system, and its main campus located in the Lawrenceville neighborhood of Pittsburgh, Pennsylvania. In addition to the primary hospital campus, it has nine offsite and satellite locations affiliated with CHP. In regard to outpatient visits, CHP had more than 1.1 million outpatient visits in Fiscal Year 2017.

Access to care, especially within highly specialized areas where there are fewer providers available with that expertise, has become an area of significant concern and an opportunity for improvement. As the only pediatric hospital within the Southwestern Pennsylvania region, the CHP locations service hundreds of thousands of children on a regional, national and international basis who seek the level of care and expertise available by CHP providers. Patients experience significant lengths of time before appointments are available for certain departments or physicians. Additionally, the scheduling process was not best suited for the patient needs in that oftentimes upon checkout of a visit, a required three month follow up visit was not able to be scheduled due to either no availability within the schedule, or the schedule was not open and

available to be scheduled. This would require a follow up call from the patient, resulting in patient dissatisfaction, lack of concern for patient preference, and poor coordination of care.

## **2.1 METHODS TO IMPROVE ACCESS TO CARE IMPLEMENTED BY CHP**

As CHP is continually focused on recruiting and educating top talent in pediatric care to meet the demand for providers, it has considered other initiatives focused on meeting the patient expectations, utilizing consumerism in a way that promotes improved access to care. CHP is committed to changing processes to provide a more consumer-centric healthcare experience for patients and families. It is through these transitions of streamlining the patient experience that access to care can be improved.

CHP has implemented many initiatives within the past year as a means to tackle the issue of significant wait times for appointments, a significant driving force for patient dissatisfaction. The first of these is the offering of same day access to care. This program means that if a patient were to call by a certain time within the day, they would be guaranteed an appointment in their desired outpatient clinic in that same day. This offering required CHP outpatient departments to allot certain appointments each day to “same day patients”, with the number of slots varying by division based on general need. To meet the demand that resulted from same day visits, CHP then implemented an initiative to hire significantly more Advanced Practice Providers (APP). These APPs serve as providers that work autonomously to see these same day patients and work alongside physicians to speed up general patient visit workflow. The push for the hiring of more APPs was coupled with the offering and enticement of a training program for APPs to further continue training within a specialty of choice.

In addition to same day access and an increase in the hiring of APPs, CHP pushed to expand and encourage specialty-practice presence in one of their offsite or satellite locations. There are nine locations outside of CHP's main hospital location in Lawrenceville where providers in various specialties of care see patients on a scheduled basis throughout the month. In an effort to decompress the Lawrenceville outpatient location, CHP began a push to encourage patients to see their provider offsite, oftentimes more quickly than if they were to wait for an appointment at the Lawrenceville outpatient location. However, one of the most significant initiatives to improve access to care was the implementation of centralized scheduling for all outpatient department visits at both main campus and offsite or satellite locations.

### **3.0 METHOD APPLICATION: CENTRALIZED CALL SCHEDULING AND BEST PRACTICES (LITERATURE REVIEW)**

A centralized scheduling model is a method that can be implemented to improve access to care, improved care coordination, and overall patient satisfaction. From the business perspective of a healthcare organization, it can also be implemented as a means of revenue cycle improvement, cost control, and a targeted effort to capture market share from the competition. Centralized scheduling is a way for an organization to save money, transfer time consuming activities from individual practices or departments, and more easily manage the patient experience. Per CoreSolutions, it relieves excess administrative burden from departments and eliminates communication barriers among departments. It also can improve the rate of “no show” patient visits by preparing consumers with insurance clearance and financial counseling in advance of the visit.

From the patient’s perspective, centralized scheduling can be a source of an improved experience and is aligned with the trend of consumerism in healthcare to offer options to the patient to provide a seamless, improved experience. A positive patient experience starts with the appointment scheduling, and a greater experience can be achieved through a well-organized and centralized focus. Patients are looking for a streamlined, “one stop shop” experience that centralized scheduling can offer. For example, the previous model of disjointed and decentralized scheduling was not suited to customer needs, requiring patients with multiple

appointments to schedule directly with different departments with no cohesiveness and no care coordination. Under the new model, all appointments can be scheduled in one place, at one time with the primary focus on the patient's needs.

Regarding implementation, best practices as noted by Becker's Hospital Review, are to first reduce provider template variation and minimize variability in the scheduling process by division. Along the transition, it is suggested to hold check in meetings to identify which strategies work well and what needs to change. Additionally, the article spoke to the importance of hiring the right schedulers in the role, suggesting that individuals have medical experience, customer service skills, and open and frequent communication with management. Amongst the benefits noted are an increase in levels of patient satisfaction as a result of reduced wait times, quicker call backs from medical staff, increased scheduling availability, and multilingual call staff. Centralized scheduling can also assist in keeping patients in the system and prevent avoidable emergency department visits, which can be costly to revenue cycle and care coordination.

Industry best practices, per HFMA, stressed the importance of building relationships with key stakeholders through regular and frequent communication throughout the process. This includes gaining buy in by including leaders in the planning stages and addressing concerns early in the process. Transparency is also important to ensure that there is understanding of the changes that will be taking place in the transition. Most importantly, the article addressed that significant organizational process change, such as the transition to centralized scheduling, cannot be rushed.

#### **4.0 CENTRALIZED PATIENT SCHEDULING AT UPMC**

UPMC, the parent health system of CHP, created the Patient Contact Center in 2006 as a result of patient complaints that calls to provider offices were not answered, returned, or responded to within a timely manner. In addition to poor response and communication, there was also not an organized manner in dealing with misdirected patients and connecting them to the right contact information they required. These issues led to dissatisfied patients, poor care coordination, and, of greatest concern, a barrier to access to care. Additionally, as UPMC was facing competition within the Pittsburgh healthcare market, market share loss was at risk due to patient dissatisfaction and unmet patient needs.

The Patient Contact Center is a part of the UPMC Corporate Services, specifically within revenue cycle management. It is staffed by Contact Center Specialists who operate a multi-line telephone system to schedule patient appointments for providers, lab work, ancillary services, and outpatient surgery. The Patient Contact Center operates at expanded hours, greater than traditional practice office hours. This allows for increased access for patients to speak to a scheduling agent, including a voicemail service during off-time hours essentially providing 24/7 access for patients. The Patient Contact Center provides scheduling for many UPMC hospitals, outpatient locations, and other varied types of care. For purposes of this essay, the UPMC corporate “Patient Contact Center” will be referred to as the “Corporate Contact Center” or “Corporate”.

The primary goal of the Corporate Contact Center is to improve access to care for UPMC's patients. By centralizing the process of patient scheduling, a more seamless experience is created for patients. Centralized scheduling allows for greater management and control of customer service, with an expectation that every time a patient calls, the experience will be consistent.

From the patient's perspective, the process is mostly consistent with the previous experience for initiating the scheduling of their appointment. For example, if a patient were to call to schedule a routine primary care visit, they call the provided number for their practitioner and select "scheduling" from the phone tree message. The other items generally located on the practice's phone tree include contacting a nurse or requesting a prescription refill. With the change in scheduling, instead of having the associate at the location of the physician answer the call, the call will go to the central scheduling site. The call agent will have the patient answer a series of questions regarding their personal identifying information, their visit history, reason for visit and requested provider. This questionnaire is built into the scheduling system based on the phone number that is associated with a particular medical practice.

The agent will then select an allotted time of the requested physician within the system. The appointment availability is based on the provider's scheduling template as given to the central scheduling department by the practice manager of the division under which that provider works. It is important to note that the scheduling agent only has access to schedule appointments during time slots that are listed as "open" and currently available in the system. If the patient has an issue that acquires more immediate attention or if there is not an appointment available within a reasonable timeframe deemed acceptable by the patient, the scheduling agent will send a message to the medical department practice manager notifying them of the conflict. Unless there

is an issue that arises, the scheduling agent will schedule the appointment as planned, which will be reflected within the Epic scheduling system of the practice department and respective physician. If a scheduling message, called a CRM (Contact Resolution Management) is sent to the practice manager, the practice manager will receive a message via a SharePoint site that both Corporate and the practice managers can access. The responsibility of patient follow up for outstanding matters is then transferred to the practice manager and the practice manager must reach out to the patient to address a resolution for the scheduling conflict.

## **5.0 CENTRALIZED PATIENT SCHEDULING AT CHP**

CHP approached the UPMC Corporate Contact Center management with a plan to operate the first centralized scheduling outpost located onsite. Other UPMC service lines, such as Community Medicine Incorporated (CMI), were utilizing “virtual outposts” in which a distinct group of schedulers performed all of the scheduling responsibilities for CMI, separate from the centralized corporate contact center. These schedulers were separate from the primary corporate group and were located at various CMI locations and not centrally located at a CMI centralized scheduling location. CHP suggested an outpost in that all CHP-specific schedulers would be located at one facility, with offices housed at CHP’s primary hospital location in Lawrenceville. CHP administration and providers wanted to safeguard the personalized, distinct, patient-centered CHP experience and felt strongly that the best way to do this was to have all centralized schedulers onsite and service only CHP departments. As such, the planning for the CHP Contact Center Outpost or “the CHP Outpost” began.

### **5.1 PLANNING AND ENGAGEMENT**

The transition to centralized scheduling began in January 2017. The planning and project implementation was led by an executive director at CHP, with assistance by an administrative resident, the author. To plan for this transition, various CHP administration visited Corporate to

establish a relationship with the Corporate revenue cycle management team who would be assisting in the process and to review general best practices expected of the CHP Outpost. The initial transition plan for 2017 was a phased implementation approach with ultimately 24 out of the total 35 outpatient departments live on central scheduling by December 2017. Although the goal was to transition as many clinical departments as possible with the allotted space and staffing available, not all departments had the ability or the readiness to switch to central scheduling in 2017.

At the time, CHP was utilizing the centralized scheduling service for the “overflow” calls that were going to their practices phone numbers. If a patient were to call a department and no one answered, the phone rang busy, or it was after department hours, the call would be transferred automatically to an agent in the call center for assistance. This was primarily due to the office being out of normal business hours as the centralized scheduling center is open 7am to 7pm whereas most departments are available for calls 8:30am to 4:30pm. A large percentage of these calls would not end up with a scheduling appointment and a CRM would be sent back to the practice manager to address.

To initiate the transition for change and notify the key stakeholders involved, CHP administration met with practice managers and clinical leaders in a “town hall” meeting format. The purpose of this meeting was to establish buy in and engagement. The primary reason for this change was because, per patient satisfaction surveys received by CHP patients about their experience, access and appointment availability was the number one complaint. Additionally, this transition is part of CHP’s strategic initiative of a consumer-centric focus.

Significant concerns from the clinical leaders and practice managers regarding this shift to centralized scheduling arose during these meetings. The greatest concern was that the

transition of the control of the scheduling process from the departments to the scheduling agents in the Outpost would lead to an impersonal experience for the patient. Physicians were concerned that the quality of patient experience would decrease without the longstanding skill and knowledge of the various clinical nuances that the departments have while scheduling patients. Additionally, there was concern about the loss of control of the provider's schedule and the risk of the wrong provider or department being scheduled for the patient. These concerns were acknowledged by administration and were to be considered in the implementation process moving forward to be handled appropriately.

## **5.2 SPACE AND FACILITIES PLANNING**

Space is a concern at CHP, as most of the facility is fully utilized. However, it was of utmost importance that the pediatric central agents be onsite, feel the culture of CHP, and have the inclusionary, unique experience of working as CHP employees. As such, two locations were identified within the main campus facility, one in the basement and one on the ground floor of the hospital. These identified rooms required construction and rework in order to serve as the locations for the CHP Outpost.

CHP administration worked closely with facilities to identify construction needs such as painting, resurfacing, floor work, and wall installation. Additionally, components such as air quality and sound were considered. To comply with Corporate requirements and best practices, sound absorption panels and privacy walls were added to new and existing work cubes. Additionally, the cubes and desks were outfitted with computers with dual monitors, required telemetry technology, and locking drawers. Other considerations of space planning included

identifying breakrooms and restrooms due to the increased number of employees working in certain areas of the hospital building.

### **5.3 TRANSITION**

To begin the transition, the lead executive administrator and administrative resident created a portfolio of historical scheduling data. This data came from the overflow calls handled by Corporate for each of the departments that were planned to transition in July through December 2017. The phased transition was determined by call volume analysis, openness to transition by the practice, and whether the division already utilized the overflow services by Corporate. The plan was that the first phase of five departments would go live with six agents onsite at CHP in July 2017.

Once the data was collected regarding historical call volume for overflow purposes, which included the number of appointments actually scheduled and the count of CRMs sent to each department's practice manager, an individual meeting was held with each division's practice manager and clinical director. At these meetings, the CHP call center team discussed the transition, the timeline, and the expectations from both the practice side and the administration side. Any additional division-specific concerns such as known difficulties in scheduling for certain types of patients were noted for review at a later date in the implementation.

Following the initial introductory meetings, a second round of meetings were held with each division and attended by Corporate management who served as consultants on the implementation of centralized scheduling. These meetings had a goal of improved standardization regarding workflow processes across all of the CHP outpatient departments who

would utilize the CHP Outpost. Specifically, physician templates were to be made available 13 months in advance, appointment types were to be reduced to a management number, and appointment lengths were to be standardized within the division. Additionally, phone trees, which are the various options available when a patient calls a division number, were to be consistent in length and number of options.

Scripting of the scheduling process was a key consideration when transitioning from in-department scheduling to centralized scheduling. Significant work was done to revise the scripting to be more user-friendly and universally understood. Part of the scripting is the questionnaire template, which is the series of questions that a scheduler addresses while on the phone with a patient who is actively trying to schedule an appointment. The questionnaire was critically reviewed line by line with the CHP Outpost leadership team, Corporate management, and division practice managers. This process addressed changes necessary to make the scheduling process more seamless and accurate when done by a universal scheduling agent. Additionally, the listing of providers and templates of available providers in each division was discussed in these meetings to ensure accuracy and availability. This included confirming that the appointment types, lengths, and restrictions were correct in the Epic scheduling system used by the agents.

The questionnaire template used when scheduling by the scheduling agent is a live document that is also housed on a mutually-accessed SharePoint website for Corporate management and CHP practice managers. This document is to be maintained and updated on a regular basis by the practice manager to account for general practice changes, including changes in physicians available for appointments, clinic hours, and locations of clinics offered. Amendments made to this document are then uploaded into the live questionnaire used by

scheduling agents in the scheduling process by Corporate staff. These meetings emphasized the importance of the continual engagement of the management of the division, including clinical leadership, for success and accuracy of patient scheduling done through the Outpost.

## **5.4 STAFFING**

Once the departments agreed to the go live schedule, the final count of departments in each phase was identified and a volume analysis was performed to identify the quantity of schedulers needed to handle the call volume at each phase of implementation. The model to identify the number of agents needed to handle the call volume was provided by Corporate and based on historical data noting an appropriate ratio of calls to agents. In total, it was identified that the CHP Outpost would require 31 FTE (full-time equivalent working hours) allotted to scheduling agents and two supervisors to manage the agents onsite at CHP.

To initially staff the call center, certain experienced agents from the Corporate Contact Center were electively transferred to CHP to ease in the implementation and to have experienced staff serve as the first schedulers at CHP. As more departments went live on the CHP central scheduling, certain individuals who only primarily scheduled in each CHP medical department already, such as an administrative assistant (AA) or a patient intake coordinator (PIC), were transferred from their department to schedule as an agent in the CHP call center. As many AAs or PICs within the departments had other responsibilities outside of scheduling and only partial FTE allocated to scheduling within their role, a number of individuals had to be hired to fill positions within the CHP Outpost. In total, 24 new positions were required to appropriately staff the CHP Outpost.

In order to open these new positions, human resources and finance at CHP had to approve the new position control numbers (PCNs) to be created to post job openings for these roles. Once approved, the job descriptions and pay scales needed to be determined and posted as open positions. It is important to note that these positions at the CHP Outpost were consistent in pay scale and level with that of the agents located at Corporate. Once the hiring process occurred, including general application acceptance, interviewing and clearance review required of working in a hospital, the agents began training. Both the transitioned and newly hired agents went through a mandatory six-week training experience at Corporate to understand the process and methodology of central scheduling before they would return to CHP to work as a central scheduling agent.

## **5.5 PHASED IMPLEMENTATION**

The phased implementation was based on the schedule of which departments would go live each month during the implementation period of July to December 2017. The schedule of transition would dictate the number of agents required to handle the volume and the location of the scheduling room in CHP that would be utilized. The order of transition also required a department to have their questionnaire up to date to reflect current activities within the department, such as the correct listing of active providers and their template schedule availability. Additionally, if the medical practice was previously utilizing Corporate for overflow scheduling or the entirety of their scheduling, such was the case for pediatric ophthalmology, the practice would generally be more prepared to transition to the CHP Outpost earlier than other departments.

The practice preference of the practice manager or clinical director also controlled the transition schedule, as some practices with more complex scheduling nuances, such as orthopedics, requested to transition later in the implementation to allow for ample time for preparation. It is important to acknowledge the importance of practice managers who championed and embraced the transition to the call center. The willingness to cooperate and work in a unifying manner with CHP administration and Corporate Contact Center representatives significantly improved the transition process.

The transition schedule by department was drafted and amended multiple times throughout the course of scheduling and even after the transition period began in July. Certain departments had difficulties updating their templates within a timely manner and other departments embraced the change and decided to move up their originally scheduled date to transition. This proved to have minimal impact on the planning process, as staffing was appropriate to manage full call volume for the number of departments transitioned by about October 2017. Additionally, certain planned departments, such as pediatric dental, did not transition to the CHP Outpost due to delayed transition to EPIC scheduling, a prerequisite to be able to utilize central scheduling.

Five pediatric departments (allergy, infectious disease, general surgery, ophthalmology, and pulmonology) transitioned in July 2017, with a total of 24 departments fully utilizing the CHP Outpost by December 2017. In this six-month time frame, the transition averaged four departments per month, with the highest number of departments transferred in the third month of transition (September) and the fewest number of departments transferred in the last month of transition (December).

## 5.6 PEDIATRIC SPECIALIZATION POOLS

To improve patient experience in scheduling, agents in the Outpost were organized in a pooled format to answer calls within certain clinical specialties. Certain agents would handle scheduling needs for certain specialties in order to improve specialization and customer service for understanding the nuanced needs in each medical department. For example, if a call came into the system, it would have the potential to only be answered by a select group of schedulers. If one agent within that pool was unavailable, it would bounce to another agent within that same pool to be answered. If no agents within a given pool were available within a certain number of rings on the phone, a CHP scheduling agent outside of the specified pool would address the call.

The pools were identified by specialty of care and identified historical call volume. The three answering pools were divided into two generalized medical pools and one subspecialty pool. For example, one “medical pool” handled scheduling calls for audiology, adolescent medicine, behavioral health, medical genetics, neurology, primary care, and rehab medicine. The pooled format was a compromise for the concern of practice managers and clinical leaders that there would be a loss in direct communication with the clinical team with scheduling patients. As the practice managers now know which agents would be scheduling for their division, they are able to establish relationship with the supervisors and agents handling their calls. This established channel of communication allows issues and concerns regarding scheduling to be addressed on a more immediate and regular basis.

To further aid in the specialization and improved knowledge of the services, education sessions were offered to the scheduling agents. On a monthly basis, different divisions would send representatives to meet with schedulers to provide additional information and training regarding the nuances of their division regarding clinical questions or needs that may arise while

speaking with patients during scheduling calls. This attention to detail and further commitment to quality in scheduling is an additional way to deliver the CHP experience to patients and improve the personalization and ease of the scheduling experience.

## **5.7 PROVIDER ENGAGEMENT**

From the beginning stages of implementation of the CHP Outpost, there has been variation in support from providers at CHP. Understandably, their concern was for the patient experience and how the vast nuances of the scheduling of care delivery would be transitioned from being managed and controlled by their own departments to a third party within the hospital. In addition to general concern by providers, the limitations on their templates proved to be a significant hurdle in the planning and implementation of the Outpost. While variations of template challenges occurred, the overarching limitation was that provider templates are closely guarded and the understanding of the components to scheduling were understood by practice managers through longstanding interactions and mutual communication between practice manager and provider. However, in order for centralized scheduling to be a success, a degree of control relinquishment was required, reasonably causing unease amongst providers. Ultimately, the more that providers or clinical directors from each department were engaged, involved, and provided feedback throughout the transition, the better the department fared in utilizing the Outpost and limiting reported issues and CRMs.

Notably, there are a few provider champions of the CHP Outpost. These individuals are open to the transition and able to consider the complexity that is the outpatient scheduling process. One example of this is that they understand that the patient does not speak in medical

terms consistent with what is used in clinical practice, such as in describing symptoms or need for treatment and are able, through experience, to have a greater understanding as to how patients think. This proves to be an issue when a prospective patient calls to schedule an appointment. Per the questionnaire in the scheduling system for each department, there is a “Reason for Visit” section which includes multiple words or phrases to describe the same symptom of ailment. This is set up in this manner because patients often do not know the true clinical terminology to describe their reason to be seen by a provider. As clinicians are aware of this, those who are more involved are able to assist in optimizing in the questionnaire to meet their patients’ needs.

In addition to a higher level of engagement, these champions understand what is necessary for centralized scheduling to succeed. Certain providers have served as advocates to standardize provider template schedules in order to improve the scheduling process, further considering the patient and improving access to care. The providers who have aided in the transition to the Outpost have also discussed the needs of provider engagement and involvement to other providers via physician faculty and clinical administrative meetings that occur at CHP.

## **5.8 CORPORATE INVOLVEMENT**

Revenue cycle management Corporate staff and managers assisted in the Outpost implementation by serving as consultants on the project. They provided high-level project management throughout the entire process. They met with practice managers from each division to assist in clarifying and “cleaning up” the questionnaire to be used by the scheduling agents to ensure ease in scheduling. They also managed the SharePoint website and interface to be used to upload changes to the questionnaire by the practice managers. Following implementation,

members of the Corporate management staff that assisted in the transition later moved into supervisor roles for the CHP Outpost. Corporate analysts also continue to provide data regarding call metrics and volume that is provided to CHP administrative on a monthly basis.

## **5.9 ADMINISTRATIVE RESIDENT INVOLVEMENT AND REFLECTION**

As an administrative resident at CHP, the author's primary project has been to assist in the development and transition of departments of the CHP Outpost. She worked very closely with executive administration to complete the required tasks. In the planning stages, the author completed department packets for each of the CHP departments with outpatient visits that would potentially transition to the Outpost. These packets included the current scheduling phone line, the CRM trends by month of overflow calls currently received by Corporate, the number of schedulers in each department, and the Epic department IDs for each department. To create these packets, she worked closely with practice managers and utilized available overflow call scheduling scorecard reporting for each department created by Corporate. The author also facilitated communication with each division by organizing multiple meetings to discuss the transition with practice managers and clinical providers.

Throughout the transition phase, she worked closely with Corporate management to serve as the liaison for CHP and fostered relationship development between Corporate and CHP representation. The author attended all planning meetings with Corporate management and practice managers from each department to assist in improving scripting of the department's questionnaire to be used by scheduling agents. For purposes to improve scheduling, the author reviewed and compiled a listing of the "Reasons Not Scheduled", which are instances where

scheduling agents are not able to schedule an appointment for a patient for various reasons. The reasons these appointments could not be scheduled were determined with input from the practice managers. The indications for management by the department and not central scheduling were determined. Support for these scheduling exceptions were required for Corporate review and approval.

Additionally, the author completed and updated multiple staffing analysis to identify the need for the Outpost. This included consideration of the number of schedulers currently working at CHP within departments and their role's FTE distribution. Based on this information, the author identified the number of CHP employees that would be able to transfer to the Outpost and determine if their position within the departments would require a backfill hire. This number indicated the number of staff required to be hired to fill roles within the Outpost. The author then worked to compile data to support the request for additional PCNs to be created at CHP, including the identification of the cost centers used, the pay grades and the hiring date. Lastly, regarding staffing, she created a schedule to define the cadence to train and transfer agents into the Outpost based on call volume needs identified through the implementation schedule.

In the phases of "go-live" implementation and ongoing review and management, the author assisted in onboarding the newly hired and transferred agents to the CHP Outpost. She created welcome packets with general CHP information, facilitated tours of the CHP main hospital to improve wayfinding for new employees, and created guided maps to facility resources such as break rooms and the cafeteria. From a quality review standpoint, she has facilitated meetings with practice managers to discuss issues that may have occurred, including creating issue reports and managing a monthly dashboard review for all CHP departments on the Outpost that tracks various indicators of call management and scheduling adherence.

In reflection of the experience of assisting in the implementation of the CHP Outpost, there are many takeaways and learning opportunities. Overall, change management has been a significant theme in this transition. It has highlighted the importance of establishing a relationship and building trust with stakeholders. The importance and difficulty of establishing buy in and engagement of clinical leadership cannot be understated. Most importantly, change cannot be rushed in large initiatives such as this, and resilience and patience in process implementation are key.

#### **5.10 ONGOING REVIEW, BENCHMARKING, AND MANAGEMENT**

After the initial transition phase in 2017, there has been ongoing review between CHP administration, Outpost supervisors, and division practice managers. Follow up meetings have been held regularly ongoing scripting and template review, in addition to discussion regarding common scheduling issues that have occurred. Specifically, if a certain division has had a significant number of CRMs, a meeting will be held to discuss room for improvement or changes. The ongoing issue identification and reporting of issues by practice managers via the SharePoint site is crucial to the success and refinement of the Outpost. The input and support from practice managers to report problems allows administration to track and address common themes of issues or CRMs identified.

Various metrics and dashboards have been created and reviewed by Corporate and CHP administration. Corporate maintains a variety of call data and utilizes benchmarking across all centralized scheduling for quality assurance, average call handling time, and schedule adherence. CHP has established an Outpost dashboard, managed by the administrative resident, to track the

number of calls, the calls available for appointment, the number of appointments made, the number of CRMs sent to practice managers, and the number of issues logged by practice managers.

CHP is identifying additional metric review and benchmarking to assess the performance of the Outpost. This includes trending the number of CRMs sent to practice managers and the number of unanswered calls. They also look to compare the implementation of centralized scheduling with patient satisfaction and HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) scoring. Additionally, it has been difficult to measure the change in the increase of patient access attributable to the CHP Outpost due to the number of initiatives to improve access that were implemented concurrently with the Outpost.

## **5.11 FUTURE CONSIDERATIONS IN ACCESS TO CARE IMPROVEMENT AT CHP**

Following the transition to centralized scheduling for the primary outpatient departments, the next step is to transition ancillary departments such as radiology, lab work, and rehabilitation to further promote the cohesive patient experience that is desired through the usage of centralized scheduling for patients. As mentioned previously, there was difficulty in the implementation of the call center due to restrictions in access to provider scheduling templates, which resulted in a lower percentage of appointments to be successfully scheduled and a higher number of CRMs sent to practice managers. The transition to centralized scheduling has placed a spotlight on provider scheduling templates and how they need to be redesigned to better accommodate that centralized scheduling format. Examples include opening the scheduling template for 13 months in advance and removing schedule blocks that were previously utilized and understood by

department practice managers and AAs, but not central schedulers. However, this is a challenge since agents have difficulty navigating the many variations in template design established by individual specialties and by providers.

CHP is also placing significant time and efforts on better utilization of ambulatory clinic space on the second and third floors of the hospital that are dedicated to ambulatory patient visits. As previously discussed in the limitations on access, in certain specialties, utilization of reserved space for clinic visits by providers generally ranges below expected capacity. Because of this, CHP has made changes to improve space utilization in order to improve access to care and accommodate a greater number of patients who are critically in need of visits with high-end specialists. To address this task, CHP has worked extensively with industrial engineers and trained project managers. However, this is an ongoing challenge that many hospitals are facing in providing access to care.

## **6.0 CONCLUSION**

The implementation of the Outpost at CHP has been a positive step in the direction of improving access to care in outpatient services. This project is an example of change management and a lesson in the complexity of balancing changing consumer demands with the culture of care. It has also highlighted the importance of data analysis to support project goals and the significance of organizational management to drive successful outcomes. Although challenging at times to implement change throughout an organization, it is key to remember how the goal of a project connects to the mission of the organization. The implementation of centralized scheduling has enhanced access and expanded opportunities for Children's Hospital of Pittsburgh of UPMC to provide more patients with a high quality, person-centric experience.

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