Diagnostic Assessment: Centralized vs. Decentralized Scheduling

Sample Scheduling Models

Instructions: Cancer programs should use this diagnostic assessment to guide their choice of centralized or decentralized scheduling.

When thinking about scheduling models, it is important to remember that models vary widely in scope. Even within decentralized or centralized scheduling, there are different degrees of decentralization or centralization of scheduling responsibilities. The sample scheduling models below illustrate this point.

Follow the steps outlined on the subsequent pages to help determine whether a more centralized or more decentralized scheduling model is appropriate for your cancer program or organization.

Sample Scheduling Models Along Spectrum from Completely Decentralized to Completely Centralized

Scheduling Unit	**By Physician**	**By Clinic**	**For Whole Cancer Center**	**For Whole Organization**
Example	Each physician in medial oncology clinic has specific staff member responsible for scheduling their patients	Medical oncology clinic, infusion center, and radiation therapy center each have their own set of schedulers	One set of schedulers make appointments for all patients seen in the cancer center	One set of schedulers make appointments for all patients seen across the organization

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Step 1: Assess Performance of Current Scheduling Model

Use the metrics listed in the table below to determine how well the current scheduling system is working. Target performance can be based on internal organization goals or external benchmarks. Then, compare current and target performance for each metric and assign an overall level of satisfaction with current schedule model performance.

Metric[1]	Current Performance	Target Performance[2]
Call answer speed		Best Observed: 18 seconds
Online request answer speed		
Call handle time (i.e., average call length)		Best Observed: 2 minutes and 38 seconds
Online request handle time (i.e., average time spent scheduling an appointment submitted via online request		
Call abandonment rate (i.e., percentage of inbound phone calls that are abandoned by patient before speaking to scheduler)		Best Observed: 2%
Call volume (per scheduler)		
Number of appointments scheduled (per scheduler)		
Total call scheduling time (i.e., average of time spent on phone scheduling with an individual patient plus additional staff time spent scheduling appointment outside of direct conversation with patient)		Best Observed: 4 minutes and 15 seconds
Scheduling workload (i.e., percentage of staff work hours spent scheduling patients)		Sample Target: 88% or more of staff time spent assisting patients on the phone or logged into system waiting for call
Patient satisfaction with scheduling experience		Best Observed: 93% service excellence
Referring physician satisfaction with scheduling experience		
Internal physician satisfaction with scheduling model		
Staff satisfaction with scheduling model		
Other:		
Other:		

Level of Satisfaction with Current Scheduling Model Performance (circle one):

1. Not at all satisfied 2. Slightly satisfied 3. Moderately satisfied 4. Very satisfied 5. Extremely satisfied

Additional Notes:

1) See Cancer Program Access Metric Dashboard for additional access-related metrics and benchmarks.
2) Best observed and sample target performance benchmarks pulled from *Develop a Centralized Scheduling Model*,.

Source: Marketing and Planning Leadership Council, *Develop a Centralized Scheduling Model*, Washington, DC: The Advisory Board Company, 2011; Oncology Roundtable interviews and analysis.

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Step 2a: Prioritize Goals of Ideal Scheduling Model

The table below includes a sample list of desired goals from an ideal scheduling model. Evaluate the goals provided and prioritize which goals are most important to your organization. Empty lines are provided to write in additional goals. Use the table on the next page to see which scheduling model corresponds to your most important goals.

Goal	More Important	Less Important
Reduce interruptions for staff with other responsibilities		
Create a single phone line to market to patients and referring providers, and track marketing effectiveness		
Increase consistency of scheduling across cancer program or organization		
Make interactions feel more personal for patients		
Enable staff to change appointments during patient visits		
Equip staff with clinical expertise to right-size appointments		
Reduce personnel dedicated to scheduling across cancer program or organization		

Source: Oncology Roundtable interviews and analysis.

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Step 2b: Evaluate Alignment of Goals and Scheduling Models

The table below lists select benefits of centralized and decentralized scheduling models. Empty lines are provided to write in additional benefits. Use the table to see which scheduling model most closely aligns with your cancer program's prioritized goals from the previous page.

Centralized Scheduling Model		Decentralized Scheduling Model	
Benefit	**Aligns with Prioritized Goals**	**Benefit**	**Aligns with Prioritized Goals**
Fewer interruptions for staff with other responsibilities	❑ Yes ❑ No	Patients feel interactions are more personal	❑ Yes ❑ No
Single phone line to market program and track campaign effectiveness	❑ Yes ❑ No	Schedulers can often use clinical expertise to right-size appointments	❑ Yes ❑ No
Schedule more often consistent	❑ Yes ❑ No	Staff can change appointments during clinic visits	❑ Yes ❑ No
	❑ Yes ❑ No		❑ Yes ❑ No
	❑ Yes ❑ No		❑ Yes ❑ No
	❑ Yes ❑ No		❑ Yes ❑ No
Total Number of Benefits in Alignment with Prioritized Goals:		**Total Number of Benefits in Alignment with Prioritized Goals:**	

Source: Oncology Roundtable interviews and analysis.

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Step 3: Evaluate Resource Availability

The table below outlines key questions to consider when evaluating the resources available to support a change in your scheduling model. Use these questions to determine whether it is feasible to change your scheduling model.

Resource	Questions to Consider
Staff Capacity	• Which staff are currently responsible for scheduling? • How busy are scheduling staff? • Would additional staff be needed to change the scheduling model? If so, how many? • If we centralize scheduling across the organization, which resources could we consolidate? • •
Staff Expertise	• What are the areas of expertise of current scheduling staff? • What additional training would scheduling staff need if we change the scheduling model? • • •
Technology (e.g., telecommunication and information technology capabilities)	• What are our existing telecommunication and information technology capabilities? • What additional technology capabilities would be needed to change scheduling models? How much would this cost? • • •

Source: Oncology Roundtable interviews and analysis.