Improving Patient Access

2026

Expanding scheduling capacity and reducing wait times for consults and procedures

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Performance period: 12 Months

Agenda

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Declining access to consults and procedures

02 **My Role**
Leading the initiative end to end

03 **Approach & Execution**
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Four years of measured performance

06 **Challenges & Lessons**
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The Why: Access Was Slipping Away From Patients

By late 3rd Quarter, fewer than one in three new patients was seen within two weeks of referral.

29.7%	20.4	78	32.7%
New patients seen within 2 weeks	**Days from scheduling to appointment**	**Distinct appointment types in the schedule**	**Cancel and no-show rate**
September low point	Peak lag, September	Confusing for schedulers	Yearly average

What patients and staff were experiencing

- Patients waited weeks for an initial consult, and some sought care elsewhere
- Procedures were ordered in clinic but scheduled only after the patient had left, adding handoffs and phone tag
- Schedulers navigated 78 appointment types, which slowed booking and blocked online self-scheduling
- Clinical and procedure slots were capped below what the space and staffing could support

My Role: Owning the Problem End to End

Project Lead	Framed the problem, set the scope, and drove the initiative from evaluation through sustained control.
Analyst	Built the measurement baseline, pulled and validated scheduling data, and defined the two metrics we would be judged on.
Facilitator	Ran voice-of-the-customer sessions and workflow mapping with schedulers, front desk staff, physicians, and regional leaders.
Change Agent	Negotiated the appointment-type reduction and the schedule-before-departure standard, then held the line during rollout.
Steward	Established the monthly review cadence that has kept these gains in place for four years.

Approach & Execution: Lean Six Sigma DMAIC

A structured method kept the work evidence-based rather than opinion-driven.

DEFINE	MEASURE	ANALYZE	IMPROVE	CONTROL
1	2	3	4	5
Named the access problem and scoped it to consults and procedures across the region.	Established the baseline using New Patient Seen in 2 Weeks and Schedule-to-Appointment Lag.	Mapped current-state workflows and gathered voice of the customer to find the real constraints.	Simplified appointment types, moved procedure scheduling before departure, and expanded daily capacity.	Standardized the new workflow and monitored both metrics monthly to hold the gain.

Guiding principle

Design a process that is easier to do correctly than incorrectly — so the improvement holds without constant enforcement.

Stakeholder Collaboration: Voice of the Customer

The people closest to the work identified the constraints — my job was to structure and act on what they told me.

Scheduling Team

Too many appointment types to choose from; frequent rework when the wrong type was booked.

What we changed: Reduced appointment types to a usable set

Front Desk Staff

Patients left the clinic before procedures were on the calendar, creating callbacks and lost appointments.

What we changed: Schedule the procedure before the patient leaves

Physicians

Order-to-procedure delay was unpredictable and hurt continuity of care.

What we changed: Predictable lead time and protected slots

Regional Leaders

Capacity was inconsistent across clinics with no shared standard.

What we changed: One repeatable standard applied region-wide

Approach & Execution: The Three Changes That Mattered

01

Simplify the schedule

Consolidated appointment types so schedulers could book confidently and patients could self-schedule online.

78 → 36

appointment types

02

Schedule before departure

Front desk now books every ordered procedure before the patient leaves the clinic, then insurance authorization follows.

0

handoffs after the visit

03

Unlock daily capacity

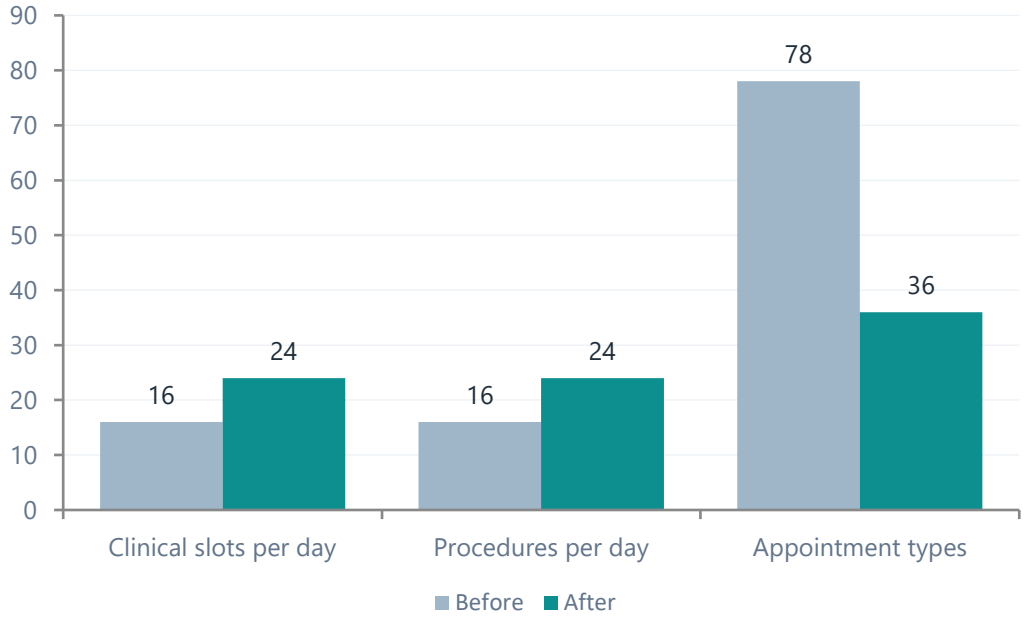
Rebalanced templates to open more clinical and procedural slots per day without adding physical space.

+50%

daily slots available

Approach & Execution: Rebuilding Daily Capacity

Capacity gains came from redesigning the template, not from adding rooms or staff.



Clinical slots per day

16 → 24

Follow-ups and consults, +50%

Procedures per day

16 → 24

Higher-volume clinics reaching 32, up to +100%

Appointment types

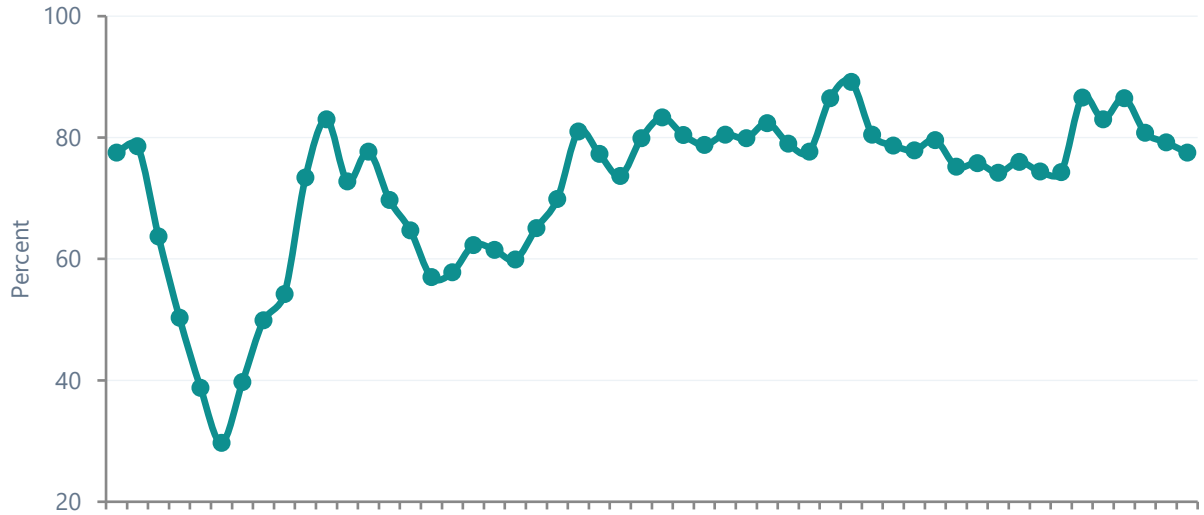
78 → 36

A 54% reduction, enabling online self-scheduling

Fewer appointment types made the schedule usable; a usable schedule made the added slots fillable.

Data & Metrics: New Patients Seen Within 2 Weeks

Higher is better. Recovery from the September low, then held above baseline for four years.



Best month on record: 89.2% post improvements.

48.0%

Second-half average for 1st year

Baseline before changes

81.1%

Last year-to-date average

Current sustained state

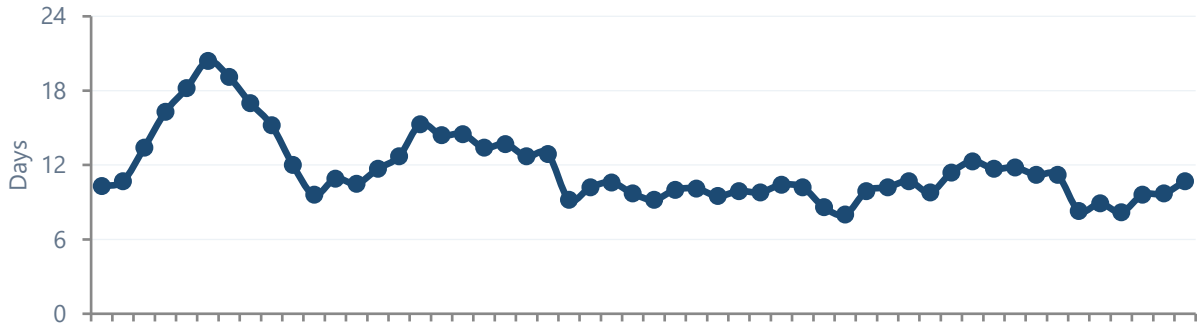
+33 pts

Improvement

Nearly a doubling of access

Data & Metrics: Schedule-to-Appointment Lag

Lower is better. Average days between scheduling and the appointment itself.



16.9 days
Second-half average 1st year

9.5 days
Final year-to-date average

-44% reduction
Sustained since implementation

Annual performance summary

Year	Baseline	1st Year	2nd Year	3rd Year	4th Year
Seen within 2 weeks	56.2%	67.1%	78.8%	78.8%	81.1%
Lag (days)	15.0	12.6	10.1	10.5	9.5
Cancel / no-show	32.7%	29.7%	27.6%	27.7%	26.2%

Challenges & Lessons Learned

Challenge	What I learned
Reducing 78 appointment types meant asking people to give up options they were attached to.	**Show the data. Once staff saw how often the wrong type was booked, the case made itself.**
Front desk staff absorbed a new task at the busiest moment of the patient visit.	**Change the sequence, not the workload. Scheduling first and authorizing second removed callbacks entirely.**
Access dipped again as volume climbed.	**Improvement is not self-sustaining. The monthly metric review caught the drift and we recovered within two months.**
Clinics wanted local exceptions to a regional standard.	**Standardize the process, flex the volume. Higher-capacity clinics scaled to 32 procedures without breaking the model.**

Outcomes & Impact

+33 pts

New patient access

48.0% → 81.1% seen in two weeks

-7.4 days

Scheduling lag

16.9 → 9.5 days to appointment

+50%

Daily capacity

16 → 24 clinical and procedural slots

-6.5 pts

Cancel / no-show

32.7% → 26.2% of scheduled visits

Why it matters

- Patients reach care faster, and procedures are booked before they leave the building
- Online self-scheduling became possible once the schedule was simplified
- Gains have held for four years across the region, not just during the project

What comes next

- Extend the schedule-before-departure standard to remaining service lines
- Target the 26% cancel and no-show rate as the next constraint on capacity
- Scale the 32-per-day procedure model where volume supports it