

Predict the Expected: Contingency Plans to Manage Advanced Access Schedules

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Predict the Expected: Contingency Plans to Manage Advanced Access Schedules

Recommendations and Words of Wisdom from Mark Murray

Things will happen over time to disrupt even the most balanced schedule. Providers go on vacation and they go to conferences. There are days when people need to leave the office early. Patients miss appointments or arrive late. And some days are just plain busy. These are not extraordinary events; they are part of the day-to-day variation in every practice.

Here are recommended methods, called contingency plans, to manage the most common issues that will come up in primary care. To keep your system running well, it is essential to have plans in place to manage the disruption of life's everyday occurrences.

This document provides detail about the principles behind the recommended methods described by Mark Murray MD MPA.

About Mark Murray MD MPA*

Principal, Mark Murray and Associates
Technical Advisor, Idealized Design of Clinical Office Practices (IDCOP),
Institute for Healthcare Improvement
Sacramento, CA

Mark Murray is widely published and is recognized as an international authority on the development of access systems and flow systems in health care. He has consulted in Alberta, British Columbia, Saskatchewan and most recently with Health Quality Ontario (HQO) and formerly with Ontario's Quality Improvement and Innovation Partnership (QIIP). Primary Care Quality Improvement (QI) Coaches at HQO and QI Champions selected from participating HQO primary care teams in the field have been privileged to receive extensive training and consultation from Dr. Murray. When it comes to improving access and quality care for patients, Dr. Murray is well known for his passionate, no-nonsense, pragmatic delivery and has coined the mantra "See your own patient and don't make them wait."

***Acknowledgement:**

This material is compiled and adapted, with permission, from the unpublished correspondence of Mark Murray MD MPA. HQO is most grateful to Dr. Murray for allowing his excellent work to be shared with the Ontario primary care community.

IN MARK MURRAY'S WORDS

“There are many events that occur in practices that seem unpredictable: flu season, the demand for school and sports physicals, an admission to the hospital, trauma, laceration, excision, procedure, a visit that takes longer than expected, a mother who brings three children instead of one, etc. Unexpected events are just part of office practice. We often respond by restricting access by the development of rigid appointment types or by delaying or deferring that care.”

There are three variables at play here: demand which exhibits a natural variation that we can influence but not control, supply and delay. If we decide that supply is non-variable, or rigid, then delays will ensue. On the other hand, if we decide that patients will not wait, then we have to learn to flex the supply in order to meet the naturally occurring demand fluctuations.

Understand your System

Understanding the demand in your system is essential to providing access and quality care.

Carefully measure demand and supply to understand your system:

- The most important principle is “demand will vary”.
- Variation in demand is often more predictable than the variation in supply.
- Demand varies by hour, by day, and by season.
- Measure over time to see patterns.
- Demand is not the same for every practice – you have to measure it to understand your practice.

Measure Demand Correctly

- Use your demand data to predict demand daily, weekly and seasonally.
- Demand is often measured incorrectly.
- To calculate demand correctly, please see the Advanced Access and Efficiency Workbook for Primary Care (section 4.2).

IN MARK MURRAY'S WORDS

“In an access model wherein the task is to complete today’s work today, a key determinant of daily success is the correct prediction of demand. Demand is often incorrectly measured by looking at past activity i.e. if we saw 125 patients on our practice on a specific day, we conclude that the demand for service was for 125 appointments. This actually measured the supply of services that we offered rather than the true demand for service on that specific day.”

Predict and Plan for the Expected: Daily Demand Fluctuations

- Plan for the unexpected.
- Measure daily demand and compare it with daily supply to understand your system.
- Ensure adequate daily supply to meet the demand.
- Most demand declares itself by 11 a.m. each morning. You may also experience “blips”

late in the afternoon, particularly for pediatric patients.

- Sequence appointments in consecutive order during the day – avoid creating “holes” in the schedule.
- Monitor the demand continuously over the course of the day to reduce “crises”.
- Keep communications flowing during the day between the receptionist and the care team:
 - Use huddles.
- Ensure rooms and procedures are planned “just in time”.
- Standardize rooms and equipment:
 - Have all necessary tools and equipment ready.
- Cross train staff and share the work when team mates are absent.

Use the Reason for a Visit to Prepare for the Appointment

- The open advanced access system no longer has different appointment types (e.g. urgent/routine, physical, well baby, etc.)
- You still need to screen for emergency issues and also gather information in order to prepare rooms, equipment and staff for the visit.
- Use a script to determine the reason for the visit.
- For example, after the appointment is made say: “Your appointment is for today at 2 p.m. In order to be prepared for your visit today, your provider and her team would like to know why you are coming in.”

IN MARK MURRAY’S WORDS

“In a practice operating with Advanced Access, the schedules are not filled far in advance and the day starts with maximum flexibility and capacity. A standard appointment length sets the rhythm of the practice but does not mandate rigidity. Since the practice team works together and patients see their own provider more often than in the past, process steps can be rearranged or reversed in order to maximize the patient’s experience and reduce the delay. The process of each task is broken down to see what the work is and who needs to do the work.”

Return Visits

IN MARK MURRAY’S WORDS

“There is often a great demand for the late afternoon appointments. On occasion, those appointments will fill and there will be ‘holes’ in the schedule earlier in the day. Use a script to try to pull the work towards the appointments earlier in the day: when a patient leaves one appointment and makes a required follow up appointment, we can say: ‘Your provider has an appointment open at 8:30 a.m., would that work for you?’ If the patient declines, we then offer the 8:45 a.m. appointment and so on. In addition, when a patient calls, we first offer the earliest open appointment and attempt to fill sequentially. If the patient requests a later appointment, we provide that.”

- Internally generated demand, such as follow-up appointments is demand we can control.
- Use return visit demand to “shape” the total demand.
- Pull work toward appointments early in the day.

- Consider strategies to lengthen the return visit interval.

IN MARK MURRAY’S WORDS

“In light of improved continuity, automatically appointing patients to return in order to ‘keep track of the patient becomes less necessary, so return visit intervals can be extended. Generally return visit intervals need to be explored. With the development of case managers, or care managers on the team, and in the light of team and provider continuity with the patient, many return visits for chronic illnesses can be managed in tandem with a shorter visit by the provider and a longer connected visit on the same day with the case manager or care manager.”

The End of the Day

IN MARK MURRAY’S WORDS

“The most important contingency plan in an improved access approach wherein we will offer an appointment today for any problem, is obviously a decision about what is today? In a saturated model, ‘today’ is over before we start. The schedules are full and demand is either forced into an already filled schedule or sent to another venue of care. This is just not acceptable to our patients, especially when they are ill, sick and vulnerable; they want to see their own provider. Thus, we need to make a conscious and intentional decision about what is today. Just as ending the day before we start is not acceptable, so is working each night until midnight.

To resolve this, some groups make a decision to see all patients who declare that they can arrive before a specified ‘cut-off’ time. This can be 4 p.m. or 4:30 p.m. for example. In this way the patient’s ability to arrive at the practice determines the care. This is not a decision based on: ‘Are we full?’, but on a patient’s ability to get into the practice for care. In practices where there are evening hours, there is often an afternoon ‘cut- off’ for the providers working in the daytime and another one (e.g. 7:30 p.m. or 8:00 p.m.) for the evening hours.”

Recommendations:

- Make a plan to manage the end of the day.
 - If you work in a group decide together how the end of the day will be managed.
- Decide what is “today”.
- Choose a time for the last appointment (e.g. 4:30 p.m.)
 - For evening clinics set another last appointment time (e.g. 8:00 p.m.).

The Schedule is Now Full for Today – What to Do

IN MARK MURRAY’S WORDS

“On occasion in Advanced Access there will be a day when demand is greater than supply and we will have to make more appointments than exist in order to do today’s work today. The best way to manage this is to prepare in advance how each provider or how we as a group will manage this situation. If our ‘what is today?’ cut off time is 4:30 p.m., we are not saying that if we are out of appointments or that we won’t see the patient, but that if the patient can get here by 4:30 p.m. we will see her. Thus, if the 4:30 p.m. appointment is filled and we have more patients to see, the cut off time is 4:30 p.m. but the appointed time may be later than that or even earlier than if we have a pre-arranged commitment to see

all our patients today. The 4:30 p.m. question just defines for us if we have committed to see that patient 'today'. This puts a boundary on what is today from the patient perspective but does not put a boundary on the number of appointments or the time of the visit which may actually occur at 4:45 p.m. In order to avoid confusion for our patients who can get here by 4:30 p.m. but we can't see them until 5 p.m. Instead of asking: 'can you get here by 4:30?' and then appointing them at 5 p.m., we may ask a more open ended question: 'when can you get here ?' and if the answer falls before 4:30 p.m. we appoint them to the first opening which may or may not be 4:30 p.m.. If the answer is after 4:30 p.m., we make other arrangements even though the provider may be still seeing appointed patients at 5 p.m."

- Make a commitment to do today's work today.
 - Ask if the patient can arrive by the end of day cut-off. If they can, then offer to see that patient.
- Avoid "stacking patients".
 - Don't give everyone a 4:30 p.m. appointment – this is not fair to the patient. If there is more than one patient who can arrive by 4:30 p.m., give appointments at intervals after 4:30 p.m. (e.g. 4:45, 5:00, 5:15).
- Develop a script.
 - For example: "Your provider wants to see you today. She has been busy (don't say overbooked) and can see you at 4 p.m. There may be a wait but probably not more than 15 minutes. She does have appointments in the morning; I could also appoint you at that time."
- Don't automatically shunt patients to another provider, walk-in, or ER if one provider is "full". This reduces continuity.

IN MARK MURRAY'S WORDS

"Consequences of moving the patients away from the primary care provider are clear. Patient satisfaction drops with this lost opportunity for continuity, the likelihood that a patient will return after seeing an unfamiliar provider increases therefore decreasing total system capacity, the likelihood of unnecessary testing and inappropriate referrals to specialists also increases as patients cascade away from their own provider.

Finally, moving patients away from their own provider even at the end of the day for provider convenience sake, creates adverse incentive for the practice as a whole. For example, if the providers who are 'full' send their patients to the providers who are 'not full', then the incentive for those providers with little or no backlog and who have worked hard all day long, is to find a way to make sure that their schedules are full with their own patients to protect themselves from overflow from colleagues. From a total systems viewpoint the most efficient system maintains continuity even through the end of the day."

Late Patients

- Many people are late occasionally.
- Some patients are habitually late.
- Manage these two situations differently.

IN MARK MURRAY'S WORDS

“On occasion in any practice some patients will be late for their appointment. The most effective strategy for this occurrence involves developing a simple non-blaming script for the receptionist. This script acknowledges that the patient is indeed late for the appointment, does not blame the patient for that lateness and offers reassurance immediately that that patient will be seen. This reassurance tends to reduce the patients stress and anxiety and takes potential pressure away from the receptionist. The most effective strategy in this regard involves getting the patient in to see the provider as soon as possible.”

Recommendations:

- Develop scripts for patients arriving late.
- Offer a shorter visit on that day.
- Always use a non-judgmental approach.

IN MARK MURRAY’S WORDS

“Strategies that seem to patients like punishments (e.g. making the patient reschedule, absolutely making wait until the end of the session, or sending the patient away to another venue for care) are certainly not effective. While it is important to also recognize that providers ought not to let their other patients be delayed in their office experience it is also important to see these late patients, again, as soon as possible.”

- Develop a different plan for patients who are habitually late.
 - The patient’s provider should have a face-to-face conversation to acknowledge the behavior and describe the effect on the rest of the practice.
 - Develop a plan for improvement with the patient.

Is your Registration System Causing Patients to be Late?

Sometimes the patient arrives on time but complicated registration procedures cause delays.

IN MARK MURRAY’S WORDS

“Many practices recognize that it’s often the system that causes patients to be late. If the resources at the registration area are inadequate to manage the demand, if the registration process involves more steps than can be done in the allotted period of time often that bottleneck at the front office process will cause delays in the back office process.”

- Make registration steps as efficient as possible.
- If the registration still causes delays, consider the concept of arrival time and appointment time.
 - Distinguish between appointment time and arrival time, and let the patient know that there is a specific person waiting for them at a specific time.
- Develop a script.
 - E.g.: “Your provider would like to see you at 3:00 p.m. In order to have all of your paperwork and registration information completed before the time of your appointment, we would like you to arrive in time to see Mary our receptionist at ten minutes to three.”

Weekly Demand Fluctuations

IN MARK MURRAY'S WORDS

"... since in most practices we recognize that while external demand is generated during the day, many of those patients cannot arrive until mid-morning, so the best place to schedule return visits is for the first appointments. In addition, since there is more external demand generated on Mondays, it is better to not only schedule return visits for early in the morning, but early in the morning and later in the week."

- Measure weekly demand and compare it with weekly supply to understand your system.
- There is always fluctuation in demand during the week.
 - For example, demand for appointments is normally high on Monday and there is more demand for prescription refills on Friday.
- Flex the supply over the week to meet these patterns.

IN MARK MURRAY'S WORDS

"... it makes no sense to have three quarters of the practice gone on Mondays when that practice knows that most of the demand will occur on Mondays. In addition, just as practices currently, but reluctantly flex their resource to meet the demand, this can be done in a much more formal and organized approach. For example, if the prediction tools predict that a specific day in the future is going to be difficult, it is better to be prepared for that by adding extra capacity or extra hours rather than spilling that demand out into the future. This is done in current practices with overbooking mechanisms and in addition is often done formally in practices when extra days are added for school physicals, etc. With improved demand prediction tools (e.g. looking ahead to see which days are filling with good backlog) these demand can be flexed around those future days and plans can be made in advance to add more capacity on those particular days."

- Encourage demand you have control over to come at non-peak times.
 - For example offer pre-booked appointments and recall appointments early in the morning and later in the week when demand is lighter.
- Don't protect or freeze appointments at busy times.

IN MARK MURRAY'S WORDS

"Trying to protect this time by freezing it, actually can make it worse. Rework is created, underground systems are created that fill that demand as soon as it is unfrozen and the demands for those times of the month, days of the week, or hours of the day don't disappear."

Missed Appointments or "No-Shows"- What to Do

No-shows (also called "fail to keep appointments") are wasted supply that could have been used by another patient.

IN MARK MURRAY'S WORDS

"While most providers secretly enjoy the respite, failure to keep appointments represents potentially unused system capacity. Often resource or work is devoted to pre-planning these visits. For example, charts are pulled; registration papers are prepared, etc. When the patient doesn't show up for an appointment, that capacity is wasted and that resource time is gone. In addition, when a patient fails to

keep an appointment, there is a gap, space or hole in the schedule that could have been filled by another patient.”

Why do Patients “No-Show”?

- People miss appointments for different reasons.
- Work to understand the root cause of failure to keep appointments.

IN MARK MURRAY’S WORDS

“The most common cause of failure to keep appointments is delays in the system. Failure to keep rises linearly as delays approach three weeks. As delays extend past three weeks, failure to keep appointments start to rise exponentially. The most effective strategy to reduce failure to keep appointments is to reduce the delay. This is not to say that if patients call the same day, they all show up for their appointments. Surprisingly some do not.”

- For those patients who are scheduled in advance, consider calling patients 24 or 48 in advance of an appointment.
 - Advise the patient of the appointment and offer an alternative to reschedule if the patients desires.
 - In some settings it is done automatically through a voice response unit.
- In a more open scheduling system, this is not as effective because there are fewer “pre-booked” appointments.
- Consider stratifying the patients you will call.
 - E.g.: the first appointments of the day, longer appointments, patients scheduled for procedures, etc.
- Consider calling specific patients after they have failed to keep an appointment and inquire as to why that failure occurred. Invite the patient to reschedule.
- This is a longer term strategy but has been shown to be effective.
- Avoid booking appointments more than 2 months into the future.

Nurse Practitioners (NP) and Physician Assistants (PA) as a Substitute For Providers who are Booked – A Caution

- Plan the role of NPs or PAs carefully.
- When a provider is busy but in the office, avoid shunting patients to an NP or PA.
- NPs and PAs can effectively see patients of absent providers.
- NPs can also have their own partial panel.
- Patients may choose to see an NP as their primary practitioner.

Nurse Practitioners function in different ways on various primary care teams. For example, on some teams, nurse practitioners manage a panel of their own patients within their scope of practice and in others, they cover for absent providers and/or provide urgent care. Other practices have developed a blended role for NPs. In Ontario primary care, the Physician Assistant role is emerging.

With respect to Advanced Access, the role nurse practitioners and physician assistants play on a team will impact the balance of supply and demand in significant and distinct ways. Your coach can suggest resources to explore these issues.

IN MARK MURRAY’S WORDS

“One of the most important contingencies is to develop a planned method on how to work with nurse practitioners (NP)/physician assistants (PA) in the practice. In many systems of care, the role of the NP/PA is to substitute for the physician. In this approach, when a physician’s schedule is ‘full’ and the clinical condition permits it, patients are diverted from their own provider who is present and scheduled to see the NP/PA. This results in a number of adverse outcomes: patient satisfaction is reduced (even if patients say they ‘don’t care who they see’, the satisfaction ratings for a non-familiar provider are lower), there are more return visits generated and the system has lost the opportunity to truly maximize the efficiency of that visit. So what –on the surface- appears to be a smart plan, results in more work and less satisfied patients. In addition, it is much easier for a provider to see his or her own patients – there is less time involved in new relationship building and clinical care starts where the provider left off last time, not as a new event.

The best approaches we have seen involve having the NP/PAs see patients for absent physicians. In this way, the physicians present can provide what they do best: healthcare in the context of relationship. The NP/PA still generally sees patients with acute medical problems but these are patients from physicians who are absent and not from physicians who are present.

In addition, the question is asked: ‘What do the NP/PAs do when all the physicians are present?’ First, in most practices of medium to large size, this is unusual and, second, this is the place to have patients choose the NP/PA as a primary provider. In many environments, there is a great desire on the part of patients to have a female provider and, since most NP/PAs are female, this provides an opportunity for patients to choose a female provider. The role then for the NP/PA is to care for that partial panel of patients in addition to the role of seeing patients for the absent physicians.”

Managing Seasonal Fluctuation

- There are also high demand times during the year. For example, school physicals and flu season.
- Encourage the demand you can control to come at non-peak times.
 - Develop a plan to spread school physicals over a longer time frame, (e.g. encourage children to have physicals on birthdates).
 - Standardize and prepare all forms ahead of time.

Flu Season

IN MARK MURRAY’S WORDS

“... many times what appears to be a surge in demand actually represents a previous loss of supply. This is commonly seen in the flu season, which often follows a dramatic loss in supply over the Christmas and New Year holidays. This tends to make the flu season look worse than it is, since there has been a batching of demand.”

- Develop strategies to shape demand during flu season.
- Emphasize flu shots.
- Ensure providers see their own patients throughout the year (continuity).
 - Patients who get advice from providers they know and trust are less likely to request a follow-up appointment.
- Emphasize and constantly reinforce home care and home treatment.
 - In systems where there is high discontinuity and consequent mistrust, this strategy is not very effective.

IN MARK MURRAY'S WORDS

- *“With improved access and the opportunity for patients to get an appointment with their own provider at any time that they choose, home care alternatives become more palatable.”*
- *“With a stronger team linkage between patient, provider, and the provider’s team, advice and management by protocol is more highly accepted by the patient.”*
- *“Finally, with the reduction of backlog, the surge in demand does not have the same overwhelming effect that it has on a practice or organization that is completely saturated with backlog even before the flu season starts.”*

Vacations and Other Leave – What to Do

When providers book time off, manage the amount of work and appointment demand when they are absent to prevent work from becoming overwhelming when they return.

Consider these three important parts:

1. Time-off policies
2. Post-vacation (and other time-off) scheduling
3. Spread absent provider appointments evenly (see below)

Time-Off Policies

Develop policies to ensure minimal staffing (supply) to meet patient demand.

Post Vacation Scheduling Method

As soon as a provider books time off, follow this procedure:

- If a provider plans a single week vacation, hold the schedule for two weeks.
- When the provider leaves for the first week of vacation, open the mornings of the second week. This allows accumulating demand to fill the mornings on that second week.
- When the provider returns on the second week, open each afternoon day in sequence, allowing that to fill on each day.

- For an example see Appendix A.

IN MARK MURRAY'S WORDS

“This creates essentially a ‘carve out model’ (holding appointments) in the middle of an Advanced Access approach. Patients who call during the planned week of absence no longer have to wait until the end of the long routine queue or have to see another provider. The wait time is no longer than a week. This tends to increase the continuity for the absent provider since many patients will wait and this also tends to preserve the schedules of the present providers allowing them to see their own patients.

This approach results in increased patient satisfaction due to shorter waiting times, a better continuity, increased provider satisfaction and the space to be able to do the work when the provider returns from a vacation. None of this is possible except in Advanced Access since carving out in any other approach just extends the wait time for the routine queue. With reduced backlogs and the commitment to do all the work today, the practice is in the best capacity position and holding these appointments in the first post vacation week has little adverse effect.”

Spread Absent Provider Appointments Evenly

When a provider is off, in most cases, 50% of absent provider’s patients will wait for him or her to return. The other half need to be shared among those providers present on any given day. Spreading work evenly among providers, or “covering”, for the absent provider prevents overloading providers with backlog.

- Follow the post-vacation scheduling method described above.
- When the provider is away, offer his or her patients requesting an appointment the choice to wait for the provider to return, or to be seen today.
- Develop a script (e.g.: “Your provider is out of the office today. She will return in two days. I can make an appointment for you with her in two days or, if you wish, I can make you an appointment with her practice partner today.”
- If the patient chooses to be seen today, offer an appointment with a provider who is present.
- Do not overload one provider with patients of the absent provider.
 - Rotate the assignment of these appointments among the providers who are present. Assign the first patient to provider A, the second to provider B, the next to provider C, and so on.
 - The next time you need to assign a patient, start where you left off.
 - If a provider is “over-paneled”, the group may decide to leave this provider off the rotation.

IN MARK MURRAY'S WORDS

“In Advanced Access approaches, appointment types are reduced to a minimum number in order to increase scheduling flexibility for patients. In these models, since appointment requests are no longer sorted by clinical condition, but rather by the presence or absence of the provider.... The key here is to avoid appointing all the patients from an absent provider into the first open space on any provider who is present. This tends to ‘punish’ those with a reduced backlog and daily open schedule... no provider can

avoid contributing to the general good. A full schedule is not an excuse for not contributing in an equitable manner to the work from the absent providers.”

What to do About Extremes

IN MARK MURRAY’S WORDS

“At the same time it is recognized that there are unlikely periods of extreme fluctuation in demand, unexpected events, and/or the requirement that specific provider must leave in the afternoon at certain times. These events ought to be treated as a special contingency plan to be put in place. In the most efficient practices this is unusual and often informal.”

Appendix A– Post Vacation Scheduling Technique

Follow this example to prevent backlog accumulation when a provider is off.

As soon as the provider knows when s/he is going to be off, block the week off and the following week. In this example, the provider is taking off the week of March 12.

▶ March 2012

Monday	Tuesday	Wednesday	Thursday	Friday
Feb 27	28	29	Mar 1	2
5	6	7	8	9
12	13	14	15	16
VACATION - DO NOT BOOK				
19	20	21	22	23
DO NOT BOOK				
26	27	28	29	30

Screen clipping taken: 1/25/2012 1:13 PM

On the week that the provider is away, start opening up the mornings of the return week sequentially. When a patient calls in during that week, offer an appointment for the mornings when the provider returns or offer an appointment with another provider if available (see Spread Absent Provider Appointment Evenly, page 13).

▶ March 2012

Monday	Tuesday	Wednesday	Thursday	Friday
Feb 27	28	29	Mar 1	2
5	6	7	8	9
12	13	14	15	16
VACATION - DO NOT BOOK				
19	20	21	22	23
8:00am BOOK APPOINTMENTS 12:00pm				
12:00pm DO NOT BOOK 12:00am				
26	27	28	29	30

On the provider's first day back, the morning appointment slots will be filled. Open the afternoon for the same day demands. If the demands are greater, you can start open the following days sequentially.

▶ March 2012

Monday	Tuesday	Wednesday	Thursday	Friday
Feb 27	28	29	Mar 1	2
5	6	7	8	9
Click to add event				
12	13	14	15	16
VACATION - DO NOT BOOK				
19	20	21	22	23
8:00am BOOK APPOINTMENTS 12:00pm				
12:00pm OPEN FOR S 12:00pm DO NOT BOOK 5:00pm				
26	27	28	29	30

For each day, open the afternoons to the patient demands so that the provider can do today's work today and not create a large backlog by pushing the work into the future.

▸ March 2012

Monday	Tuesday	Wednesday	Thursday	Friday
Feb 27	28	29	Mar 1	2
5	6	7	8	9
12	13	14	15	16
VACATION - DO NOT BOOK				
19	20	21	22	23
8:00am BOOK APPOINTMENTS 12:00pm				
12:00pm OPEN FOR S.	12:00pm OPEN FOR S.	12:00pm DO NOT BOOK 5:00pm		
26	27	28	29	30

When providers are away for 2 weeks, block 2 weeks following the vacation, etc.