Table 2: List of Barriers and Facilitators Identified by Delphi Panel

Barriers
Providers at our healthcare organization are not familiar with evidence that supports self-scheduling.
Patients believe that they can get a better appointment by calling (versus using self-scheduling).
Patients can be overbooked by scheduling staff (to get an appointment sooner), as compared to the self-scheduling solution.
Scheduling workflows must be customized by specialty.
Scheduling workflows must be customized by provider.
There is no consistency in our organization's approach to self-scheduling.
Providers have specific scheduling requirements and guidelines that cannot be accommodated by our self-scheduling solution.
Coordination with the providers or departments as it relates to self-scheduling is lacking.
Variability about scheduling protocols across providers or specialties within a department.
Self-scheduling cannot accommodate our requirements related to insurance—coverage, eligibility, referrals, authorizations—or other financial clearance matters.
Self-scheduling requires triage and/or review [of appointments] by department.
Providers will or prefer to only see certain patients.
Self-scheduling cannot accommodate linking tests or other pre-appointment services to appointments.
Templates are not optimized.
Template management is decentralized.
Templates are not standardized.
The amount of information required upfront in order to schedule an appointment correctly cannot be accommodated by self-scheduling.
Self-scheduling does not allow appointments to be timed and/or allocated fairly. (Examples: Unable to randomly distribute appointments; unable to sequential scheduling; openings can only be displayed by first available.)
A barrier to self-scheduling at our healthcare organization is that self-scheduling cannot be integrated with our existing technology platform.
Our patients are not enrolled in the access point to self-scheduling. (Note that this typically refers to the “patient portal” but can be any access point.)
Our patients do not use the access point to self-scheduling. (Note that this typically refers to the “patient portal” but can be any access point.)
Self-scheduling is not accompanied by clear, helpful instructions for our patients.
Self-scheduling is presented in a manner where patients may think that something previously provided—an access point—is being taken away.
Patients are not aware of our organization's self-scheduling solution.
Patients are not willing to use our organization's self-scheduling solution.
Patients are not technically capable of being users of our self-scheduling solution.

Our organization's self-scheduling is confusing and difficult for patients to navigate.
Our self-scheduling solution does not offer the technological experience that patients expect.
There are limitations on our ability to schedule new patients through our organization’s self-scheduling solution.
Self-scheduling requires the cost of staff who must triage and/or review for the department.
Self-scheduling requires the cost of staff who must proactively communicate with patients (i.e., outbound calls) before their appointment to gather information, prepare for visit, etc.
Self-scheduling requires the cost of staff to register the patient(s) before they can use the solution.
Providers will not accept self-referred patients.
Patients schedule appointments on our organization's self-scheduling solution, but do not arrive (i.e., no show).
Our market size is so large that our organization cannot create a one-size-fits-all solution to account for geographical differences in our patient population.
Poor access results in “unfriendly” self-scheduling (e.g., no slots are available).
Our organization's self-scheduling solution cannot accommodate compliance with regulations related to patient privacy.
Our healthcare organization lacks structure to “get out of the whirlwind.”
Our healthcare organization has challenges with patient access (i.e., providers have no availability, regardless of the mode of scheduling).
Our healthcare organization does not have an adequate transition of ownership from IT (information technology) to owner of solution (e.g., ambulatory care management) after the design/build of self-scheduling is complete.
Our healthcare organization lacks a coordinated approach to self-scheduling.
Our healthcare organization desires perfection not progress.
Our healthcare organization has a low risk tolerance for innovation.
Participation in self-scheduling for providers is optional.
Our healthcare organization does not have templates constructed for self-scheduling.
Self-scheduling cannot be implemented because there is no organizational vision associated with self-scheduling.
Our healthcare organization lacks a strong administrative leader to guide the implementation of self-scheduling.
Our healthcare organization does not have a leader(s) to mandate or enforce self-scheduling with providers.
There is a lack of leadership buy-in for the self-scheduling initiative.
There is a lack of provider buy-in for the self-scheduling initiative.
There is a lack of organizational buy-in for the self-scheduling initiative.
Our IT (information technology) department does not have the resources for the design/build phase of the self-scheduling solution.
Our IT (information technology) department does not have the resources for the maintenance related to the self-scheduling solution.

Our IT (information technology) department does not have the understanding to successfully accomplish the self-scheduling build.
Our healthcare organization does not offer information about the self-scheduling solution for providers and staff to familiarize them with it.
Providers are frustrated by scheduling mistakes (e.g., “mis-scheduled” patients).
Providers are concerned about the loss of control (as it relates to scheduling via self-scheduling).
Providers are resistant to or unwilling to implement self-scheduling.
Providers are concerned over the lack of records, testing, clinical review, authorization, etc., for self-scheduled patients.
Providers believe that their patients’ needs do not qualify for self-scheduling.
Providers do not understand self-scheduling.
Providers fear patient abuse/misuse of self-scheduling.
Providers fear self-scheduling may result in “wasted” visits.
Providers are resistant to self-scheduling because they [providers] are too specialized.
There is a lack of trust in patients, as they can “game” the system when self-scheduling.
Providers fear that established patients will seek appointments outside of the desired frequency.
Some of our providers do not desire new patients.
Self-scheduling cannot be implemented because some providers want to restrict scheduling.
There is no champion for the self-scheduling initiative.
There is a lack of staff buy-in for the self-scheduling initiative.
There is a lack of staff understanding about the initiative.
The project timeline for the implementation of self-scheduling cannot be met.

Facilitators
There is evidence from providers who are using self-scheduling that are experiencing positive new patient growth.
There is evidence from providers who are using self-scheduling that are experiencing improvements in the arrival rate (e.g., reduced no-shows, reduced same-day cancellations).
There is evidence from providers who are using self-scheduling that are experiencing improvements in their patient satisfaction scores.
There is evidence from providers who are using self-scheduling that are experiencing improvements in their payer mix.
There is evidence from providers who are using self-scheduling that are experiencing improvements in the satisfaction of their staff.
There is evidence from providers who are using self-scheduling that are experiencing improvements in their revenue.
There is evidence from providers who are using self-scheduling that are experiencing higher slot utilization (i.e., more slots are filled).

There is evidence that our scheduling errors have declined.
There is evidence from our access (call) center that performance (e.g., service level and hold times) has improved.
There is evidence from our access (call) center that labor costs have decreased.
There is evidence from our access (call) center that phone volumes have decreased.
There is an advantage of patients being able to schedule 24/7, as compared to our access (call) center.
There is an advantage of integrating health promotion/preventive health reminders, as compared to our access (call) center.
There is an advantage of patients having increased exposure to all providers and all locations, as compared to our access (call) center.
There is an advantage of marketing providers by co-listing them on third-party sites, as compared to our access (call) center.
Our ability to customize our self-scheduling solution to meet the needs of our providers and departments.
Our ability to identify patients who have self-scheduled.
Our ability to seamlessly implement the solution without the knowledge of the providers.
The lack of triage required for self-scheduling.
Our ability to set time-based parameters for our self-scheduling solution (e.g., the time between the booking and the date of service [DOS]).
Our ability to set parameters regarding acceptable insurance types for our self-scheduling solution.
Our ability to set parameters regarding appropriate visit types for our self-scheduling solution.
The success of our self-scheduling pilots.
The ability to integrate other digital benefits such as reminders, wayfinding, test scheduling, and/or online payment.
The standard template build and use of visit types.
The evolution of technical features and capabilities in self-scheduling.
The ability for the user to search by availability.
The ability to access advanced tools, such as scheduling algorithms.
The high percentage of patients who have access to our self-scheduling solution (i.e., large number of portal users).
The ability to display provider profiles via our self-scheduling solution.
Staff who explain the benefits of and encourage the use of self-scheduling to the patients.
Providers who explain the benefits of and encourage the use of self-scheduling to the patients.
Our marketing materials about the solution aimed at patients.
The ability to promote new providers.
Convenience for patients to schedule appointments via our self-scheduling solution.
Ease of use for patients to schedule appointments via our self-scheduling solution.
The autonomy for patients to schedule appointments via our self-scheduling solution.

The contactless experience for patients to schedule appointments via our self-scheduling solution.
The access for patients to schedule appointments via our self-scheduling solution.
The transparency of information for patients available via our self-scheduling solution.
Our self-scheduling solution results in higher patient satisfaction.
Our self-scheduling solution results in higher patient engagement.
Patients are requesting access to it.
Our self-scheduling solution results in better access to appointments.
Necessary to be competitive in our market.
It allows us to differentiate ourselves from our competitors.
The rise of telemedicine/virtual appointments.
The use of the solution to accommodate COVID-19 vaccine scheduling.
The pressure of our electronic health record (EHR) vendor.
Self-scheduling is a necessity, not a luxury, in the current environment.
The ability to rapidly deploy associated technology for rapid situations.
The confidence of providers in technology gained by the rapid implementation of telemedicine/virtual care in 2020.
The necessity of financial stability in the current environment.
Our culture of patient-centeredness.
Our culture to improve access to care.
Buy-in of providers.
Buy-in of staff.
Buy-in of leaders.
Our ability to manage the expectations of staff and providers.
Our rapid response to issues as they develop.
Openness to change.
Our perception that it is necessary to offer self-scheduling to our patients.
Our perception that it is necessary to reduce our call volume.
The compatibility with virtual visits/telemedicine.
The collective perception of the importance of the self-scheduling solution as an organizational priority.
Opt-in is assumed unless a reason for opting out is given and approved.
The organization has established goals associated with self-scheduling.
Our clinical/provider leaders are engaged in our solution.
Executive leaders are engaged in our solution.
Our leaders are mandating the self-scheduling solution.
Our organization's investment into the IT (information technology) build/design for self-scheduling.
Our organization's investment into the IT (information technology) maintenance for self-scheduling.
A resource team dedicated to self-scheduling.

Our organization's internal orientation and training for practices/departments related to our self-scheduling solution.
The interest and engagement of younger providers.
Frustration with our current manual process.
Growing confidence in our self-scheduling solution.
Our providers’ willingness to see patients who have self-scheduled regardless of whether the patient is the “right” patient.
Our providers' willingness to try self-scheduling.
Our providers' recognition of the benefits of self-scheduling.
Our methodical, controlled implementation of self-scheduling.
The adequate time allocated for development and testing of our self-scheduling solution.
Our provider champions.
The internal “word of mouth” positive feedback from providers who have implemented self-scheduling.
The partnership between operations/scheduling and IT (information technology) for our self-scheduling solution.