This group's improved availability has contributed to increases in patient satisfaction, new patients and productivity.

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Implementing Advanced Access in a Group Practice Network

Primary care practices face numerous challenges on their way to improving patient access. Patients compare the service they receive in health care to the service they receive in other industries and expect equivalent convenience. Since patients are increasingly likely to choose or change physicians based on service, it is crucial that practices change their behavior and processes to improve patient access.

The mission

In the face of significant economic challenges in the late 1990s, our practice network, the Geisinger Health System (GHS), had to refocus (see the description of GHS on page 36). Since the late 1980s, the network had served primarily as a delivery system for GHS' HMO, Geisinger Health Plan (GHP). Changing market dynamics in the 1990s led us to adopt a more market-oriented, all-payer approach, and the ability to expand our patient base became central to our success.

In many network sites, provider schedules were completely booked. For the practices to grow, we had to open them to new patients and add physicians. Also, our patient satisfaction surveys demonstrated less-than-desired accessibility. Not only was this limiting growth, it was also jeopardizing the loyalty of established patients. Our challenge was to reverse this situation quickly and effectively.

The obstacles

GHS' access improvement plan developed from our participation in the Institute for Healthcare Improvement's

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ILLUSTRATION BY JIM FRAZIER

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When the Geisinger Health System (GHS) decided to grow its group practice network to combat economic challenges, the entire network made the transition to advanced access.

GHS developed its goals for improved access from the Institute for Healthcare Improvement's Idealized Design of Clinical Office Practice (IDCOP) collaborative.

The biggest challenge the network faced was to convince physicians that advanced access could reduce backlog without increasing their workload.

To begin the process, GHS created a workgroup to evaluate the two pilot sites' experiences with advanced access and to educate, train and support the other primary care sites.

Idealized Design of Clinical Office Practice (IDCOP) collaborative. This four-year initiative involving 23 health systems across the United States and Europe focused on developing innovative ways to deliver office-based health care. One of the fundamentals to emerge from the collaborative was a structured way of understanding and managing access within the office practices.

Two GHS network sites served as pilot locations for developing techniques and tools to improve access. One pilot site was able within one month to reduce the length of time a patient has to wait for an appointment with the provider of his or her choice from 10 days to two days. Within two months, this site had also accomplished a 54-percent reduction in the number of minutes from check-in to checkout. Early results at these sites and in other IDCOP-participating organizations demonstrated the potential for improvement across the entire network.

However, we faced several major challenges. Perhaps the most fundamental of these challenges was getting physicians to accept the concept of advanced access. Many of our physicians found it difficult to understand how access could be improved without increasing their workload. They struggled to understand how they could reduce the backlog in their practices and ever be able to see a patient for a routine check-up on the same day the patient calls.

A second challenge we encountered was to find an approach in keeping with our culture of local initiative and ownership. While it was critically important to move quickly to realize gains in access, we did not wish to mandate the change. Our approach had to create the ability for each provider to understand and implement improvement within his or her unique practice circumstances.

Local leadership and diverse representation were important to create sustainable results.

KEY POINTS

- The Geisinger Health System, a large practice network, implemented advanced access scheduling to increase its patient base and combat economic challenges.
- The network set up two pilot sites and created a workgroup in charge of education, training, support and evaluating the advanced access processes in the pilot sites.
- Once advanced access scheduling was in place across the network, each site experienced an increase in physician availability and patient satisfaction.

The third major challenge was to accomplish access improvement across our diverse and distant network sites. It quickly became apparent that success would require a thoughtful approach and a significant commitment of resources.

The plan

We began our initiative with a small workgroup that evaluated the IDCOP processes, focused primarily on advanced access, and the experience of our pilot sites. This group developed a three-pronged approach involving education, training and support. Our first step focused on educating our medical and administrative leaders at monthly leadership team meetings. The meetings centered on the strategic and business benefits of improved access: increased patient satisfaction, practice growth and improved economic performance. We incorporated the success stories from pilot sites within GHS and from other organizations. We also published case studies in our monthly network newsletter and gave presentations at various site meetings. Additionally, we invited individuals from other health care systems that had adopted advanced access to share their experiences with our network leadership.

As the leadership group and general network staff were introduced to the benefits of improving access and the concepts of how to attract new patients and enhance satisfac-

ABOUT GEISINGER HEALTH SYSTEM

The Geisinger Health System (GHS) has a 31-county service area that spans north-central and eastern Pennsylvania, with network sites located in 17 of these counties. The sites consist of approximately 200 physicians: 85 percent primary care physicians and 15 percent specialists. The network provides care to approximately 350,000 patients annually, and the sites vary dramatically in size, from an office with a single physician to large multispecialty groups.

tion and service, the workgroup designed a 10-week education and implementation program for our primary care sites and specialty departments. Local clinical and administrative leaders led this program with support from a trained facilitator. GHS provided six of these facilitators, referred to as system access specialists, to support implementation. To implement the 10-week performance improvement model, we created an IDCOP team at each site. These teams were jointly led by a physician and an administrative or support staff member and included a cross section of practice staff. Local leadership and diverse representation were important to create sustainable results. A system access specialist supported each team by providing training and ensuring that the group remained on target.

> Once we reduced this backlog, sites were able to provide same-day requests without having to overbook or juggle schedules.

Initial team meetings focused on improvement tools, methodology and establishing goals and objectives. Teams were encouraged to identify issues and barriers concerning access improvement and physician interaction with patients. They completed surveys to assess morale and perceptions of the work environment. Some teams decided to tour their sites to get a patient's perspective on office appearance and functionality. These tasks were designed to give staff a fresh outlook on site operations and identify opportunities for improvement.

In addition to this early work, teams quickly identified and measured important aspects of practice operations. In regard to access measurement, teams looked at several key areas: demand, backlog, lead-time, cycle time and supply. These measures formed the core data around which we developed our access improvement strategies. We defined these areas as follows:

• **Demand.** This is the volume of services sought by patients in the practice. Staff measured daily demand using log sheets to record demand by category: telephone requests for appointments, prescription refills, advice, referrals and follow-up visits. These log sheets were then compiled to provide a picture of the volume and type of demand per provider by day of the week. We encouraged practices to collect this data for at least a two-week period to get a balanced view of patterns and fluctuations.

• **Backlog.** This includes requests for services waiting to be provided, which is a key component of demand. We focused on existing scheduled appointments. Using our electronic scheduling system, staff identified the volume and type of existing appointments by provider and for the practice as a whole. This view showed how much work was required to reduce the current backlog and what types of services (preventive, follow-up, acute care, etc.) we typically pushed into the future.

• **Lead-time.** This is the length of time a patient has to wait for an appointment with the provider of his or her choice. We counted lead-time as the number of days until the third available appointment. This measurement was done for each site and each physician within the site. Our primary goal was for all primary care physicians to have their third available appointment within 24 hours so patients could be assured of seeing their own provider.

• **Cycle time.** This is the number of minutes from check-in to checkout. Our process was designed to measure segments of cycle time, such as time in the waiting room, time in the exam room, time with the provider and time waiting for ancillary services. To accomplish this, we asked patients to carry tracking forms throughout their visit for staff to use to record the beginning and ending times of each segment of the visit. This detailed breakdown pinpointed bottlenecks in patient flow that affected efficiency and, therefore, capacity.

• **Supply.** This is the time available for providing patient care. Providers' daily schedules were reviewed to create a picture of patient care capacity at each site. Overall capacity is affected by the way schedules are built. For example, schedules with slots based on multiple appointment types (preventive, acute, recheck, etc.) decrease access by limiting schedulers' flexibility to respond to the types of calls received that day.

Many sites discovered they had the capacity to handle same-day appointments but couldn't offer them because schedules were full at the beginning of the day. Once we reduced this backlog, sites were able to

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The workgroup set up an IDCOP team at each site to facilitate the 10-week advanced access implementation process.

The IDCOP team meetings focused on setting goals for improved access, identifying current barriers to access and creating an implementation approach that would fit the team's specific site.

Access improvement strategies centered on five main measurements: demand, backlog, lead-time, cycle time and supply.

Because most physicians' schedules were full at the beginning of the day, practices added office hours and combined patients' acute and preventive visits to reduce backlog.

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Several sites found that adding more acute appointments on Mondays and Fridays and making seasonal schedule adjustments helped minimize backlog.

After one year, the 25 network sites with advanced access had two-week appointment schedules that were 35-percent more open than sites without advanced access.

During the two years of advanced access implementation, patient satisfaction scores increased by 48 percent.

With strong leadership efforts, any practice can establish advanced access to increase its patient base and improve patient satisfaction.

meet same-day requests without having to overbook or juggle schedules. They understood the daily variation in demand and designed their schedules accordingly.

To work down the backlog of current appointments, we tried several tactics. Some providers chose to add office hours. A second approach focused on combining patients' preventive and acute visits, referred to as "max-packing," to reduce the number of duplicate visits for each patient. A third method involved assessing the frequency of return visits and lengthening the return interval when clinically appropriate.

As sites worked to reduce their appointment backlogs, they also worked to maintain access. First, they obtained an accurate picture of daily demand and designed schedules to meet that demand. A common finding was the need for more acute appointment availability on Mondays and Fridays. Some sites found that seasonal adjustments were needed. They also adjusted pre- and post-vacation templates to minimize backlog created during time out of the office. Sites also simplified their schedules to reduce the number of appointment types and give schedulers maximum flexibility.

> **Fifty-three percent of the physicians had two-week appointment schedules that were at least 40-percent open.**

The results

When evaluating our results, we focused on two key numbers: the percentage of open schedules and lead-time. These were measured at the site and individual physician levels. By looking at both measures, we could quickly monitor the ease of patient access. Our initial network-wide efforts confirmed our ability to improve the percentage of open schedules. In the first year, 25 network sites completed the structured implementation plan. These sites' two-week appointment schedules were 35-percent more open than those at sites that had not been through the process.

We also observed improvement at the individual physician level. Fifty-three percent of the physicians had two-week appointment schedules that were at least 40-percent open. At sites that hadn't completed the implementation, only 34 percent of physicians could offer this level of access. By the time implementation was complete across the network, 59 percent of all network physicians had reached this benchmark. Lead-time across the network is very low as a result of this work. At the completion of implementation, 84 percent of network sites had a lead-time of one day or less.

Greater accessibility has contributed to increases in patient satisfaction, recommendation and retention. Over the two years of implementation, patient satisfaction scores across the network rose by 48 percent. Patients' likelihood to recommend our practices increased by 28 percent. In the second year of implementation, we began tracking patients who transferred out of our network sites and the reasons for their departure. At that time, approximately 5 percent of patients who transferred cited access issues as the source of concern. In the first full year since overall implementation, this dropped to 2 percent. While other initiatives also affected these improvements, changes in access were a significant reason for our gains.

We also discovered that improved availability led to new patient growth and increased physician productivity. The percentage of new patient visits grew by 33 percent between the first and second year of implementation. Even with the significant increase in access and open schedules, physician productivity increased 8 percent over this period.

The summary

The leadership efforts in this complex process emphasize the importance of communication, education and buy-in to implement advanced access in a group practice network. These key components, along with timely feedback, staff support and necessary resources, are especially significant when the end point and the benefits are not immediately apparent to those directly affected by the change. Once these elements are in place, however, any practice has the ability to establish advanced access, increase its patient base and improve its economic performance. FPM

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