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The Easy Access Program: A Way to Reduce Patient No-Show Rate, Decrease Add-Ons to Primary Care Schedules, and Improve Patient Satisfaction

The Easy Access Program is a model plan to improve personalized care and patient access to primary care practitioners. In this model, Health Plan members who call for an appointment can see a clinician from their primary care module team within 48 hours.

This article describes the background, rationale, design, and positive results of implementing this model access plan.

Introduction

After months of planning and after educating our physicians and staff, the Easy Access Program started on June 1, 1998, at the Southern California Permanente Medical Group (SCPMG) Antelope Valley Medical Offices. The Easy Access Program was created to solve problems of patient and staff dissatisfaction with our appointment system. Identified problems included long waiting time for appointments and inability of members to schedule an imminent, timely appointment with their primary care physician. In addition, clinical teams "added-on" patients to fully booked schedules each day; consequently, physicians' and other staff's stress levels were high. These issues are not limited to our clinic but have been reported elsewhere.¹⁻⁵

The system's inefficiency caused members to schedule more than one appointment for the same medical problem to help ensure being seen when the need arose. As a result, our no-show rate (ie, rate of patients who neither kept nor cancelled scheduled appointments) was 22%. Because appointments with members' regular practitioners were nearly impossible to obtain on a same-day or nearly same-day basis, the volume of patients using the Urgent Care Department began to rise and ultimately exceeded 50% of all adult primary care visits. Our system required considerable "rework," ie, follow-up visits to other, nonurgent care departments for medical problems not addressed earlier in the Urgent Care Department.

Working Within the Supply-and-Demand Model of Health Care

Before changing our appointment system, we had to determine if the number of appointments provided by our system (ie, the supply) was large enough to meet our members' needs (ie, the demand). "Demand" in this context is defined as the number of patients seeking services—patients who call the clinic for advice or unsuccessfully seek service plus patients who obtain an

Urgent Care or a routine appointment. The supply-and-demand model for health care hypothesizes that our appointment capacity meets the needs of our Health Plan members. Studies of our clinic population show a mean of approximately 3.0 appointments per year per adult member: 116,529 appointments made during a 12-month period divided by 37,685 adult members.

Given that a full-time equivalent (FTE) clinician in our system works five days per week, spends six weeks per year outside the clinic for continuing education and vacation, and can be scheduled for 22 appointments per day, each clinician can be scheduled for 5060 appointments per year (ie, 5 days/week × 22 appointments/day × 46 weeks). By definition, this figure is our projected supply of appointments.

According to these calculations, we need 23 full-time clinicians to care for our member population (ie, 116,529 appointments divided by 5060 appointments). Our supply of appointments must take into account the total number of clinician hours spent in the clinic. These clinicians include our full-time staff clinicians, extra clinicians, per diem practitioners, and clinicians working in the Urgent Care Department.

The supply-and-demand model should be used to guide a medical center to operate more efficiently. When, for example, patient panel size (ie, number of members assigned to a primary care practitioner) increases to the point that the need for appointments exceeds the number available, then demand exceeds supply, the system becomes less productive, employee stress levels rise, and satisfaction is decreased. At that point, members might leave the health care organization, causing a decrease in revenue and consequent rise in costs. In addition, a decrease in patient panel size and clinic FTE ratios would decrease the need for clinicians, and costs would begin to rise because salaries would exceed revenue. The ideal ratio of panel size to clinic FTE matches the supply of appointments to the demand for them.

Groundwork for Solving our Access Problem

Important work in the area of access within the Kaiser Permanente system had already been reported by Murray and Tantau,³ who showed that an open-access system improves members' satisfaction and decreases waiting times for return appointments. Data presented by these authors³ and others⁴ were instrumental in allowing us to develop the concepts that were successfully implemented in our clinic.

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After we determined that our appointment capacity was sufficient to accommodate development of an Easy Access Program, we examined ways to improve our office efficiency. "Brainstorming" sessions with staff members identified two major areas of hidden capacity at our clinic: 1) a high percentage of patients who neither keep nor cancel a scheduled appointment, and 2) patients who are seen in the Urgent Care or Emergency Departments and are later seen by the primary care clinician for the same medical problem within one week after the initial visit. The Ambulatory Satisfaction Questionnaire (ASQ) survey was used to compare members' general satisfaction with the Health Plan—and, in particular, their satisfaction with our appointment system—before implementation of the Easy Access Program.

A Gantt chart was developed to identify clinic stakeholders, and teams were formed to address issues relating to implementation of the program. In addition, we analyzed the function and length of appointments and developed appointment types that would guide our call center personnel to give members the type of appointments they need.

Design and Implementation of the Easy Access Program

As an initial step in designing the new system, we agreed that all appointments would be 20 minutes long to avoid confusion between the 15-, 30-, and 45-minute appointment types used in our old system; 15-, 30-, and 45-minute appointments were eliminated. The call center receptionist scheduling an appointment would thus need only to look for one appointment type—the type which most members request. Appointment types were reviewed with the primary care provider teams, and 18 appointment types were replaced with four: hold, new, return, and same-day. Adjustments were made to accommodate Family Practice clinicians who provide pediatric services and other procedures on a same-day basis.

When members call for an appointment in our new system of access to care, the call center receptionist determines if the patient's primary care clinician is available for a same-day appointment; in this sense, the new system is resource-specific. If an appointment is available, the receptionist gives the member the appointment; if the clinician is not available for a same-day appointment, the call center representative identifies another module team member who is available; in this sense, the new system is module-

specific. If no module provider is available, the receptionist identifies an available clinician within the department; in this sense, the new system is department-specific. If no same-day appointments are available, the member is given an appointment in the Urgent Care Department.

Categories of future appointments were identified as "new member entry," "preoperative screening," and "hospital follow-up." Clinic staff who interact with members needing these appointments were given the responsibility and authority to schedule future appointments for these patients.

To accommodate this change, the Medical Records Department had to change its chart-delivery system: instead of pulling charts only for routine future appointments—and thus deliver charts once or twice per day—personnel had to be available to pull charts and deliver them to the module several times per day on an as-needed basis.

Knowing that the long-term success of the program depended on encouraging both accountability and the potential for rapid change at the local level, we developed module teams consisting of nurses, physicians, pharmacists, social workers, receptionists, and clinical assistants and including a physician as team coleader and a nurse as team coleader. Teams met daily, weekly, and monthly to discuss quality and performance improvement issues. Original thought was encouraged. Every month, all module teams met jointly to share best practices. A physician master scheduler reviewed vacation and other absences to assure that not more than two providers from the module would be absent at one time. Module leaders were responsible for scheduling a clinician to be present in each module for after-hours clinic appointments.

The final step before implementing the Easy Access Program was to reduce the backlog of patients on the clinic or medical center's appointment waiting list. One way to reduce the backlog would be for the clinic to increase the number of providers available to meet the future demand for appointments; however, this method is costly and generates a new list of patients waiting to be seen. In our clinic, therefore, we telephoned most of the patients on the waiting list and discovered that 25%-50% of these patients did not need a return appointment. Instead of being sent a card with appointment date, the remaining patients were sent a letter reminding them to call for an appointment. After initiating this process, our backlog was eventually reduced to a number which was easily absorbed by our new access program.

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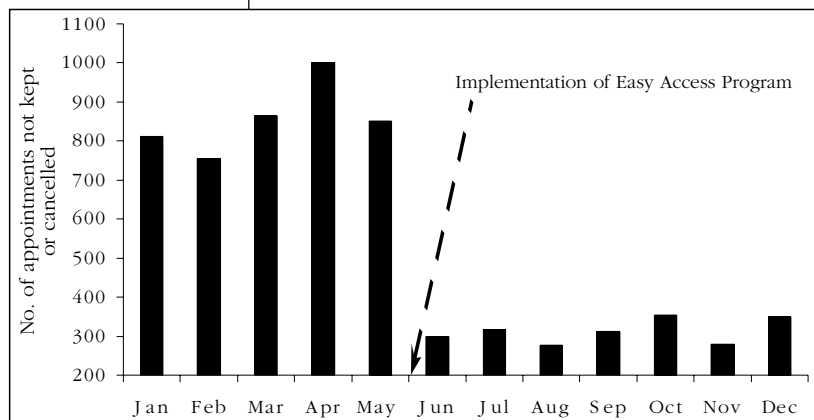


Figure 1. Number of "no-show" appointments at SCPMG Antelope Valley Medical Offices during the five months before and seven months after implementation of Easy Access Program.

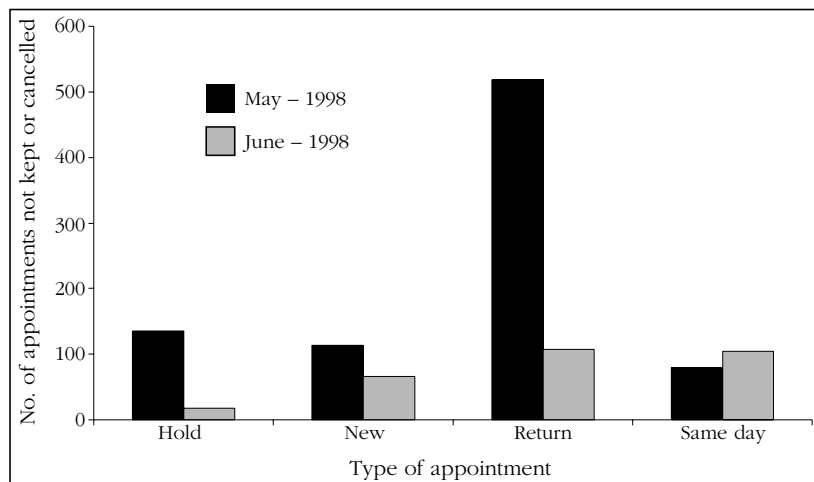


Figure 2. Number of "no-show" appointments during the one-month periods before and after implementation of Easy Access program.

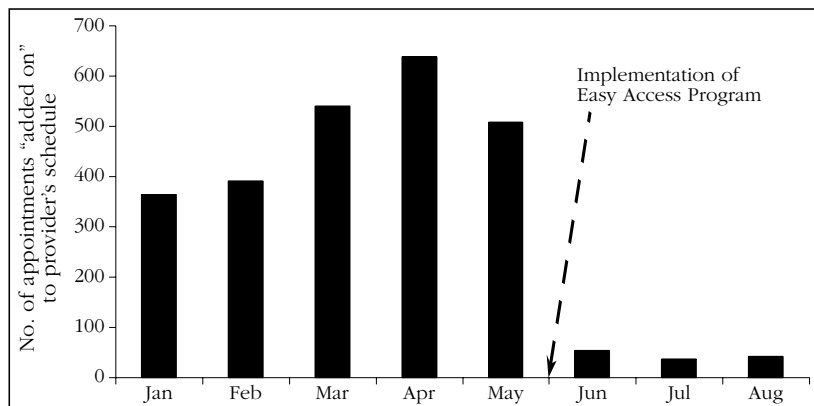


Figure 3. Number of appointments added to clinicians' schedules during the five months before and three months after implementation of Easy Access Program.

Results

The numbers of no-show appointments for the five months before and seven months after implementation of the Easy Access Program are shown (Figure 1). The no-show rate dramatically decreased after we started the new program on June 1, 1998. The overall no-show rate decreased a mean of 857 appointments per month (for the five-month period before the program started) to a mean of 312 appointments per month (for the seven-month period after the program began). This decrease corresponded to a reduction in no-show appointments from about 214 per week to 78 per week. The most dramatic change among the four types of appointments—hold, new, return, and same-day—was seen for return appointments (Figure 2).

Because the new system allowed for same-day appointments, the number of appointments added to clinicians' schedules was substantially decreased from a high of 639 (in April, 1998) to a low of 42 (in August, 1998) (Figure 3). In addition, because clinicians had increased their capacity to see Health Plan members in the primary care clinic, the percentage of Health Plan members seen in the Adult Urgent Care Department decreased from 48% to 29% after implementation of the Easy Access Program (Figure 4).

The Internal Medicine Department waiting list for routine appointments—an indicator of unmet demand—was reduced from a mean of 852 per month to a mean of 20 per month (Figure 5), a result which took about three months. After one month of experience working within the Easy Access program, we randomly surveyed several clinicians and receptionists to determine their opinions about the program. On a scale of 1-10 (a score of 10 was most positive), both groups gave the program a score of 8. Results of the patient satisfaction questionnaire asking for patients' appraisal of physician and staff services showed dramatically improved patient satisfaction after implementation of the Easy Access Program—both for individual indicators of satisfaction and for overall satisfaction (Table 1).

Conclusion

The reasons for us to consider changing our present appointment system were related to specific clinic issues: Our member satisfaction scores were the lowest in our service area; no-shows (ie, appointments that are neither kept nor cancelled) contributed approximately 20% of all primary care visits scheduled per day; and the number of visits

Table 1. Results of patient satisfaction questionnaire distributed to ambulatory patients at Internal Medicine Department of SCPMG Antelope Valley Medical Offices during last three quarters of 1998^a

Indicator	Mean questionnaire response score		
	April-June	July-September	October-December
Scheduling routine appointment	6.55	7.02	7.69
Wait for appointment	7.23	7.74	8.59
Attention from nonmedical staff	7.90	8.21	8.65
Attention from physician	7.60	8.07	8.18
Attention from nurses	7.88	8.34	8.66
Overall opinion of Kaiser Permanente	7.33	7.60	8.25

^a Easy Access program was implemented on June 1, 1998.

to the Adult Urgent Care Department per day was exceeding the number of visits to nonurgent care clinicians per day. Our system encouraged patients to schedule follow-up visits for medical problems addressed earlier at the Urgent Care Department, yet members did not perceive visits to the Urgent Care Department as a satisfactory replacement for seeing their primary care practitioner.

The Easy Access Program implemented at the Antelope Valley Medical Offices has made our clinic more efficient, has changed the way we work with our internal and external customers, and has increased their level of satisfaction with the Health Plan. We have decreased the number of wasted appointments as well as the aggravation felt by clinicians as patients are added to schedules that are already fully booked. In addition, physicians and support staff now communicate daily, weekly, and monthly to monitor and improve patients' access to appointments. The overall benefit of the Easy Access Program is development of a system of health care delivery that matches appointment supply with appointment demand.

We hope that further evaluating this system will help us to develop a program that fully meets both the acute and long-term needs of our members while reducing unpredictable deficiencies in appointment scheduling. Further work is needed to integrate the Easy Access Program with population care management programs and to accommodate members who want to schedule an appointment with their clinician in excess of 48 hours. The data presented in this paper suggest that the Easy Access Program may make our system of health care more efficient while meeting access needs of our members.

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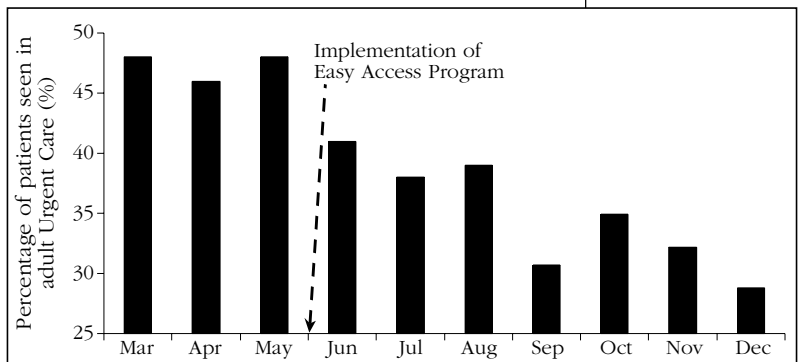


Figure 4. Percentage of adult Health Plan members seen in Urgent Care Department during the three months before and seven months after implementation of Easy Access Program.

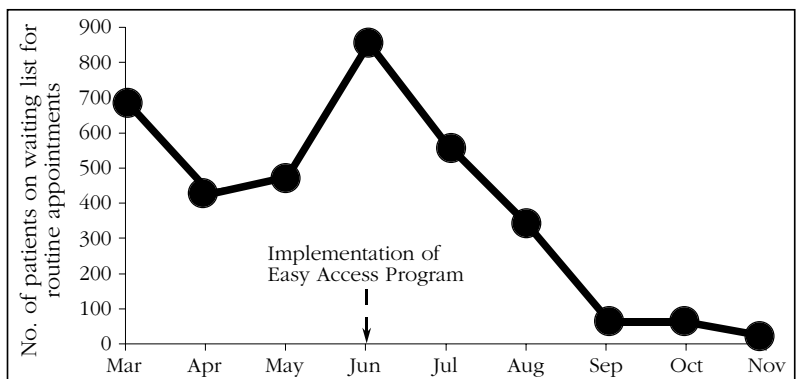


Figure 5. Number of patients on waiting list for routine appointments during the three months before and six months after implementation of Easy Access Program.