Clinical Services Plan: Case Study 19

Extended Hospital Outpatient Hours

Increasing convenience for patients

JHAH's five-year Clinical Services Plan
Transformation Project 2D

Champions
Dr. Ahmed Jameel and Dr. Nabeel Faify

نحن نهتم
We Care

September 2025

Clinical Services Plan

مركز جونز هوبكنز أرامكو الطبي
Johns Hopkins Aramco Healthcare

Case Study 19: Extended Hospital Outpatient Hours

Increasing convenience for patients

Project details

The objective

To extend the time during which outpatient appointments are offered in order to increase patient access, convenience and satisfaction, and improve the utilization of the hospital facility and equipment.

The priorities

- To engage with a large number of stakeholders so that any concerns can be understood and addressed.
- To assess different options for the new shift arrangements and make recommendations.
- To develop and implement a roll-out plan according to an ambitious timeline.
- To monitor implementation and make any continuous improvement changes.

The timeline

- **Project kick-off:** August 2024
- **Project closure:** September 2025

The project team

Sponsor:

- Dr. JJ de Gorter

Champions:

- Dr. Ahmed Jameel
- Dr. Nabeel Faify

Team members:

- Rawan Al Jehairan
- Dr. Peter Bibawy
- Joren Exconde
- Somaya Hajri
- Dalal Al Mohaisen
- Maha Makled
- Ahmed Zahrani
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About the Clinical Services Plan

Johns Hopkins Aramco Healthcare (JHAH) serves more than 140,000 Aramco employees, their relatives and retirees with a comprehensive range of inpatient and outpatient services. JHAH has carried forward the legacy set by Saudi Aramco of healthcare for all, putting caring for its community at the heart of everything it does.

In 2023, JHAH launched its five-year Clinical Services Plan (CSP). The CSP was developed in response to changing patient expectations and the realization that JHAH must evolve if it is to survive and thrive. The Plan's vision is that JHAH will become the Kingdom's first choice for outstanding integrated healthcare.

The CSP contains 16 strategic objectives to deliver against five goals (service excellence, access, people, sustainability and reliability), and is supported by four delivery principles (accountability, pace, pragmatism and outcomes). The Extended Hospital Outpatient Hours project was included as Objective 2D in the CSP.

The rise of the consumer society

The last 120 years have seen a global shift from production-driven to consumer-led economic and social models.

Until the early 1900s, economies tended to be "steady state … capable of meeting the basic needs of all", and for most of the population their experience of consumption involved "frugality and thrift (in) situations where survival rations were not guaranteed" [1]. According to historian William Leach, it was during the years leading up the first World War that a cultural transformation began, firstly in the United States, ushering in a "land of desire" built around concepts such as "comfort and luxury." [2]

Today, most sectors have completed the shift from a producer to a consumer mindset, responding to the "different emphasis on value" that consumers place [3]. As Ben Weinberg comments, "being able to consume … has never been easier or faster. You can stream vast amounts of

music, download movies within minutes, and have food delivered to you at the click of a button."[4] Tidio, a firm that specializes in frictionless consumer experience, rates 'convenience' as one of the eight core customer needs, placing it first in its rank order [5].

Despite these sweeping transformations in how the public expected services to be delivered, for many years healthcare provision was resistant to change and failed to rise to the challenge. The forces of inertia were simply too powerful, perhaps because "the new is intimidating" or "the vision is not shared" or there is an unaddressed "fear of the unknown" [6]. Yet inertia cannot retail indefinitely. Gradually, patients came to expect the same convenience in their interactions with physicians to which they had become accustomed during the rest of their daily activities. Engineering architects Stantec have provided an apt description of this phenomenon. They wrote, "In a world where we are all looking for better and faster, it was only a matter of time before (the culture of convenience) reached healthcare." [7]

Figure One: Convenience – one of the eight core customer needs

Source: Tidio

Embracing patient convenience at JHAH

OPEN

In 2024, the availability of the core patient services at JHAH's main hospital facility had stayed remarkably unchanged throughout this period of rapid social change. Its 60 clinics opened for their first appointment at around seven o'clock in the morning, and closed their doors by mid afternoon. By four o'clock, with the exception of the emergency department and the in-patient wards, the entire building was largely deserted.

Not only was this out of step with the model at neighbouring hospitals, it also meant considerable inconvenience to patients. A large number of individuals looking to schedule a specialist appointment held positions of responsibility at Aramco; it was not straightforward to find an empty couple of hours in the calendar during which to travel to the hospital for an in-person consultation. Moreover, the short working hours intensified pressure on the limited car parking spaces. When patients were juggling their various commitments, they faced the additional awkwardness of having to account for the time spent trying to find somewhere to park their vehicle.

The previous year, JHAH had already introduced extended opening hours in its primary care service as part of an urgent drive to improve access (details of these changes are provided in Case Study 05 in this series). This has been well received by patients, and what began as a time-limited pilot had evolved into a permanent feature.

The Clinical Services Plan provided the ideal framework to scope and test whether the same approach could be applied within the rest of the hospital's services. To explore the options, Chief of Staff Dr. J J de Gorter turned to his Chief Medical Adviser Dr. Ahmed Jameel, and Lead Clinical Administrator Dr. Nabeel Faify. The project objective, endorsed by the program's oversight committee, was "To deliver extended hospital operating hours in order to improve the utilization of JHAH's facility and equipment, and increase patient access, convenience and satisfaction." With their appointment as project co-champions confirmed, Dr. Jameel and Dr. Faify mobilized a project team with expertise in many disciplines to assess and deliver the most relevant solution.

Dr. Faify commented, "We recognized this was a high profile project, but also one that needed to be handled with extreme sensitivity. The goal was clear and could not be compromised. However, we were open to suggestions about every aspect of implementation. So rather than impose an unworkable model upon our people, we began with a lengthy period of engagement and discussion. This enabled us to design a solution that was practical and sustainable, and didn't simply replace one problem (lack of patient access) with another (physician burnout)."

Scope of the changes

Around 60 clinics were potentially affected by a change to operating hours. This included services with a large number of physicians as well as single physician services; it also included core hospital services as well as niche specialisms. Figure Two provides a selection of clinics that were within scope

Three core options were subjected to detailed modelling as part of the feasibility exercise, and assessed according to the operational complexity (in particular the management of shift patterns), patient impact, financial criteria, reputational criteria and other factors. These options were:

- **Option One:** Outpatient clinics operate from 7:00 am to 9:00 pm
- **Option Two:** Outpatient clinics operate from 8:00 am to 11:00 pm
- **Option Three:** Outpatient clinics operate from 7:00 am to 10:00 pm

Change management principles

Having noted the need to manage change sensitively, Dr. Faify and his project team constructed a program that followed four core principles in assessing the options and recommending an implementation plan.

Figure Two: Examples of outpatient clinics within scope

Cardiac	Anesthesia	Medicine	Specialized therapies	Surgical	Women and children
Cardio lab	Pain clinic / anesthesia	Gastro clinic	Adult physical therapy	ENT	General OB/GYN
Cardiothoracic surgery		Dermatology	Pediatric physical therapy	Neuro-surgery	Maternal fetal medicine
Cardiology		Endocrinology	Respiratory care	General surgery ex. Baria/colo	Urogyne
Cardiac rehabilitation		Rheumatology	Speech language path	Ophthalmology	Gynecology oncology
		Pulmonary	Adult occupational therapy	Orthopedics	Reproductive endocrinology
		Neurology	Adult medical nutrition	Urology	Genetics
		Nephrology clinic	Orthotics prosthetics	Bariatric surgery	Neonatology services
		Infectious disease clinic	Pediatric occupational therapy	Colorectal surgery	GI clinic
		Adult allergy clinic		Vascular surgery	Pediatric cardiology
		Social services		Ped general surgery	Pediatric nephrology
		Psychiatry		Plastic surgery	Pediatric endocrinology
		Clinical psychology			Pediatric neurology
		Community counselling			Pediatric rheumatology
		Adult oncology			Pediatric infectious disease
		Adult hematology			Pediatric pulmonary
		Ped oncology hematology			Pediatric allergy clinic
		Radiation			Pediatric behavioral development
		Palliative care			

Core principle: Widespread engagement

Dr. Faify comments, "We invested substantial time over many weeks to listen to the perspectives of everyone who would be affected. Our consultation deck set out the need for change, and made clear that we could not back away from the over-riding goal; however, the details of implementation were all open for debate. The 'what' was fixed; the 'how' was flexible." More than half a dozen workshops were held with Chief Position Holders and others. Three aspects of the engagement process were crucial to its success (see Figure Three):

- Explaining the case for change
- Two-way dialogue – major focus on 'listening'
- Commitment to a post-implementation review

Core principle: Option One (7:00 am to 9:00pm)

Having assessed the three options identified in the 'scope' exercise, the project team settled on the 7:00 am to 9:00 pm solution, comprised of two overlapping eight-hours shifts – early (7:00 am to 4:00 pm) and late (12:00 noon to 9:00 pm). Analysis of the experience from benchmark organizations suggested that patient demand tended to tail off beyond the 9:00 pm threshold. After this time, the scale of patient benefit no longer over-rode various operational downsides.

Core principle: Phased rollout

"It quickly became apparent that a sudden switch carried unnecessary risk, and meant no opportunity to learn as we proceed," said Dr. Faify. For this reason, a phased rollout was designed. In the first phase, 27 clinics began to offer late availability in four waves across September to December 2024). The remaining clinics – principally the single physician services – were bought within the program as part of a second phase in the first quarter of 2025.

Core principle: Continuous monitoring

The new operating hours were not set in stone regardless of the consequences. In the period immediately after the change, weekly analysis of the impact was conducted; as the situation settled, this was relaxed to a monthly assessment. Small refinements were made to how the new opening hours affected specific clinics in order to optimize the new arrangements. One of these refinements included how the extended opening hours functioned during Ramadan; another was how they aligned with other access initiatives within the hospital such as the 'Super October' push, which happened at around the same time, to deliver 1,000 procedures in a single calendar month (see Case Study #13).

Figure Three: Engagement sessions

Core principle: Project-specific Risk Register

This was a valued tool for ensuring any unintended consequences were understood and addressed. Twelve key risks were listed on the Register, including ones that were of a financial nature ("Increased labor costs due to overtime, locum requirements technical support to the clinics"), people-related ("Fatigue and burnout, as shown in increased sick days"), and operational ("Later clinics will exacerbate the bed crunch if there is less capacity for early morning rounding and pre-noon discharge.") The central role of risk assessment in JHAH projects, and the assessment methodologies used, are covered in Case Study #18.

These core principles were amongst the 'Service Rules' published as part of the post-consultation report (reproduced in Figure Four). Dr. Jameel explained, "The Service Rules were designed to ensure fairness. Once these had been endorsed, there could be no exceptions. We knew the entire transformation would lose credibility if certain services were seen to be treated with greater leniency than others. This was a collective commitment on behalf of the entire hospital."

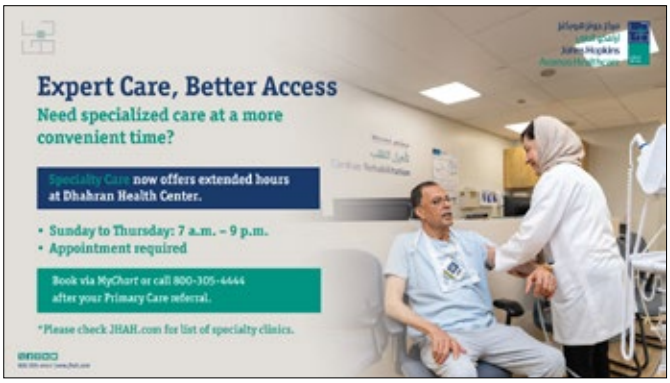
High profile communications were an essential element of the change, to raise patient awareness of the increased accessibility of hospital services. Dr Faify noted, "It would be pointless to go through all the effort of making these changes if the later slots were empty because nobody knew about them".

Working with the marketing team, a campaign called 'Expert Care, Better Access' was delivered – with high profile messaging used across many different channels including digital screens within and outside the hospital, the website, and the MyChart booking app. A selection of communication activity is displayed in Figure Five.

Figure Four: Service rules

1. Every service must offer some weekday ambulatory availability to 21:00, starting with those with four or more clinicians (Stage 1).
2. Every clinician is required to contribute one late shift per week pro-rata. Clinicians have flexibility to swap shifts with one another.
3. Implementation for Stage 1 Services (27): full implementation equals Late Clinic availability five days per week (unless there are only four clinicians in which case it is four days per week).
4. Implementation of Stage 2 Services (37): full implementation equals Late Clinic availability as many days per week as there are clinicians.
5. Services have up to 90 days to achieve full implementation following their start date.
6. All service activity must be templated according to physician contracts and supporting guidelines.

Figure Five: Communication messages (examples)



The results

Ten months after the rollout commenced, the project team reviewed the impact, assessing both the level of compliance with the Service Rules and the measurable benefits. An 'Insights' report was shared with the Transformation Board.

Amongst the key findings were that:

- The vast majority of services have been complying with the new templates (14 separate measures of compliance were evaluated).
- Patient satisfaction with access has risen strongly; this is similar regardless of whether the patient attended during regular or extended hours.
- There is a similar distribution of new cases to follow-ups during regular and extended hours.
- Almost all services show an improved 'no show' rate during extended hours compared with regular hours.
- Some services show a higher rate of virtual visits during extended hours – the reasons for this need to be better understood.
- A higher proportion of virtual visits were undertaken >30 minutes before the scheduled time during extended hours, compared with normal hours.

Figure Six provides some of the data behind these findings.

Reflecting on the year-long project, Dr Jameel commented on some of the lessons that emerged and which will inform future change initiatives. "It was important to build support and credibility," he said. "If the first clinics that made the change had reported a poor experience, it would have been difficult to proceed. On the other hand, positive outcomes generate further momentum."

Extended hours represent an important element in JHAH's accelerating drive to modernize and enhance patient convenience; however, it is far from being the only one. Looking ahead, a key theme for the next two years of the Clinical Services Plan will defining what is meant by a 'virtual hospital' – able to deliver an increasing number of outpatient services separate from the physical hospital building and closer to the patient's home. Consumer-led healthcare has taken a long time to arrive – but, now that it is being embraced, there is no reverse gear. In fact, the journey has only just commenced.

Figure Six: Impact of the changes

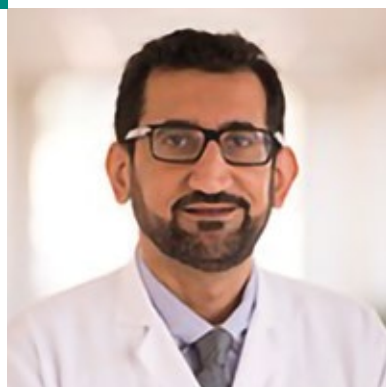
			Before the changes (2024 FY)	After the changes (2025 Q2)
	Medicine Department	Lead time	7 days	5 days
		Patient satisfaction	83.1%	84.2%
	Surgical Department	Lead time	7 days	7 days
		Patient satisfaction	80.8%	81.5%
	Anesthesia Department	Lead time	14 days	7 days
		Patient satisfaction	77.0%	79.6%
	Rehab	Lead time	37 days	12 days
		Patient satisfaction	74.5%	81.8%

Note: Rehab data relates to Q2 2024.

Notes

1. Kerryn Higgs, 'How the world embraced consumerism', BBC, 2021: https://www.bbc.com/future/article/20210120-how-the-world-became-consumerist
2. William Leach, 'Land of Desire', 1993
3. Consumer vs. Producer – A Change in Mindset That'll Change Your Life, 'The Art of Improvement': https://artofimprovement.co.uk/consumer-vs-producer-a-change-in-mindset-thatll-change-your-life/
4. Ben Weinberg, 'The producer vs consumer mindset', https://benjweinberg.medium.com/the-producer-vs-consumer-mindset-9a407d686055
5. Tidio, 'What Are 8 Customer Needs and How to Identify Them?', https://www.tidio.com/blog/customer-needs/
6. Barlow/McCarthy, '10 Reasons Why Healthcare Resists Change', https://barlowmccarthy.com/blog/10-reasons-why-healthcare-resists-change/
7. Stantec, 'A culture of convenience is finding its way to healthcare', October 2019

About the project champions



Dr. Ahmed Jameel

Dr. Jameel is Chair of the Medicine Department and Chair of the Credential and Privilege Committee at Johns Hopkins Aramco Healthcare.

He was educated at King Faisal University (Saudi Arabia) and his residency was with the Endocrinology & Metabolism Department at Dalhousie University (Canada).

Previous roles have included Chief of Internal Medicine Division at the Saudi Aramco Medical Services Organization (SAMSO), Chief of Specialty Medicine Division (SAMSO), Medical Director (SAMSO), and General Internal Medicine Consultant and Hospitalist (JHAH).

Dr. Nabeel Al Faify

Dr. Al Faify is the Lead Clinical Administrators at Johns Hopkins Aramco Healthcare.

He was educated at the King Saud University, Riyadh, KSA (Bachelor's Degree in Radiological Technology), University of Surrey, Guilford, UK (Master's Degree in Medical Physics), and University of Phoenix, Phoenix, USA (Degree of Doctor of Health Administration).

Before joining JHAH, he was a Senior Medical Physicist at the Saudi Aramco Medical Services Organization.

Also available

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Scanning the horizon for healthcare innovations

Case Study #02: The Back Referral Program

Enhancing access to JHAH for non-registered Saudi Aramco EMRs

Case Study #03: Endoscopy

Endoscopy waiting times cut from months to weeks

Case Study #04: Operating Rooms

Faster access to surgery

Case Study #05: Adult Primary Care Access (Dhahran)

The doctor will see you now

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Case Study #08: Cath Lab

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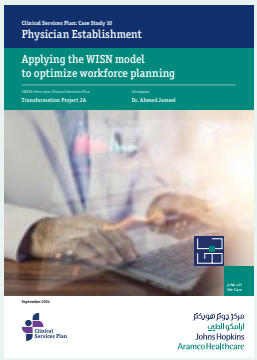
A joined-up approach to same-day care needs



Case Study #10: Physician Establishment

Applying the WISN model to optimize workforce planning

Note: Additional CSP case studies are constantly under development. Please email or call your JHAH contact for information on future editions.

This case study is one in a series that showcases stories from implementation of the JHAH Clinical Services Plan (CSP). The JHAH Board approved the CSP in June 2022. It is an ambitious multiyear program to enhance and modernize a wide range of clinical activities. For more information about the CSP or any projects included in the program, contact the CSP Program Management Office: pmo@jhah.com.

Case Study #11: Program Management

Delivering a five-year clinical transformation program

Case Study #12: Hospital At Home

Recovery in the comfort of the patient's home

Case Study #13: Super October

Meeting the challenge of 1,000 procedures in one month

Case Study #14: Healthcare Marketing

Multi-channel engagement to turbocharge healthcare transformation

Case Study #15: Telehealth

How virtual technologies enable 24/7 healthcare access

Case Study #16: Physician Leadership Development

Enhancing leadership capability to deliver a complex transformation

Case Study #17: Musculoskeletal Services

Advancing patient care and innovation

Case Study #18: Risk Management

Experiences in identifying and mitigating risks during healthcare transformation

Case Study #19: Extended Hospital Outpatient Hours

Increasing convenience for patients

Case Study #20: Mid-Term Review

Building on the achievements of the first half of the program

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