Addressing Poor Ambulatory Satisfaction Questionnaire's Access Score for Moreno Valley Heacock Medical Office Building

Department of Pediatrics

Kaiser Permanente Southern California Permanente Medical Group – Riverside

Deborah Wu

Preceptor: Dr. Christine Evans

December 2018

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Southern California Permanente Medical Group

Laura Erskine, PhD
Director, MPH Program
UCLA Fielding School of Public Health
Box 951772
Los Angeles, CA 90095-1772

December 3, 2018

Dear Dr. Erskine,

I have read the consulting report for Deborah Wu describing the internship project conducted in summer 2018 at Kaiser Permanente Riverside under my supervision. The report accurately reflects the student's activity with Kaiser Permanente Riverside and contains no proprietary information or breach of confidentiality concerning Kaiser Permanente's products, procedures, etc.

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Sincerely,

Christine Evans, PhD
Assistant Medical Group Administrator
Southern California Medical Group
Kaiser Permanente Riverside County
UCLA MPH Liaison Preceptor

10800 Magnolia Avenue
Riverside, California 92505

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Executive Summary

Background

Outpatient pediatric care is largely comprised of preventive annual visits to ensure children are growing and developing appropriately. Kaiser Permanente Riverside has made it their clinical strategic goals to ensure pediatric patients complete their well child appointments at the developmental milestones. In order to provide high quality care, however, patients must be present at the clinic to receive the care. After inquiring feedback from patients through the Ambulatory Satisfaction Questionnaire, one of the medical office buildings, Moreno Valley Heacock (MVH), has been found to have lower than usual patient perceived access corresponding to their lower reported quality performance. The score is not only below the regional standard for the organization but also reflects poor patient care engagement and thus reflects poorly on the organization with regards to its ability to provide high quality family and patient centered care.

Methods & Objective

An iterative data analyses was conducted to understand every factor that could potentially impact a patient decision to score low on their satisfaction in their ability to get the appointment as soon as they wanted it. Various data reports were analyzed and multiple stakeholder interviews were conducted to create a whole picture of the patient experience in seeking care. The objective of this report is to analyze of these potential factors and provide a set of feasible recommendations from which the pediatric department leadership and pediatric providers can choose from to implement in order to improve their ASQ score.

Significant Findings & Recommendations

There were multiple factors identified from patient's decision to seek care to the completion of care or no-show to the appointment. All of these factors fall under two overarching themes of patient experience and appointment availability.

Three opportunity areas with the most potential were found in the analyses:
1. Poor clinic utilization
2. Unclear paneling and clinic cancel processes
3. Lack of physician operating structure.

To address these factors, three recommendations were given.
1. Increased enforcement of standardized well-defined processes
2. Leveraging telephone appointment visits during open clinic slots
3. Incentivizing physicians to encourage them to do more physicals when demand is high

Background

Outpatient Pediatric Care

Much of outpatient pediatric care revolves around prevention through well-child visits and annual physicals. According to the American Academy of Pediatrics, physical examinations are recommended at birth, 1 month, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 24 months, 30 months, and then annually from 3 years through adolescence (American Academy of Pediatrics, n.d.). These preventive appointments allow pediatric physicians to check on the child's physical and mental wellness and provide education for parents at each critical point in the child's development.[1] These standards are recognized and published as a core measure set of children's health care quality metrics by the Department of Health and Human Services (HHS) under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). These Healthcare Effectiveness Data and Information Set (HEDIS) quality metrics are published for voluntary use by state Medicaid and Children's Health insurance Program (CHIP) (Medicaid.gov, n.d.). Following national standards and recommendations, Kaiser Permanente has also established a number of clinical strategic goals (CSG) for Maternal and Pediatric Care. These include completion of all Well-Baby Visits (first 15 months of life), completion of all Well-Child visits (3-6 years of age), completion of Well Child Visits (6 years of age old) and completion of all Adolescent Well Care Visits (Healthwise Staff, 2017). Meeting these goals establishes compliance with national quality standards of care and upholds Kaiser Permanente's mission.

Kaiser Permanente Riverside

Kaiser Permanente is comprised of three separate entities including the Kaiser Hospital Foundation, the Kaiser Health Plan, and the Permanente Medical Group. Kaiser Permanente's mission is to provide high-quality, affordable health care services and to improve the health of its members and the communities it serves ("About Kaiser Permanente," n.d.). To accomplish this

[1] The term "physician" and "provider" will be used interchangeably throughout this report to be inclusive of providers that are not M.D.s

mission, the organization anchors its strategic direction and goals in quality, affordability, access, and service. As a result, the three entities work collaboratively to ensure efficient delivery of high quality, innovative healthcare. There are 13 service areas in Southern California. Kaiser Permanente in Riverside services one of the largest geographic service areas in Southern California, second only to San Bernardino. As a service area, Kaiser Permanente Riverside has been performing between 9^{th}-13^{th} in ranking out of the 13 service areas in the past year on these particular CSG measures, meaning that the quality of care provided at Riverside reflects poorly against the standard of quality that Kaiser Permanente aspires to uphold.

Ambulatory Satisfaction Questionnaire

In order to ensure pediatric patients complete all the recommended preventive visits, appointments must be accessible to the patients. Patients must be present in the clinic to receive the care, thus, access to services directly impacts quality of care. The Southern California Permanente Medical Group (SCPMG) has performance incentives implemented in three focus areas: personalized care, trustworthy quality, and convenient access. To help measure these aspects of care delivery, Kaiser Permanente sends out surveys post-visit to patients called the Ambulatory Satisfaction Questionnaires (ASQ). The questions on this form measure patient satisfaction towards the quality of care and service that physicians, nurses, and staff provided during their recent visit. One question on this form asks patients: “How satisfied were you with your ability to get this appointment as soon as you wanted it?” The response to this question is based on a 1-10 scale where 1 is the least satisfied and 10 is the most satisfied. These responses are measured and recorded at a department level. Kaiser Permanente strongly values patient input. Patient perception of quality and access directly impacts the patient compliance to care and the brand reputation of the organization. Kaiser Permanente has set a regional departmental average target score of 8.80. This report will be focusing on the ASQ score specific to this question on access.

Moreno Valley Heacock Medical Office Building's Pediatric Department ASQ

Kaiser Permanente at Riverside has two major medical centers – Riverside Medical Center and Moreno Valley Medical Center. The Medical Office Buildings (MOB) by each of these medical centers host the largest population of pediatric members in the Kaiser Permanente Riverside Service Area. The Moreno Valley Heacock (MVH) MOB has been struggling to achieve a high ASQ score and has thus seen a decline in their CSG performance as well. While there is speculation regarding potential factors, the cause for this poor performance is unknown. According to the Department Administrator of Pediatric Services, the MVH MOB was previously a top performer and is staffed by veteran physicians. Therein lies the inquiry of what primary factors are driving this persistent decline in ASQ score (Figure #). This report will focus on data relevant to the most recent month June 2018. The ASQ score for the month of June 2018 for MVH MOB Pediatric Department was 8.38. The ASQ score specific to preventive-type visits was 7.14.

Literature Review

Perceived access and actual access are related but separate issues. Actual access is often defined through comparing whether or not the supply of available appointments meets the demand for the appointments. Perceived access, however, incorporates whether or not the patient feels as though he/she is able to easily obtain the appointment desired. Perceived access impacts patients' decisions to pursue and comply with care. Physicians' and patients' perception have been found to differ. One study in the United Kingdom by Guthrie & Wyke (2006) found that general practitioners did not view enabling access as part of their responsibilities. This differing perception creates a disconnect because a patient's experience in obtaining an appointment is part of the larger patient care experience and often sets the initial impression of the organization and the provider. Waiting is found to be viewed as one form of disrespect according to patients – specifically the patients' wait to get an appointment time, the wait in the waiting room, and the wait in the examination room (Lacy et al., 2004). 41% also indicated that they did not know what happens in a clinic if there is a failed appointment, causing misperception regarding cancellations and appointment availability (Lacy et al., 2004). Additionally, while providers may perceive no-

shows as a result of patient inability to arrive at their appointment, respondents noted that common logistical barriers such as transportation and child care were barriers that they could overcome (Lacy et al., 2004). The systematic barriers, therefore, feed into a patient's ability to seek care, both psychologically and logistically, and their perception of how available healthcare providers are.

Given that perceived access and actual access differ, yet another level of consideration must be added to ensure family-centered care is delivered because the patient perception of the care experience is equally important to the actual quality of care delivered. There is an increasing emphasis in pediatric care around family-centered care where the patient and family member voices are equally important to achieving health outcomes. Family-centered care is the term used to describe "optimal health care as experienced by families" (Kuo et al., 2012; Stewart, 2001). The key word in this definition is "as experienced by families [and patients]", shifting the focus of care delivery experience from the physician to the patient. Studies have found that better patient-provider communications and experiences results in increased "satisfaction with care, adherence to treatment recommendations, and discussion of psychosocial issues" (Nobile and Drotar, 2003; DiMattea, 2004). Patient experience, therefore, directly impacts operational and objective measures such as health quality outcomes. One study found many clinical benefits when using process mapping across specialties, multidisciplinary teams, and healthcare systems, allowing staff and physician to "see and understand the patient's experience" as well as coordinating multidisciplinary practices to maximize efficiency (Trebble et al., 2010). Data that observes processes from both the staff and patient's perspective is the strongest analytical method for addressing poor perceived access in a healthcare setting and therefore improving overall access and patient care experience (Trebble et al. 2010).

It is also essential to address patient's perceived access in the ambulatory setting because of its impact to care delivered in other settings. For example, the emergency department is one of these settings where costs incurred are high as a result of care that should have been delivered in the ambulatory setting. In 2001, there was an increase of 20% over a 9 year period of emergency department visits with over 22 million of these visits by children 15 years or younger (Brousseau et al., 2004). Many of these cases could have been managed in a primary care provider's (PCP) office. In a case study by Brousseau et al. (2004) on nonurgent pediatric cases in the emergency department, parental report revealed precious difficulty receiving medical care from a PCP as a

major underlying trend. Another study by Lacy et al. (2004) investigated reasons for "No Shows" from a patient perception. Particularly notable in these findings is patient perception towards disrespect of time and distrust of the scheduling system. To address some of these needs, Randolph et al. (2004) has found that healthcare organizations are beginning to use operations research to improve scheduling. These impact and improve quality of care and health outcomes. Cayirli & Veral (2003) define the environmental factors that impact scheduling in the outpatient setting as the following: number of services, number of doctors, number of appointments, the arrival process, the presence of no-shows, the presence of walk-ins, the presence of companions, service times, lateness and interruption, and queue discipline. Patient perceived unmet need and inaccessibility with their primary care provider causes a cascade of consequences elsewhere in the organization that could have been prevented with greater attention to patient input and greater focus on family centered care.

To address concerns around patient perceived access related to patient care experience, good physician leadership is necessary to encourage sustainable process improvement. The political climate of the clinic workspace impacts the positive changes and shifts capable of being implemented. Studies have found that group members are dependent on the leader and perception of leadership can cause group conflicts (Hollenbeck et al., 2015). People react to their present experiences in a direction opposite to the past experiences (Zhao et al., 2016). It is thus important to recognize the impact of the past leader on the current leader regardless of relationships between leadership styles and behaviors because group outcomes may be more contingent on unaddressed historical factors (Hollenbeck et al., 2015). In a healthcare system, this can be particularly difficult as physician leaders view their fellow physicians as peers in clinical practice despite being a leader administratively. Leadership is thus judged more critically and change can be difficult to implement within complete buy-in and compliance from peer physicians. Thus it is essential for new leadership to take time to develop and leadership self-efficacy by setting direction, gaining follower commitment, and overcoming obstacles to change (such as the affects of comparison with former leadership) (Paglis and Green, 2002). Finding the right balance for leadership of a high demand primary care setting can be difficult, but positive change requires strong transformational leadership.

Objective

What can MVH MOB's Pediatric Department do to increase its ASQ score? The objective of this report is to analyze all potential factors that may be impacting the ASQ score for MVH MOB's Pediatric Department. After a thorough analysis, the goal is to provide a set of feasible recommendations targeting certain factors from which the department administration and physicians can choose from to implement to improve their ASQ score.

Method/Approach

The investigative process of this case study involves an iterative data analysis, going back and forth between data and stakeholder feedback/interviews as can be seen in Figure 1. During this process, I requested and analyzed additional data as discoveries were made and questions arose. The initial two reports provided were the physician schedules of the most recent pay period and the most recent weekly net loss reports. Following these initial sets of data, a number of other sources of data and reports were analyzed (See Table 1). Stakeholder interviews were also conducted at various points during the process. There was constant communication with stakeholders and leadership throughout this process.

Stakeholder Interviews Conducted:

- Physician scheduler
- Primary access team representative for pediatric services
- Frontline physician
- Department administration
    - Department Administrator
    - Physician Leaders of Quality, Access, and Chief in Service

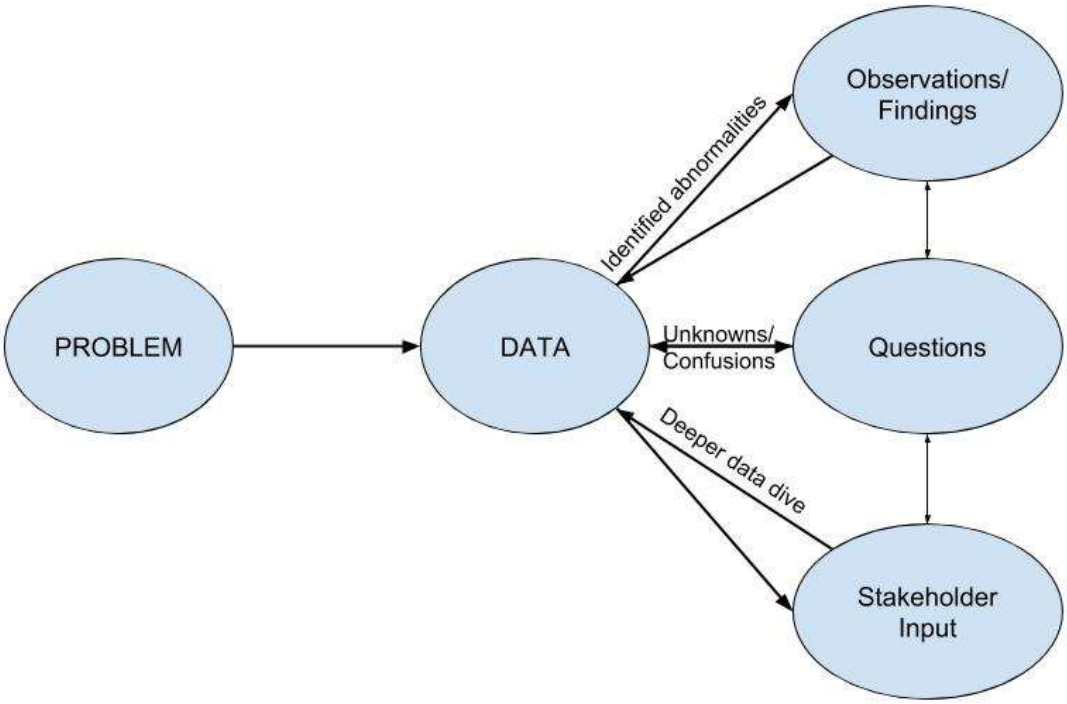

Figure 1. Iterative Data Analysis Process for Consulting Report

Data/Report	**Summary Description**
Physician Schedule Per Pay Period	The mix of pediatric physicians at MVH MOB includes 1.0 FTE, 0.8 FTE, and 0.5 FTE. Physicians are responsible for setting their own schedule for the pay period within expectations of their employment status. They send the physician scheduler their work schedule templates for any given pay period in advance.
Weekly Net Loss Report	The weekly net loss report is recorded in hours and includes: • "Supply" (clinic hours available) • "Seen" (clinic hours patient seen) • "No Show" (hours where patient did not show up to appointment) • "Unbooked" (hours not booked) • "Overbooked" (hours overbooked) • "Clinic Cancelled" (hours clinic/physician cancelled appointment).
Physician Panel	Physician panel data includes the physician name, the raw panel, current

	weighted panel, target weighted panel, panel availability, and open/closed panel status. • The raw panel is the total # of patients on physician's panel. • The current weighted panel accounts for factors including FTE, hospital shifts, administrative times, and other responsibilities the physician may have. • The target-weighted panel is the ideal panel size per provider created after accounting for factors previously mentioned. • The panel availability is the current weighted panel compared against the target-weighted panel. • The open/closed panel availability records if the panel is open to receive more patients or closed to receiving more patients.
Steady State Demand Report	The steady state demand report is recorded in hours and includes steady state demand, and target demand. The steady state demand is calculated using the number of total of appointments made on the particular calendar dates as well as the number total of appointments waitlisted for a particular calendar date. The target demand is the steady state demand with the addition of appointments that are booked beyond standard.
Individual Visit-Based ASQ Scores	The individual visit-based ASQ score report records the Member Appraisal of Physician/Physician Services (MAPP) score per physician broken down by visit-type. The visit types are "Preventive", "Routine", "Urgent", "TAV-Routine", and "TAV-Urgent" (TAV = Telephone Appointment Visits).
Member Complaint Report	The member complaint report records descriptive complaints members submitted regarding their visit or experience.
Waitlist Report	The waitlist report includes all waitlisted patients along with the type of appointment the waitlisted patient needs.
Clinic Cancel Reasons	Reports with data on physician reasons for clinic cancel measure the number of clinic cancels due to specific reason categories which include, but are not limited to: sick, vacation, template change, hospital, meeting, education leave, and administrative time.

Table 1. Data Sources for Consulting Report

Significant Findings

A lot of factors along a patient's healthcare experience for a visit from scheduling to care delivery were found to impact the resulting patient perceived access score. In the driver diagram, Figure 2, the second column from the left shows different reasons patients may poorly score their ability to obtain their appointment as soon as they wanted it. The reasons all fall under four themes: service experience, communication, scheduling, and policy and procedures. These four themes also fall under two larger overarching themes of poor patient experience and lack of appointment availability – these findings align with the initial understanding that patient perceived access and actual appointment accessibility both play into the patient's feedback on their ambulatory satisfaction questionnaire. On the far left of Figure 2 are underlying cultural themes that enabled the reasons listed in the driver diagram to occur. One or more of the reasons listed could occur and the four themes that these reasons fall under all interact with each other. The ASQ score, therefore, is a result of complex and varying causes and factors without a primary root cause. It would not be feasible to address all issues nor target one primary cause, however, after thorough analysis, there are a number of opportunity areas identified for Moreno Valley Heacock Medical Office Building's pediatric department.

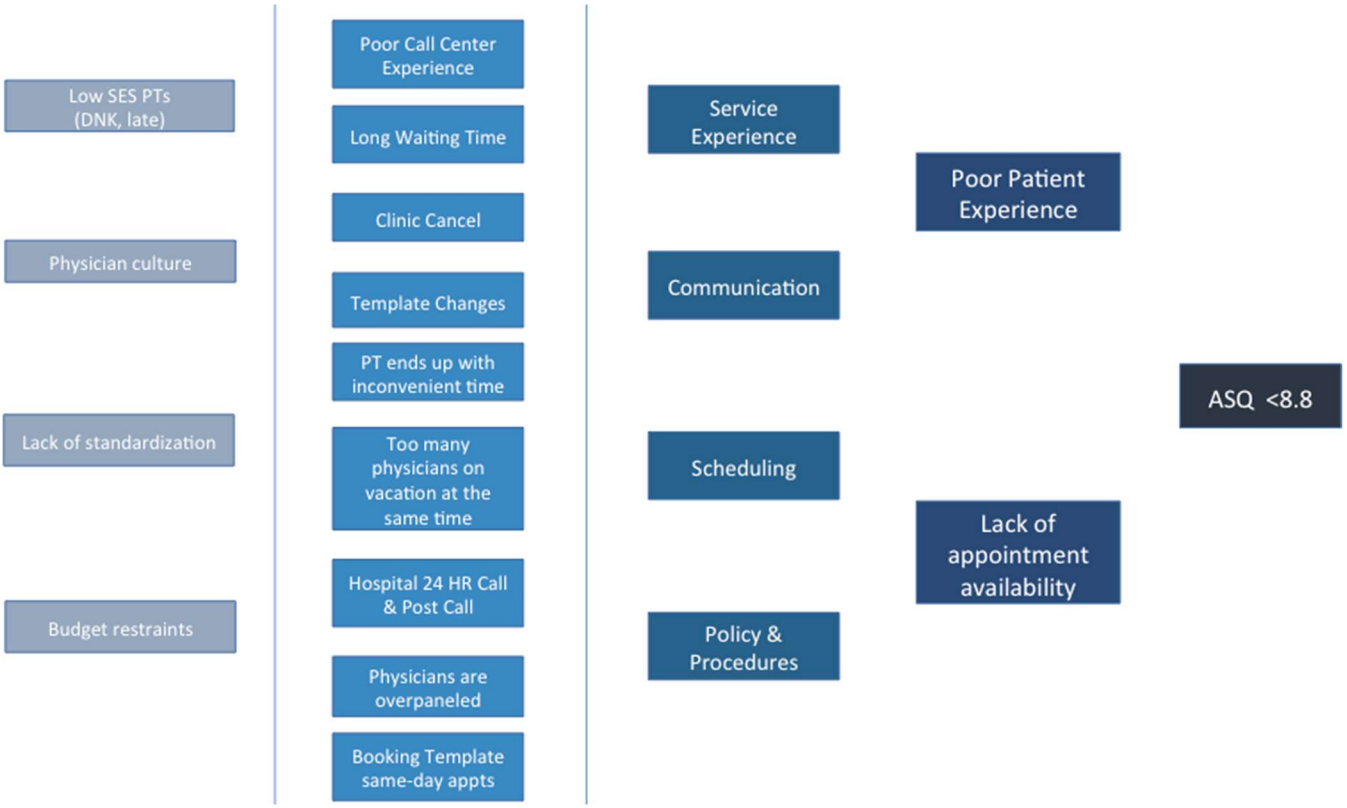

Figure 2. Driver diagram outlining factors causing poor reported ASQ score

1. Clinic utilization could be better optimized.

Initially thought to be an issue of supply and demand, the data actually shows that providers have enough supply to meet their steady state demand, however, they do not always have enough supply to meet their target demand (Figure 3). In the month of June, for the department as a whole, the supply met the demand by 117%. Only the providers who were on vacation did not see their individual supply meet their steady state demand, as can be seen in Figure X where there are three providers whose supply column (green bar) is less than their steady state demand (red bar). The percent clinic utilization, however, ranged between a low of 67% and a high of 88% with most providers' percent clinic utilization in the 70's. The target demand takes into consideration appointments that are beyond standard for booking, including all waitlisted patients who have waited longer than their targeted appointment date. As can be seen in Figure X, while individual providers may have met their steady state demand, many providers do not meet their target demand. Additionally, as of the end of July 2018, MVH MOB has the highest number of patients waiting on a preventive appointment at 1,773 patients, exceeding its most

comparable counterpart, Riverside Medical Center, by nearly 700 more patients (See Table 2). Given that the supply for the department meets the demand, the disconnect between having enough supply and having a large waitlist raises questions about the clinic utilization and whether or not it appointments are being scheduled to maximize availability of appointment slots in the clinic. Patients who are waiting for an appointment may feel frustrated and likely respond to the ASQ survey as not having received their appointment as soon as they wanted it.

Pediatrics	# Patients Waiting	Longest Waiting
	5,809	7/16/18
CORONA MEDICAL OFFICES D15 U	809	7/21/18
Follow Up	1	10/11/18
Preventive	805	7/21/18
Routine	3	9/26/18
MORENO VALLEY MEDICAL OFFICES U	1,781	7/18/18
Follow Up	2	9/13/18
Preventive	1,773	7/18/18
Routine	6	8/21/18
PALM DESERT MEDICAL OFFICES U	520	7/28/18
Follow Up	1	10/15/18
Preventive	518	7/28/18
Routine	1	10/20/18
RIVERSIDE MEDICAL CENTER U	1,139	7/16/18
Consult	1	7/22/18
Follow Up	3	8/20/18
Preventive	1,092	7/16/18
Routine	43	7/29/18
TEMECULA MEDICAL OFFICES U	1,060	7/28/18
Preventive	1,055	7/28/18
Routine	5	9/4/18
WILDOMAR MEDICAL OFFICES U	500	7/28/18
Preventive	475	7/28/18
Routine	25	8/14/18

Table 2. Pediatric department waitlist by visit category by MOB

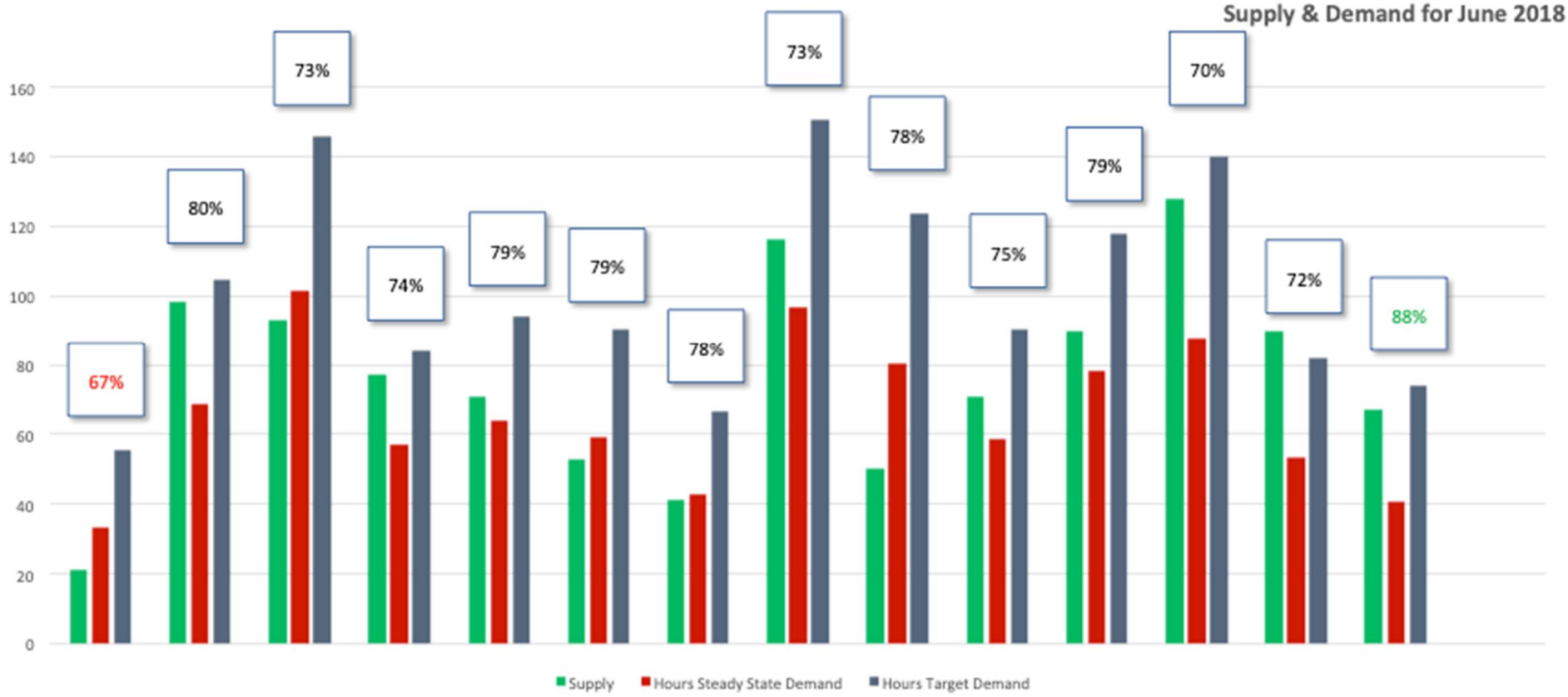

Figure 3. Supply & Demand vs. Clinic Utilization with clinic utilization in boxed percentages

2. There are a number of processes that are not standardized and enforced including paneling and clinic cancellations (both those that are last minute and in advance).

A. Physician Panels

According to multiple stakeholders, there appeared to be a lack of clarity around the process by which a patient is paneled. There were too many staff members capable of paneling patients and multiple channels by which patients could be paneled (Figure 4). This could either be a result of a lack of understanding among staff involved regarding the paneling process or a lack of policy and procedures in place to ensure a clean standardized paneling process. Kaiser Permanente regional policy states that 50% of pediatric physicians must have open panels. An analysis of the physician panels showed that 6 of MVH MOB's pediatric physicians have open panels despite being beyond their target-weighted panel, thus overpaneled. In comparison, its most comparable peer MOB, Riverside, only has 2 physicians whose panels are overpaneled but open. A physician's panel is the expected number of patients who have the particular physician assigned as their PCP, thus, their default primary physician. The target panel takes into consideration the time availability and commitments that the physician may have with the goal that the patient panel reflects the capacity the physician has so that every patient receives high quality personalized care. The assumption is that the algorithm that sets the target panel helps ensure that providers are accessible to their assigned panel patients. Since there are too many individuals with the ability to influence and impact patient paneling, it can become difficult to track provider panels. Additionally, once a patient is paneled to a particular provider, providers build a relationship with the patient and are less willing to shift their patients to a different provider. It is more ideal for patients to see their assigned PCP with whom patients and families have built a relationship so that care is more family-centered. The inability to see the assigned PCP may result in a perceived reduction in accessibility of care. It is, therefore, essential to oversee the initial paneling process so that the relationship built between provider and patient is not affected due to a need to balance out panels.

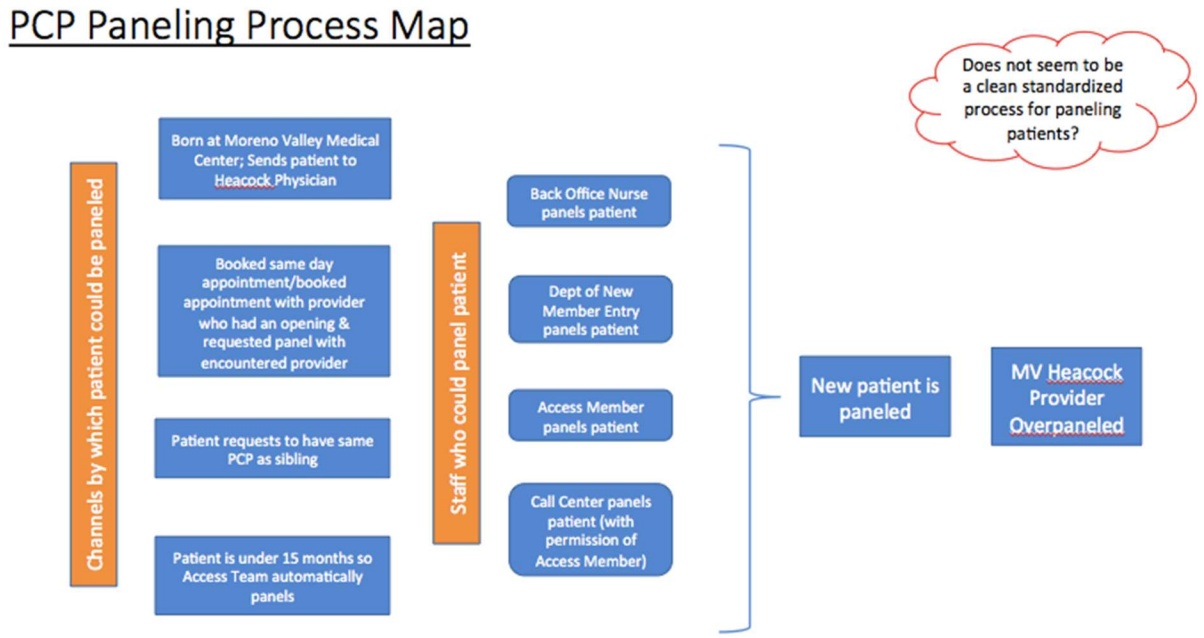

Figure 4. Pediatric Primary Care Physician Paneling Process Map (based on stakeholder interviews)

B. Clinic Cancellations

When a physician's office cancels an appointment on the patient, it is more likely for the patient to perceive this behavior, regardless of reason, as a barrier to access. Clinic cancels often refer to the last minute cancellations (within the 24 hours) where a physician calls off. If a physician calls off more than 24 hours in advance, it is usually considered a template change (a change to their available appointment slots). At a regional department level, family medicine, pediatrics, and internal medicine have the highest number of clinic cancels. Of the three, the pediatric department had higher percentage due to template changes compared to the family medicine department and internal medicine department with a higher percentage of clinic cancels due to sickness (Table 3). Furthermore, in an analysis of the pediatric department's member complaints report, ¼ of related member complaints were due to "clinic cancellations". Specifically, a few patients have explicitly expressed frustration regarding the lack of notification. Clinic cancel procedures require one call to the patient and a voicemail if there is no answer. This does not ensure that patients are aware of the clinic cancellation and is a poor representation of both service and access.

	Total		Vacation		Template Change		Sick		Off		Indirect Work		Education Time		Education Leave	
Fam Medicine	11380	6%	709	26%	2960	37%	4209	8%	943	3%	306	5%	556	2%	235	1%
Peds	3609	1%	54	**49%**	**1756**	29%	1053	3%	123	3%	120	2%	70	2%	67	0%
Internal Medicine	3043	8%	248	32%	985	33%	1010	2%	75	4%	111	3%	83	2%	49	0%

Table 3. Major reasons for clinic cancels by department

3. Providers may be operating with too little structure.

The physician chief in service for the Pediatric Department several years back was known to be rigid and strict, leaving little leeway for providers and strongly enforced operational policies such as clinic cancellations or types of appointments booked. Due to the inflexibility, however, the other providers requested a replacement for the chief in service. As a result, there is enormous pressure for the current chief in service to ensure the voice of the providers are heard and looked out for. It could be possible that the level of enforcement towards operational policies is now too loose and a balance between enforcement and tolerance has yet to be found in the new leadership.

Conducting physicals can be tiring for both providers and nurses, particularly if there are multiple scheduled back-to-back. Pediatric providers, therefore, find it difficult to conduct even just the maximum number of physicals a day and request to have fewer physicals booked. When taking a closer look at the waitlist for pediatric providers in Riverside service area, the greatest percentage of visits on the waitlist was the 15-minute physicals, otherwise known as Well Child visits (with the exception of Wildomar with the highest percentage of waitlisted appointments being Well Baby). In MVH there is a significantly higher number and percentage of physicals on the waitlist at 75% (1636 patients) compared to its most comparable counterpart, Riverside MOB, at 54% (722) (Table 4). There is a high, unmet demand for physicals among pediatric patients at MVH MOB. Given the previously discussed finding of high target demand that is and opportunity for increased percent clinic utilization, the lack of motivation to conduct the maximum number of physicals is concerning.

MOB	# Well Baby	% Well Baby	# Physical (15)	% Physical (15)	# Teen	% Teen	# Physical (30)	% Physical (30)
Moreno Valley	430	20%	1636	75%	47	2%	101	5%
Riverside	476	36%	722	54%	28	2%	80	6%
Corona	333	33%	630	62%	2	0%	48	5%
Wildomar	332	59%	196	35%	1	0%	6	1%
Temecula	309	24%	744	57%	18	1%	242	19%
Palm Desert	104	17%	410	67%	39	6%	99	16%

Table 4. Waitlist breakdown by visit-type by MOB

The providers themselves determine vacation time off. The maximum number of providers that can be on vacation at the same time is currently set to three. This standard is set and decided by the providers and they arrange among themselves when vacation will be taken. Most often, the vacation time taken is during the summer months between May and August. Taking vacation directly impacts the available hours for clinic appointments and consequentially the perceived access by patients. Providers that have commitments to both the clinic and Moreno Valley Medical Center are required to cover 24-hour shifts at the hospital. In addition to the hospital shift, the following day is taken off for providers to recover from the 24-hour shift. As a result, providers who have a hospital shift during the week are out of clinic for two days. When a provider is on vacation, another provider will take their shift. When that provider returns from vacation, he/she must make up the missed hospital shift. As a result, during weeks where with multiple providers are on vacation, these providers have significantly reduced hours in the clinic. MVH MOB providers are the only pediatric providers with the 24-hour hospital shift and post-call arrangement. While hospital shifts are required to be given back by providers who are on vacation, providers are not required to make up clinic hours up in any form.[2] The pediatric department's physician leadership themselves decided this decision regarding "giving back clinic" because they do not want providers to feel punished for taking off work hours.[3]

[2] Regional Clinic Cancel Policies 5.4.2 states "Use ET time to see those patients (not considered Worked ET) "

[3] "Giving back clinic" is a phrase referring to providers making up clinic hours that they had taken off

Recommendations

1. Standardize and Enforce Panel and Clinic Cancellation Protocols

All paneling requests/processes must go through one individual/team. The recommended individual most appropriate for this responsibility is the access team representative who receives, compiles, and organizes the data surrounding access. The access team representative is best suited to keep the panels balanced and can inform pediatric department leadership of any changes or abnormalities.

There should be protocol for clinic cancellations that sets guidelines for when changes that impact patient access can be made. If the change is last minute, leadership should put a hard limit on the # last minute cancellations to [insert # physician leaders believe is appropriate]. If more last minute cancellations are requested, then the physician must exchange with paid education time. If the change request is made over 24 hours in advance then the physician scheduler should enforce schedule change regulations and if the template change is requested beyond regulation standards, the physician requesting change should arrange with another physician to accommodate appointments that would be cancelled. Additionally, to address the frustration patients have with regards to clinic cancellations, if a last minute cancellation is made, physician, back-office nurse, or administrative staff should call the patients to ensure they are notified. This way the patient also feels heard and cared for in a personable manner.

2. Take Advantage of Telephone Appointment Visits

If there is a lower demand season, pediatric department leadership could look into reducing clinic hours and increasing those hours during higher demand seasons. Additionally, if there are open appointments not being occupied, physicians should utilize telephone appointment visits (TAV) to reduce net loss and to improve patient experience and access. While supply does already meet demand, as discussed previously in the report, there appears to be room for greater efficiency in appointments. If more patients can be seen earlier, this leaves more opening for patients who have are more likely to “do not keep” (DNK) their appointment to be able to get the

appointment that is most convenient for them. Any effort to increase appointments seen can have a domino effect to improve access. Another recommendation is to look into the new predictive analytic tool that the Kaiser Permanente Riverside access team created, the No Show Risk Tool, to estimate how much to overbook.

3. Energize (And Incentivize) Physicians

Providers get burned out from doing too many physicals. Providers should have a reward for performing a large number of physicals, especially when there is a high demand and high need for physicals. Given the tight budget, the pediatric department leadership should look for low cost reward method that would be appealing to physicians. An example for this could be for providers who complete the max number physicals for the week during high demand season of the year, free breakfast treats will be provided to those specific providers and their paired nurse at the end of the week.

Project Limitations

- Time constraint: Time working at the internship site full time is limited to the summer months, thus unable to see project through the process of implementing recommendations.
- Data constraint: Data is not always comparable. June 2018 is only one month's worth of data. It would have been better to have multiple years of data to see trends and identify changes over time.
- Operational constraint: Budget is known to be tight and limited, which also results in staffing limitations.
- Culture constraints: Different leadership styles and physician preferences enables some recommendations to be more feasible than others. It is best to align recommendations with what fits the departmental culture best.

Conclusion

The findings and recommendations given through this report aim to improve the ASQ score specific to access for the MVH MOB's pediatric department, and by doing so, improve the quality outcomes and patient care experience of families who seek care at MVH MOB. The report out provides pediatric department leadership with the data to help explain the phenomena and to emphasize the need for leadership to implement changes that improves patient perceived access. Patient perception of appointment accessibility impacts perception of care delivered, compliance to show at much needed preventive appointments, and actual ability to overcome logistical barriers that may otherwise result in No-Shows. After thorough data analyses of the various factors that impact a patient's experience in seeking care, a number of opportunity areas were identified that are both feasible and impactful for improving MVH MOB's pediatric care delivery and patient engagement. Investing in improvements around efficient clinic utilization by leveraging telephone appointment visits during available clinic time, motivating physicians to conduct more physicals, and enforcing clearly defined processes will not only improve the patient's sense of care accessibility but also improve the department's operational effectiveness as a whole. Transformative leadership with buy-in from all providers will be necessary to lead the department in becoming more family-centered. It is imperative that the physicians themselves take ownership and initiative in implementing any or all of the above recommendations. Improving the patient perception of care accessibility not only better connects Kaiser Permanente with its members but also encourages patients to pursue care knowing that their voices and feedback are valued.

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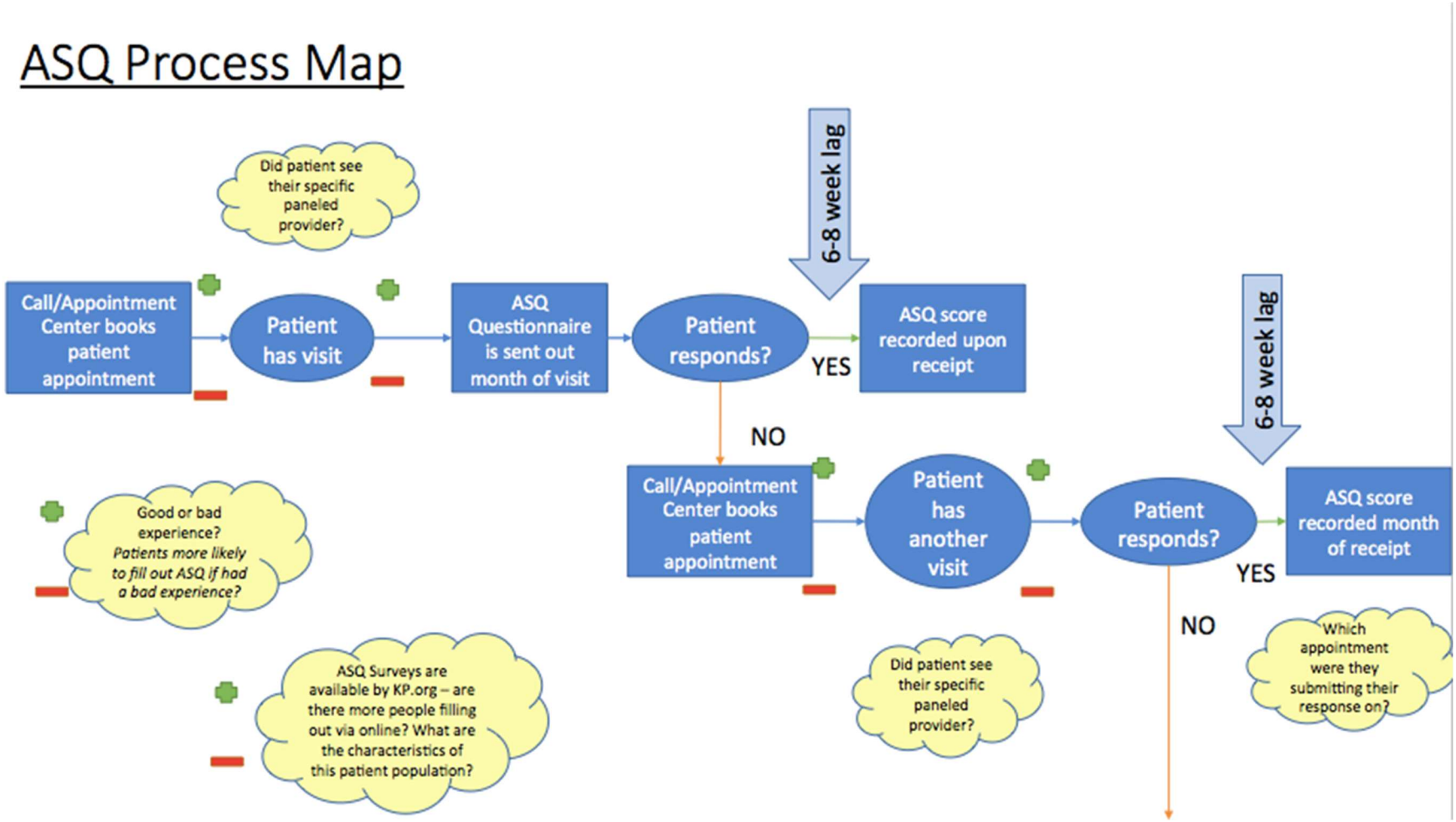
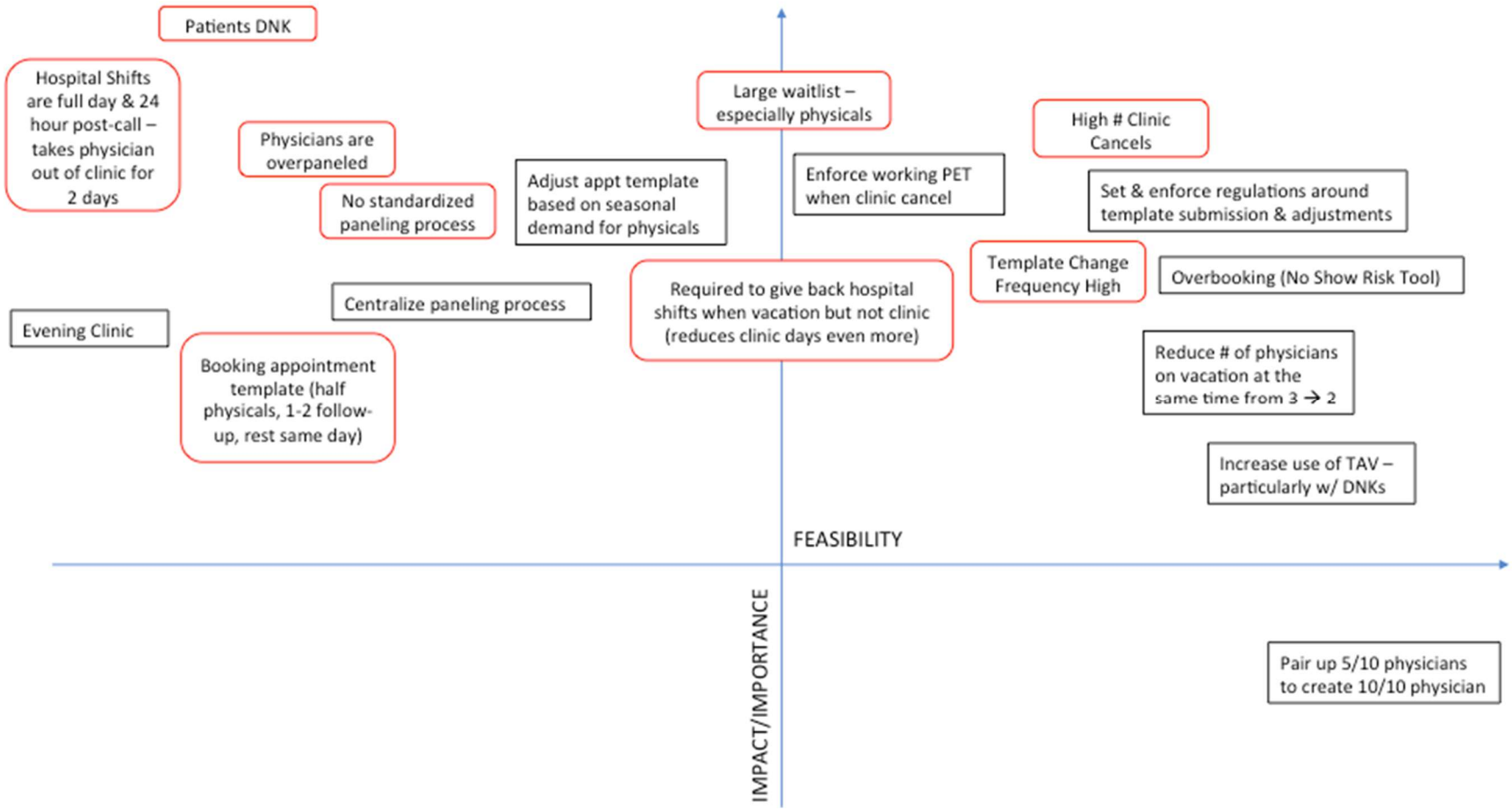
Appendices



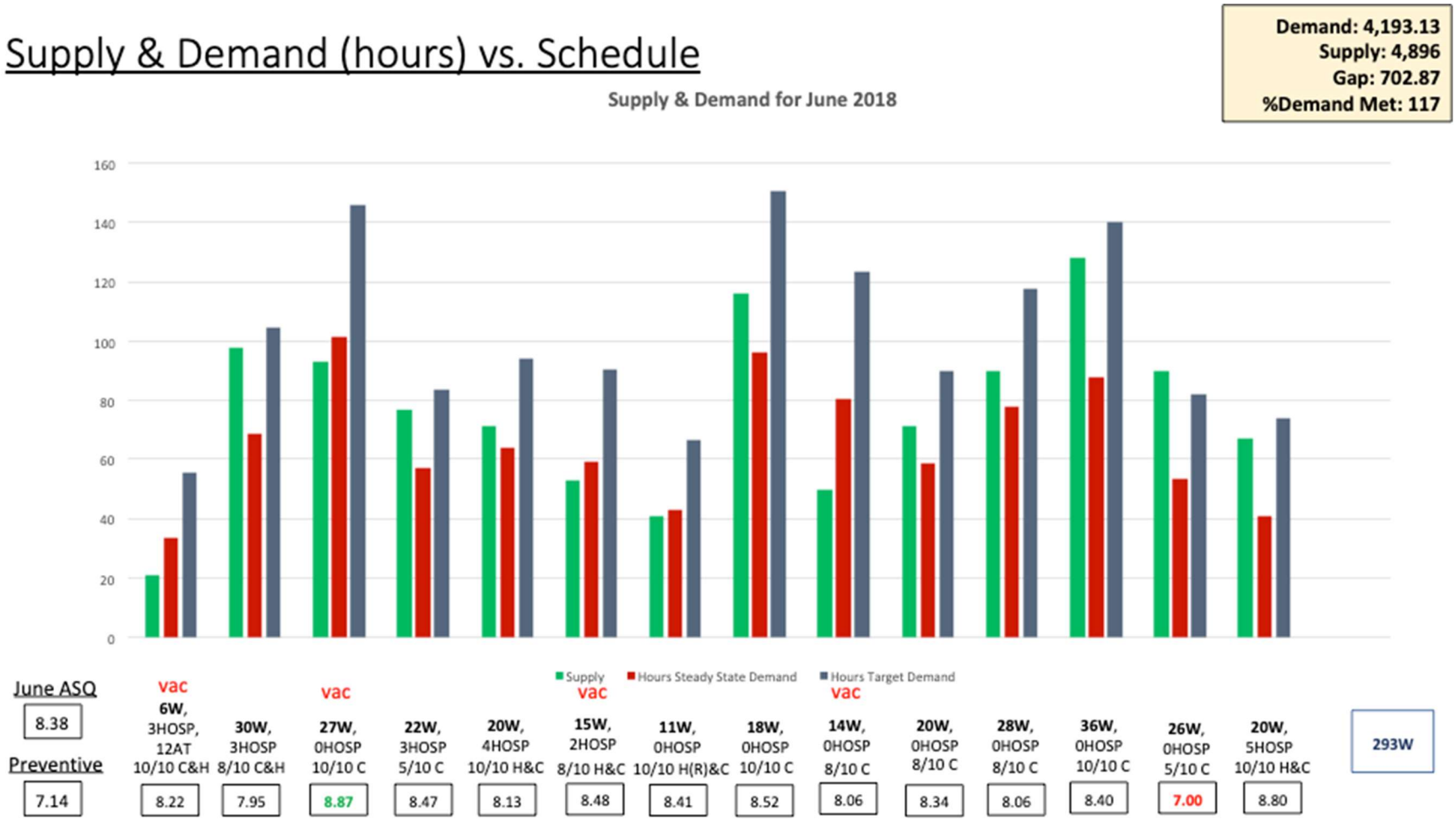
Appendix A. ASQ Process Map with green pluses and red minuses to identify patient access perception points



Appendix B. Issues/recommendations plot according to feasibility and impact/importance (red squares are issues, black squares are potential recommendations)

FTE	5/10 Clinic	8/10 Clinic & Hospital	10/10 Clinic & Hospital	10/10 Clinic & Hospital	5/10 Clinic	8/10 Clinic	8/10 Clinic	8/10 Clinic	8/10 Clinic	10/10 Clinic (& ADHD Clinic)	10/10 Clinic & Hospital (Riv)	8/10 Clinic & Hospital	10/10 Clinic	10/10 Clinic & Hospital
MAPP	7.00	7.95	8.22	8.13	8.47	8.40	8.06	8.34	8.06	8.52	8.41	8.48	8.87	8.80
Panel Availability	-84 [OPEN]	-586 [CLOSED]	-84 [OPEN]	-141 [CLOSED]	10 [CLOSED]	1295 [OPEN]	-127 [OPEN]	-114 [OPEN]	-199 [OPEN]	-194 [OPEN]	-70 [CLOSED]	-433 [CLOSED]	1352 [OPEN]	-182 [OPEN]
Panel Well Baby	144 (11%)	173 (9%)	67 (7%)	137 (7%)	115 (15%)	124 (10%)	156 (7%)	154 (7%)	190 (9%)	278 (11%)	138 (8%)	151 (9%)	115 (10%)	164 (9%)
% Waitlist Well Baby	58%	23%	25%	13%	20%	21%	16%	23%	27%	13%	17%	25%	22%	16%
Waitlist Size	38	122	38	207	136	109	212	114	193	314	122	165	105	146
Utilization	72%	80%	67%	79%	74%	70%	79%	75%	78%	73%	78%	79%	73%	88%
Net Loss	25%	18%	36%	15%	23%	26%	26%	28%	25%	25%	17%	16%	24%	12%
Bonding (Preventive)	68.9% (440)	77.3% (574)	59.6% (227)	84.7% (633)	77.8% (399)	84.3% (533)	73.2% (588)	65.9% (556)	73.4% (662)	69.1% (878)	61.7% (390)	79.1% (559)	82.5% (430)	60% (477)

Appendix C. Physician scorecards side-by-side comparison perspective (each column representing a physician; with physician names removed)



Appendix D. Supply & Demand by Staffing Comparison (with physician names removed)