**Supplemental Digital Content Appendix: Post Expert Panel In-person Meeting Impact Evaluation Survey**

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| **Question** | **Response** |
| Please describe in a few sentences the impact of your participation in the evidence-supported access management panel meeting on your organization. For example, were there any suggestions or ideas that you were able to translate into practice? | * I am not involved in clinical operations at my organization. However, hearing the patient perspective helped me as a research in designing an interview guide and conducting interviews with patients on their experiences trying to access care.
* Yes, I was able to use work from the expert panel to have a study on access management funded by […]
* As a non-clinician researcher, I was not in a position to translate material directly into day-to-day practice or management but we have relied on panel suggestions, ideas and outcomes to generate a new research grant (recently approved for funding) on the organizational variations in access management to study how widely these practices vary nationally and the extent to which different practices may be associated with access metrics.
* N/A
* The panel meeting supported the use of evidence-based strategies for panel management. We became more proactive on oversight of opening and closing panels as it related to access. Hiring of access managers.
* This of course is the most important question. As you will recall, my input involved [patient] experience in the telephone access issue (21 suggested areas of improvement). After several years of battle with administrative management, several of my ideas that were shared with the panelists have been implemented, and the telephone system has improved. The administrator in charge probably did not review your panel findings and improvements in telephone access may or may not have been because of the suggestions. The impetus for the creation of the 21 point improvement list was my own research and the fact I was suggested as a panelist. A follow-up interview with […] administrators/policy makers that were charged with implementation would be interesting. Attempts to quantify improvements and sources might be a helpful epilogue on your study...
* The biggest impact for the organization was to inform the duties and responsibilities of Group Practice Managers, a relatively new position in the organization. Because the organization had little experience with this position, the findings of the Access management panel meeting were incredibly informative.
* It was helpful to hear about how various stakeholders were thinking about the "objective" versus "patient-perceived" aspects of access, and also to realize the interdependencies of the various strategies that had been put forth to improve access. I wouldn't say that it has yet translated into practice, but it certainly has influenced my thinking.
* My specific recollection is of interactions with a Organization B physician leader regarding perceptions of access that influenced my thoughts about and approach to this.
* In short yes; in particular involvement of the [patient] who was passionate about the call center led to an improvement project here at […]
* A number of practices discussed to improve access were utilized in some access improvement tactics at our facility.
* The primary impact on my organization would be to better understand how we use, or don’t use, practice management. It appears that there isn’t a lot of literature on it and the measurement issues are not well developed.
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| Please describe in a few sentences the impact of your participation on yourself. For example, were there any suggestions or ideas that particularly resonated with you? Or were there any concepts that you incorporated into your thinking, your practice, or your research? | * The "hassle factor" described by the representative from Kaiser has been very useful for interpreting patients' descriptions of their experiences.
* I think working on the survey and seeing the rating of items was extremely helpful. I don't think I would have reached the same conclusions as the expert panel, so their perspectives were very helpful.
* As a panel observer, I appreciated the longstanding impact of the panel process itself to this day. Shared idea generation, the interplay of different levels and types of expertise in meaningful and productive ways, and the process for supporting consensus development continues to be hugely valuable. Concepts integrated into research as noted above.
* I was surprised by the number of different approaches documented in the literature that may technically improve access in terms of wait times but that make things more difficult for patients. An example is a practice model that forces patients to call on the day for an appointment rather than letting patients schedule appointments in advance. It was interesting to see that some organizations have moved to prioritizing patient experiences.
* Provided a great opportunity to hear other viewpoints and to increase my sphere of thinking regarding the issue of access.
* I was most impressed with the Organization B doctor's comments on what they do in customer service. Not only is Organization B a large/giant provider, they have moved from an extremely negative public approval reputation, like the Organization A, to one of the best I think they have done this through excellent customer service and attention to detail in access.
* The personal impact was through informing my research work in measuring access to care. The expert panel process highlighted the relative paucity of metrics to measure access and use when trying to improve access. It helped me and my research group focus on a number of novel metrics for access that we have since developed and are working to validate.
* See answer to #1.
* It was a helpful opportunity to network with others and share best practices across individuals, regions and backgrounds.
* Yes - having panel members from [different] organizations was particularly impactful, particularly thinking about motivation for care structures like virtual health modalities, and the "business case" for these versus motivators in Organization A, an integrated system of care
* Some of the best practices discussed allow me to revisit some of my efforts in clinical operations management.
* The impact on me personally is that I am pursuing research in the area of access measurement. This work reinforced my belief that access, especially timeliness, is woefully under-researched. We need better metrics.
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| Were there any barriers of translating the insights into clinical practice and, if so, what kind of barriers or issues did you encounter? | * I'm not involved in clinical operations. From a research perspective, one of the most common barriers we see is lack of interdisciplinary leadership engagement/presence. This often signals that primary care access is not a high priority with leaders.
* I think the lack of literature on access management was a barrier, but also an opportunity for new research.
* One of my takeaways was that panel members struggled with the complexity of implementation in different regional and organizational contexts, especially under the pressure of the mandates to improve access at all costs. Some embraced the complexity and challenge and others seemed wont to apply simpler conceptualizations that my experience suggest will not support effective or longstanding change.
* NA
* Main challenge has been to have enough ancillary support for providers to maximize efficiency and clinic operations.
* n/a.
* There is still a considerable amount of ignorance in the organization regarding the complexity of measuring access to care. Reducing access down to the time it takes to get a face-to-face appointment suggests a general lack of understanding of access. As an organization, we need to think bigger regarding what we think about when we consider access.
* I am primarily a researcher -- so I mostly think about barriers to implementing change from a research perspective. I'd imagine that the complexity of the different interventions to improve access -- and the need to operate at multiple levels of the organization to achieve those changes -- would pose a substantial barrier.
* In my view, leadership (senior facility leadership) is often the most important and rate limiting dimension in access improvement. If not aligned with front-line commitment, the lack of leadership is very hindering.
* I think an theoretical state an organization is met with the barriers of reality, in our case these mostly relate to space, technology and staffing. We can't innovate as much as we would like.
* Some of the efforts required additional resources, which were not always available.
* The main barrier is that I’m not convinced the leadership in my organization full appreciates both the need for good practice management, but also that we have a difficult time measuring access. They seem to think this is all pretty easy, when it isn’t.
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| Learning health care systems may use a variety of mechanisms for learning, improving practice, and initiating change. Our project focused specifically on evidence review and convening a stakeholder panel meeting. Do you have other suggestions that may help health care organizations? | * Setting aside time for interdisciplinary leaders and teams to review their own data and strategize, share lessons learned across sites, and identify solutions to quality challenges.
* I think the expert panel format works well for coming to consensus on what is important about a topic. I think future work will focus on the impact of context in implementing innovations to improve access to care.
* Rapid feedback of panel results to participants in forms they can then take to others (spread of ideas and concepts) through briefings and other short, easy-to-follow formats for diverse audiences. Help them own results and teach others about them.
* Webmeetings, measuring process statistics
* The most difficult part is maintaining efforts, having some stuff redundancy to make sure that work continues to be carried out. Institutions that are two lane rely on individuals have a hard time maintaining programs.
* Put a group of implementation scientists in a room with key hospital administrators, lock the door, and don't let them out until they have created a step by step plan that will work in the specific locale of study. From my pre-panel work and work on this study, I've seen several reports on my interest area, telephones. The ideas are always interesting and read "good", but I doubt the implementation of these plans is graded or scored.
* Ultimately it is about putting evidence into practice, which is challenging for both physicians and administrators. Evidence-based "access management" likely will take tools that can be shared across organizations to help others implement what has been proven to work. Even these tools need to be taken in context as not all methods of improving access will work in all settings.
* Ideally there would be some sort of feedback loop from the QI strategies proposed by the panel to the stakeholders who might try to implement those strategies, and then some information fed back to the panel on what happened when implementation of those QI strategies was actually tried.
* For organizations, a significant challenge is dissemination. There is a tremendous amount of information but often siloed at various levels of the organization.
* Encapsulation of complex ideas into webinars, or hands-on clinical consultation w/ experts, e.g. looking at a facilities actual numbers and doing an analysis which can be fed back
* Not at this time.
* The challenge often times for learning healthcare systems is adopting evidence into practice. It is hard enough for systems to adopt new medical knowledge and evidence, and might be harder for something like practice management where you have C-suite people plus clinical leaders working together. The one suggestion might be to include resources for operationalizing small, evidence-based improvement into practice. Otherwise, tough question to answer.
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Note: N=12 participants responded out of 40 invited. Responses were deidentified to the individuals and organizations.