TTT SERIES: ACCESS TO CARE PRESENTATION
TRAINER NOTES

Course Description: This course focuses on the patient's experience by illustrating barriers and social determinants of health which cause challenges when patients are attempting to access healthcare. The case studies included within the presentation replicate real life situations which provide your staff with the knowledge and resources needed to assist patients to access care.

Purpose: The ability to access health care will lead to improving positive health outcomes, longevity and quality of life, along with the ability for patients to live heathy and independently. Keeping in mind your patient population, the barriers that they face, and how your staff may address these roadblocks will lead to positive patient outcomes and higher satisfaction scores and ratings.

The following notes correspond to the Access to Care slide deck:

SLIDE #1: INTRODUCTION

- Here is where you can personalize the introduction to your group's meeting/session/training.

SLIDE #2: ACCESS TO CARE OBJECTIVES

- By the end of this presentation, you will be able to:
  - Explain access to care and potential barriers
  - Describe how health equity impacts access
  - Identify at least three social determinants of health as it relates to access
  - Identify opportunities to improve access to care

SLIDE #3: ACCESS TO CARE

- As you see on the slide, access to care is defined as "the timely use of personal health services to achieve the best health outcomes." (IOM: Institute of Medicine, 1993)
- Attaining good access to care requires 4 discrete steps:
  - COVERAGE: Gaining entry into the healthcare system
  - AVAILABILITY: Getting access to sites of care where patients can receive needed services
  - TIMELINESS: Providing care when needed
  - PROVIDERS: Finding physicians who meet the needs of individual patients and with whom patients can develop a relationship based on mutual communication and trust

RESOURCES:
https://archive.ahrq.gov/research/findings/nhqrdr/nhdr11/chap9.html

SLIDE #4: ACCESS TO CARE OUTCOMES/MEASURES

- Here are the key areas where access to care impacts our patients.
  - The **HOS** (Health Outcome Survey) measures tell us how we are doing relating to our patients' access to care. How well are we meeting our patient expectations?
  - (HOS has 5 measures, there are 2 measures within Physical Health: Maintaining and Improving Physical Health, Monitoring Physical Activity)
  - **HEDIS** (Health Effectiveness Data and Information Set) includes screening examples: breast cancer, colorectal, flu shot, pneumonia vaccine, etc.
- Please note that the **CAHPS** (Consumer Assessment of Healthcare Providers and Services) measures of getting needed care, getting appointments quickly, and care coordination, directly impact how patients receive care within the HOS and HEDIS measures.
- ALL of these measures are **intertwined** in creating the access to care that is important to our patients.

- Example: Patient needs to get their **A1C** checked so they **need an appointment** to go to the Lab for a blood draw and then an appointment with their PCP to review the results.
- Let's say they have to wait 3 months for an appointment but are not feeling well and their daily blood glucose has spiked in the last couple of weeks. So now the patient is **not getting the needed care**. They feel dizzy at times so they may **fall** and then end up in the hospital (or **readmission**).
- It is similar to a spider web but this web has to do with the frustration and difficulties associated with lack of access.

SLIDE #5: PATIENT ACTIVATION

- Patient activation is ensuring that patients have the **knowledge, skills and confidence** in managing their own healthcare. Bear in mind, many factors influence patients level, or ability to manage their care.
- Issues that impact a patient's activation are:
    - **Transparency** – Does the patient understand treatment, partnership expectations? Does the patient understand the instructions/information we are providing? How do we ensure they understand? (We can teach back, give written instructions, provide pictures, do demonstrations)
    - **High quality** – Are we meeting the patients' expectations of care? Do the patients trust that our office is providing the highest quality of care, with each patient, each time. Are we consistent with our practices? If we are not meeting their expectations of care, if they do not "trust" us, they will not come back.
    - **Affordable** – Healthcare is expensive. Is affordability a barrier to our patients coming in for treatment (PCP, specialist…)?
    - **Connected** – If patients do not have access to providers and information, when they need it, they will not be activated to manage their care.
- So Let's Summarize:
    - People who have low levels of activation are less likely to play an active role in staying healthy.
    - Patients with low activation levels are more likely to be hospitalized or to be re-admitted to hospital after being discharged.
    - Intervening to increase activation can improve a patient's engagement and health outcomes and is an important factor in helping patients to manage their health.
    - Patient activation provides a unique measure of engagement and empowerment that can be used to evaluate the effectiveness of interventions and to measure the performance of healthcare organizations in involving patients in their own care.

SLIDE #6: BARRIERS TO ACCESS TO CARE

- What are the barriers for the patient to access care?
- Let's look at the Barriers affecting the **PATIENT**:
    - The most common barriers to seeing a physician are the doctor's lack of responsiveness to patient concerns
    - Physicians have the patients best interest at heart, but often do not include the patients in the management of their own care. Using patient centered care, and keeping the patient's needs, beliefs and desires at the forefront is key to patient activation, engagement in treatment, and adherence, ultimately improving patients' access to care.
    - Costs – depending on patients benefit coverage they may or may not be able to afford treatment and medications
    - No supplemental insurance

- Transportation – it often takes our patients extra time to arrange transportation, and transportation can be an additional cost barrier. Availability of services are limited (transportation, location)
- Safety –environmental (safety – street)
- Socioeconomic factors – education, occupation, income, wealth, home -- which could further impede access. Additional factors include:
- Age – as patients age other factors begin to impact access to care.
    - Transportation
    - Frailer, weaker
    - More complicated medical conditions
    - More set in their ways
- Gender – Patient preference in MD gender could impact availability and access to care. How different genders may be treated in the office could affect adherence
- Health Literacy – lack of understanding of medical language, processes, benefits
- Lack of trust – if patients do not trust the doctor's office, they will NOT follow their treatment plans
    - Activation into own health care – Knowledge + skills + confidence = patient activation

- Now Let's look at the Barriers affecting the **OFFICE:**
    - Not enough availability to see patients – hard to give appointments
    - Access problems can be caused by inefficient design, waste, poor execution, inappropriate utilization of provider resources, shortage of physicians/providers
    - An office can also have confusing processes, difficulty communicating, time factors issues
- Inadequate capacity is not an excuse for inaction, and should result in a staged plan for improvement, including a focused effort to identify patient-centered alternatives to face-to-face visits.
- Here is where we now can include Telehealth appointments. They are faster and easier for both the provider and the patient. It will never replace the face to face appointments but can be an alternative when necessary.
- Once internal standards are met that are meaningful and achievable by each organization, a culture of continuous improvement should motivate further efforts, producing new national benchmarks.

SLIDE #7: HEALTH EQUITY

- What is Health Equity? Read Definition on slide.
- Sometimes equity is confused with the term equality. Both are great concepts but this picture demonstrates the difference really well.
- As it shows here, it's about not just giving everyone the exact same resources but distributing those resources according to need. The tall person doesn't need more resources to access the view of the game, but the short person does need more resources to access the view.
- Emphasize RESOURCES…resources for our patients are the doctors, nurses, medical staff, labs, medications, X-rays, hospitals, clinics, urgent care, etc.
- If we apply this to how we think about our members and their health, the principle is the same.

SLIDE #8: IMPORTANCE OF HEALTH EQUITY

- So why is Health Equity important?
- It's important because it impacts health outcomes, longevity and quality, and the ability to live a healthy and independent life for our members.
    - For example, we know that Latinos are more likely to die from diabetes than any other disease (this comes from the CDC).
    - That African Americans are at least 50% more likely to die from heart disease or stroke (these stats also come from the CDC).

- According to the US Department of Housing and Urban Development's Annual Homeless Assessment Report, as of 2017, there were around 554,000 **homeless people** in the United States on a given night, or 0.17% of the population. **Homelessness** emerged as a national issue in the 1870s.
  Homelessness in the United States – Wikipedia
  https://en.wikipedia.org/wiki/Homelessness_in_the_United_States
- Also, the pay between males and females in many jobs varies greatly. In 2017, **female** full-time, year-round workers made only 80.5 cents for every dollar earned by **men**, a **gender wage** gap of 20 percent. **Women**, on average, earn less than **men** in nearly every single occupation for which there is sufficient earnings data for both **men and women** to calculate an earnings ratio.
  Pay Equity & Discrimination | Institute for Women's Policy Research
  https://iwpr.org/issue/employment-education-economic.../pay-equity-discrimination/
- And only 12 **percent** of U.S. adults had proficient **health literacy**. More than a third of adults were in the basic (47 million) and below basic (30 million) **health literacy** groups.
  Health Literacy - Fact Sheet: Health Literacy Basics - Health.gov
  https://health.gov/communication/literacy/quickguide/factsbasic.htm
- These are just a few of the reasons why it is important to know the demographics of our population and the impact that the social determinants around their health might be having.
- These impact our patients' ability to live healthy and independent lives.

SLIDE #9: SOCIAL DETERMINANTS OF HEALTH

- **The Social Determinants of Health** are the differences involving the social, economic and environmental context that we live with and which shape our advantages or disadvantages in relation to our health. (Office of Minority Health, 2015). These are the factors that create the gaps in health between people.
- This is a variety of the SDOH. This of course does not include everything, but it includes most of the challenges for social determinants of health, and may vary dramatically from office to office.
- Barriers (patients/office) and social determinants of health are similar. Health equity is the differences in the quality of health and health care across populations.
- Let's take a look at some of the Social Determinants of Health.
  - Economic Stability: employment, income, expenses
  - Neighborhood and Physical Environment: affordable **housing,** cleanliness and walkability, access to green spaces, feeling safe, transport, and stairs when you have a wheelchair

SLIDE #10: SOCIAL DETERMINANTS OF HEALTH

- Food: Access to nutritious **food**
- Community and Social Context: social support (relatives and friends)

SLIDE #11: SOCIAL DETERMINANTS OF HEALTH

- **Education:** your language and literacy and your culture.
- Healthcare System: access to high-quality care
- **Digital/technology**: access to computers, cell phones, internet, Telehealth
- It is the context (health history resume) of a person that massively determines a person's ability to engage in their health and their health outcomes.
- It is a big misconception that as health providers and clinicians that we have the greatest impact on people's health, because all the literature and probably your experience tells you otherwise. Clinical care accounts for a mere 10-20% of all health outcomes, while social determinants (the context of the individual) accounts for 80-90%. (source: County Health Rankings 2015).
- Factoring in these and their impact on the health of our patients is REALLY important. As we can all imagine, if you've got no house, taking your diabetes meds is kind of the least of your worries.

- We need to be thinking about these factors in our members lives when we're working with them.
- Think about your patient population, and how these SDOH impact your patients' ability to have access to the care they need. Are we aware of these challenges, and do our staff have the knowledge and resources to assist in overcoming some of these barriers.

SLIDE #12: ACCESS TO CARE: NO JOURNEY IS THE SAME

Introduction The Journey

- Every patient is on a journey with their health and the healthcare industry and no two journeys are the same. We are going ask you to follow us and several patients on a journey of access to care. This is the beginning of the activity: virtual or in-person.

SLIDE #13: INTRODUCING THE PERSONAS

- NOTE TO TRAINERS: Please feel free to use "actual" case studies from your patient population and have the staff "follow" those patients through current situations and how they were assisted to access care. Or you may choose to use the following scripts:
- We have 3 patients that we will be following on their journey: **Rob, Earl and Lijuan**
    - All of them have diabetes
    - They were hospitalized overnight because of complications with Diabetes.
    - And are all being discharged from the hospital today.
- Each persona will experience an access to care journey that replicates real life situations.
- As we present each person, keep in mind your patients that have come to your offices and have experienced similar journeys or situations in order to access care.
- Try and recall if they have experienced similar barriers and successes.

SLIDE #14: HOSPITAL DISCHARGE SUMMARY

- Here is a little bit of background information.
- We have presented you with a copy of their Discharge notes.
- Note that they all have Type 2 Diabetes and are on Insulin.

SLIDE #15: INSTRUCTIONS FROM HOSPITAL TO HOME

- Each Patient has been given the same instructions from hospital to home.
- Discharge Orders include:
    - Transportation
    - Filling Prescriptions
    - New order: take 2 pills twice a day
    - Follow-up with their Provider
    - Work on their treatment plan
    - Appointment with the Specialist
- Let's look how each patient will address each item.

SLIDE #16: LET'S MEET ROB

- Meet Rob!
- Let's Review his background – (review the slide)
- Next let's follow Rob and see what the barriers and successes of Rob's journey are.

SLIDE #17: ROB – OVERALL JOURNEY

- Let's follow Rob's journey from being discharged from the hospital to the pharmacy to the provider to the specialist to home.

1) **Rob's Discharge Instructions**

- **Rob's comments**: *"My instructions are clear and concise. I understand what I need to do. I'm going to go pick up my medicine from the pharmacy"*
- Rob is **able to drive himself** home and to the pharmacy

2) **Rob's Pharmacy Visit**
   - **Rob's comments**: *"Why do they make medication instructions so confusing? I could read this a couple different ways. I'm going to **talk to the pharmacist** to get clarification."*
   - Prescription Instructions: Take 2 pills twice a day
   - Instructions can be read different ways. Rob is comfortable talking to the pharmacist about his concerns. After speaking with the pharmacist, Rob is clear on how he should take his medicine:
   - 2 pills in the morning and 2 pills in the evening.
   - After getting his prescription, he goes to his follow up appointment with his PCP.
3) **Rob's PCP Visit**
   - **Rob's comments**: *"The doctor talked to me about increasing my exercise and changing my diet. The changes sound reasonable, so **I plan to follow her instructions**. Luckily she wrote everything down to remind me what I'm supposed to do."*
   - **PCP Follow Up Visit**
     - Appointment: He arrives on time, completes all of his paperwork.
     - Treatment Plan: He talks with his doctor about his treatment plan, and what actions he needs to take. Doctor provides written instructions for exercise and dietary changes.
     - Patient Activation / Adherence: Rob agrees to follow the plan.
     - Referral to Specialist: Rob receives a referral to see a specialist in 3 weeks.
4) **Rob's Specialist Visit**
   - **Rob's comments:** *"I'm a little frustrated that I got to the specialist and they told me **I didn't need the appointment.** They did take my bloodwork and said that everything looked good. I'll follow-up with my doctor next month."*
   - Visit with Specialist is today
   - Rob arrives at the Specialist office on time and waits only 10 minutes before he is seen.
   - The specialist informs Rob that it was not necessary for him to be seen by her today, but they do his lab work while he is there.
   - Lab results look good.
5) **Rob heads home**
   - Rob has an appointment to see the PCP in 3 months.
   - His prescriptions are filled.
   - He will begin his walking plan next week.
   - He is heading home to rest.
   - His journey, for now, has come to an end.

KEY FINDINGS:

- Unnecessary visits lead to high resource utilization, and higher costs (for Rob and the system).
- Unnecessary visit wasted Rob's time, the Specialist's time, and may have denied someone else access who needed it more.
- This could impact Rob's satisfaction, which could impact our 5 Star Scores

SLIDE #18: LET'S MEET EARL

- Here's Earl!
- Let's Review his background – (review the slide).
- Next let's follow Earl and see what the barriers and successes of Earl's journey are.

SLIDE #19: EARL – OVERALL JOURNEY

- Let's follow Earl's journey from being discharged from the hospital to the pharmacy to the provider to the specialist to home.

1) **Earl's Discharge Instructions**
   - **Earl's comments:** *"I get nervous and confused at the hospital. I don't like to read; the words get jumbled up*."
   - **Discharge Instructions**
     - Instructions are confusing – He has to figure out what the words say.
   - **Things to do after discharge:**
     - Transportation home from the hospital
     - Fill Prescriptions
     - PCP follow up
     - Appointment with Specialist
   - Earl has to find transportation to the pharmacy.
     - Uses the bus system and he finds the appropriate bus route to the pharmacy.
     - The trip has 1 bus transfer and takes 30 minutes one way.

2) Earl's Pharmacy Visit
   - **Earl's comments:** *"I don't like taking pills. I'm not sure about the instructions, but I don't want to ask because they will think I'm stupid."*
   - **At the Pharmacy:**
     - Prescription Instructions are as follows: Take 2 pills twice a day
     - Earl does not understand. He will not ask because he does not want the pharmacist to think that he is illiterate.
     - So Earl takes 2 tablets a day for about 2 weeks, missing a few doses here and there.
     - He takes both pills in the morning, because it is easier to remember
   - Problems with medication adherence:
     - After 2 weeks, he forgets to take any more

3) **Earl's PCP Visit**
   - He needs to find transportation to the PCP…uses the bus system.
   - He finds the appropriate bus route to his PCP, the trip only takes 25 minutes.
   - **Earl's comments:** *"I hate doctors. They made me make this appointment and now they say I have to come back another day. I will have to call tomorrow from Jimmy's house."*
   - At the Appointment:
     - Earl arrives at his doctor's office.
     - Front office staff informs him that they tried to reach him, but were unsuccessful since they didn't have a phone number for him.
     - The doctor had an emergency and all of the appointments were canceled for the afternoon.
     - Front office staff tells Earl to call tomorrow to make an appointment.

4) How does the journey continue for Earl?
   - Treatment Plan: there will be none
   - Patient Activation / Adherence: Earl plans to call the office tomorrow from a friend's house, but he forgets.
   - **Follow up appointment with PCP: No**
   - Referral to Specialist: No
   - Follow up lab results: None

5) **Earl's Journey Destination:**
   - What is going to happen to Earl??

- Does Earl's journey end or start again???
- Where does Earl go???

KEY FINDINGS:

- We can see by the information provided that Earl is homeless and we have no way to contact him, unless he checks in with family and friends frequently. We really have no way to assess that.
- He has to use public transportation to get to appointments.
- Health literacy issues and mental health issues impact Earl's understanding, but he does not want to admit it, so he does not ask any questions. He does not want people to think of him as stupid.
- Please note that the discharge instructions state that he needs to take insulin.
- **Insulin** that is not in use should be stored in the refrigerator. If **refrigeration** is not possible, it can be kept at room temperature [15-25 degrees C] for 28 days. ... In use cartridges should be kept at room temperature and SHOULD NOT be kept in the refrigerator. **Insulin** has a 'use by' date as well as an expiration date. If he has no home, where does he store the insulin.
- Major issue is setting an appointment. Having him call back the next day is difficult due to the fact that he has no way to communicate with the office. Best decision, not a sure fix, is to just reschedule Earl immediately while he is standing in the office.
- Because he is a diabetic and may come into the office without having had a meal, it is always a good idea to have diabetic supplies on hand (juice, crackers with peanut butter/cheese, water, etc.) in the office. It's not a meal but it helps out when a patient who has diabetes needs a little something before they are able to get home.
- If Earl is not assisted, he will get lost in the system without having received access to care.

SLIDE #20: LET'S MEET LIJUAN

- Here's Lijuan!
- Let's Review her background – (review the slide)
- Next let's follow Lijuan and see what the barriers and successes of Lijuan's journey are.

SLIDE #21: LIJUAN – OVERALL JOURNEY

- Let's follow Lijuan's journey from being discharged from the hospital to the pharmacy to the provider to the specialist to home.

1. **Lijuan's Discharge Instructions #1**
    - **Lijuan's comments:** *"I don't understand"*
    - She is unable to understand instructions so the head nurse locates a Translator
2. **Lijuan's Discharge Instructions #2**
    - **Lijuan's comments**: *"The nice man explained what the paper says. I need to go get my pills. My daughter will know what to do next."*
    - Things to do after discharge:
        - Transportation home from the hospital
        - Fill prescriptions
        - PCP follow up
        - Appointment with specialist
        - Lijuan gets new instructions and family drives her to pharmacy.
3. **Lijuan's Pharmacy Visit**
    - **Lijuan's comments:** *"I don't know what the bottle says. My daughter takes care of me. She picked up my pills and told me to take 1 in the morning and 1 pill at night."*
    - **At the Pharmacy**
        - Prescription Instructions is as follows: Take 2 pills twice a day
    - Daughter is in a rush, so she doesn't talk to the pharmacist. She assumes she understands the instructions

- Daughter gives Lijuan 2 pills a day:
    - 1 in the morning
    - 1 in evening
- Is this the right dosage for her mom?

4. **Lijuan's PCP Visit** (Daughter takes Lijuan to PCP after she drops her granddaughter off at school)
    - **Lijuan's comments**: *"My daughter does so much for me. She seemed irritated with the doctor, but she said everything is fine."*
    - **At the PCP Visit:**
        - Appointment is rushed
            - Daughter had to drop her granddaughter off at school and had trouble with the wheelchair so they arrived late at the doctor's office.
        - Daughter is still upset that the hospital got a translator for her mother. She feels that they are unnecessary, that's why she is there!
    - The physician is discussing the **Treatment Plan** with Lijuan and her daughter.
    - The daughter disagreed with the treatment plan:
        - Thinks mother is too old to exercise.
        - She feels that the doctor is "judging" her mom's diet.
        - Daughter takes offense and states, *"How dare he thinks that I will cut back on my mom's food. She has been eating rice her whole life."*
    - The **Patient Activation/Adherence** to treatment plan:
        - Daughter does not plan to do anything differently.
        - And tells Lijuan that everything is fine.
        - An appointment with the specialist (an endocrinologist) is set for next week.
        - Lijuan must also see a doctor for her Vision and Hearing problems.
        - Lijuan has DME: Diabetic Macular Edema.
        - And also needs to go to the lab for a blood draw before seeing the specialist.
5. **Lijuan's Specialist Visit**
    - Daughter takes mom to Specialist.
    - Lijuan was not able to get to the lab prior to this visit, so at the specialist's office, her labs are drawn:
        - Her A1C level is dangerously high (score is 12) with a blood glucose of 300.
    - Her other issues and specialist requirements are postponed.
    - Complications from lack of medication adherence.
6. **Home? No, Lijuan's Journey Begins Again.**
    - Lijuan is transferred to the hospital.

KEY FINDINGS

- Is it realistic to assume what happened to Lijuan is due to the fact that we did not talk to the daughter and explain everything?
- Education and assistance to family members (daughter) regarding medication and treatments is essential. But not just talking, having the family member repeat back to us (teach back) as to what the instructions are for the patient's care.
- Prescription states that Lijuan is to take 2 pills twice a day…Daughter gives Lijuan 2 pills a day: 1 in the morning and 1 in evening. Is this the right dosage for her mom? So now the patient is not adhering to the medication.
- Discharge instructions state that she needs to take insulin.
- **Insulin** that is not in use should be stored in the refrigerator. If **refrigeration** is not possible, it can be kept at room temperature [15-25 degrees C] for 28 days. ... In use cartridges should be kept at

room temperature and SHOULD NOT be kept in the refrigerator. **Insulin** has a 'use by' date as well as an expiration date. Is the daughter in charge of the administration of the insulin as well as the oral meds.

- Because the daughter did not follow prescription instructions, Lijuan's A1C was at a 12 and blood glucose at 300 -- Normal A1C is between 4 and 5.6 and Blood Glucose should be under 100.
- **Definition of DIABETIC MACULAR EDEMA (DME):**
  Swelling of the retina resulting from leakage of fluids from damaged blood vessels in the eye. It is a major cause of visual loss in diabetics, and is related to poor control of blood glucose.
- Daughter is not willing or not able to assist patient so readmission has occurred.
- The major issue here is that the daughter needs assistance/serious education regarding her mother's health issues. The best would be to get the daughter in touch with a Diabetic Educator and/or a nutritionist…someone who understands the Chinese culture and their dietary needs.

SLIDE #22: BEST PRACTICES TO IMPROVE ACCESS

- **Best Practices:** What can we do to improve access to care for our patients?
- ***KEY TAKE AWAY: Practice at the top of your license/training?***
- **Opportunities to Improve Access -- Appointments**
- **Chronic Care Management-** Patients with multiple chronic conditions may need more than one appointment to address each condition, and/or, may need additional time during an appointment to discuss how the conditions interact with each other.
- **Extended Appointments** – Older patients, or patients with other SDOH may need extended appointment times to cover all topics in a manner where the patient can understand, and process all of the information needed for their care (do they need pictures, charts, written instructions, larger print, etc.)
- **Scheduling Future Appointments –** Scheduling appointments while the patient is still in the office helps to ensure patients come back to see us, and engage with their healthcare.
- **Location –** Keep the patient's location and access to transportation in mind as you schedule future office visits, referrals and specialist appointments. See if Home visits, House calls, and TeleHealth are possible and easier to meet the patient's needs.
- **Referrals**
  - Develop an auto-approval process for referrals to in-network providers
  - Establish a unified referral network team with the appropriate staff, workflows and info systems to deal with communicating to patients and providers the referral progress and outcomes
  - Develop a patient referral workflow which includes steps that patients take before leaving the office: specialist, questions, time to get appointment, and how primary physician will be informed of progress
  - Ensure your staff understands referral workflow
- **Opportunities to Improve Access -- Communication**
- **Instructions –** Provide both verbal and written instructions.
  - Use "living room" language
  - ask for teach back
  - use pictures, diagrams
  - Maps when sending to other locations
  - demonstrations
- **Education –** Provide education in a simple and easy to understand way. Use the patient's primary language. Keep it Simple. As above, use other methods to teach or demonstrate

- **Language –** SCAN has a translation service available. Here is where you get to speak to the patient, not the interpreter.
    - SCAN not only has phone translators, but an office translator is available as a benefit and can be scheduled to go to appointments.
    - Do Telephone Follow-up/Patient Portal: easy way to check in on how the patient is doing.
    - For the elderly, it is important to identify their care taker and how they assist them with their needs and concerns.
- **Opportunities to Improve Access – General**
    - Be aware of the patient benefit's coverage.
    - Work with transportation companies to ensure patients make it to the appointment. SCAN provides transportation services to and from the patient's home to the doctor's office.
    - If possible, provide education materials in the primary language of the patient population.
    - Utilize community resources – SCAN has a database called Aunt Bertha which provides local social and health services to seniors – it is updated every 6 months so the information is current.

SLIDE #23: THE COMPLETE PATIENT EXPERIENCE

- The true patient experience goes far beyond giving patients what they say they want, or completing a checklist.
- Patients moving seamlessly from check in to check out.
    - In order to achieve high-quality patient experience there must be a simple approach to creating the seamless merging of the services provided by multiple individuals.
- Providers operating efficiently.
- Identify Touch Points:
    - Patient experience is about the design of the complete experience with every touch point before, during and after an episode of care.
    - Parking, patient portal, reception area, furniture, desk, magazines, kiosk, medical records, referring physicians, lab, doctors, nurses, medical equipment, and billing.
- Patients feeling respected and cared for by the provider and their staff.
- Focus on the journey:
    - From home to PCP to lab to pharmacy to home
- Patient experience focuses on their journey through the practice and it may not even be about the care they receive.
- A well-designed experience begins with a service mentality; the patient is the reason we do what we do.

SLIDE #24: EQUALITY VS EQUITY

- So is Access to Care all about equality or is it about health equity?
- Here is where you and the physician will help by assessing what your patient needs to access the appropriate and customized care.

SLIDE #25: SUMMARY

- In summary, we covered:
    - Health Equity versus Health Equality
    - Social Determinants of Health
    - Patient Activation: knowledge, skills, confidence
    - Resources
    - Access to Care Measures: HOS, HEDIS, CAHPS
    - Good health outcomes

SLIDES #26 and #27: Extra Slides

- Are examples of what you can add in the form of announcements, additional activities, quiz questions, etc.
- Here are some examples of **POLL QUESTIONS/KNOWLEDGE CHECKS:**

1. True or False: Patient activation is ensuring that patients have the **knowledge, skills and confidence** in managing their own healthcare.

Answer is **True**

2. Identify which of the following are Social Determinants of Health:
   A. Affordable Housing
   B. Nutritious Food
   C. Access to Computers
   D. All of the above

Answer is **D) All of the above**

3. True or False: Scheduling appointments while the patient is still in the office helps to ensure patients come back to see us.

Answer is **True**