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Redesigning care

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Starting point

Every system is perfectly designed to achieve the results it gets

So to change the results - change the design rules

Some of our current design rules are not very good…..

Odd design rules

- Organise around
  - Medical disciplines not patient problems
  - Individual events not patient journeys
- Separate primary and home care from hospital care
- The sickest patients see the most junior doctor
- Batch and queue systems
- Store patients until you are ready to see them

New design principles

Some that are already accepted:

- Standardise where possible
- Centralise where necessary, decentralise where possible
- Safety as a system property

New design principles: Purposeful design

Purposefully focus on the design and improvement of the system:

- Remove unnecessary complexity
- Focus on continuous improvement and develop skills and leadership to support this

Population health management

Understand the population's health needs and match services to patient/user characteristics based on need and risk. :

- Registries
- Shared assessment processes
- Proactive care to anticipate need
- New ways to target and work with different populations

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Match need to services

Develop the capability to deal with the complexity of patient needs and match these to services:

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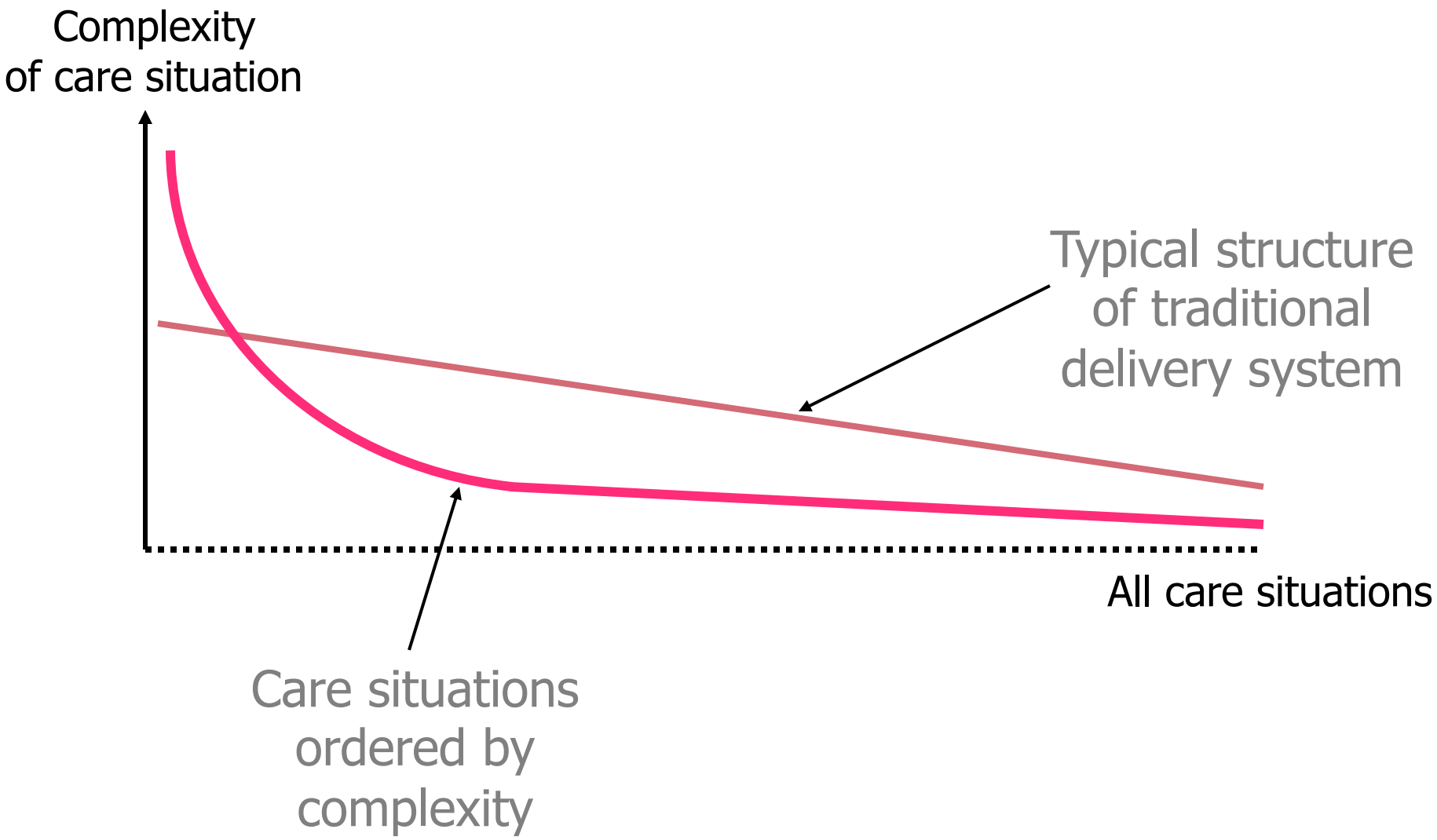

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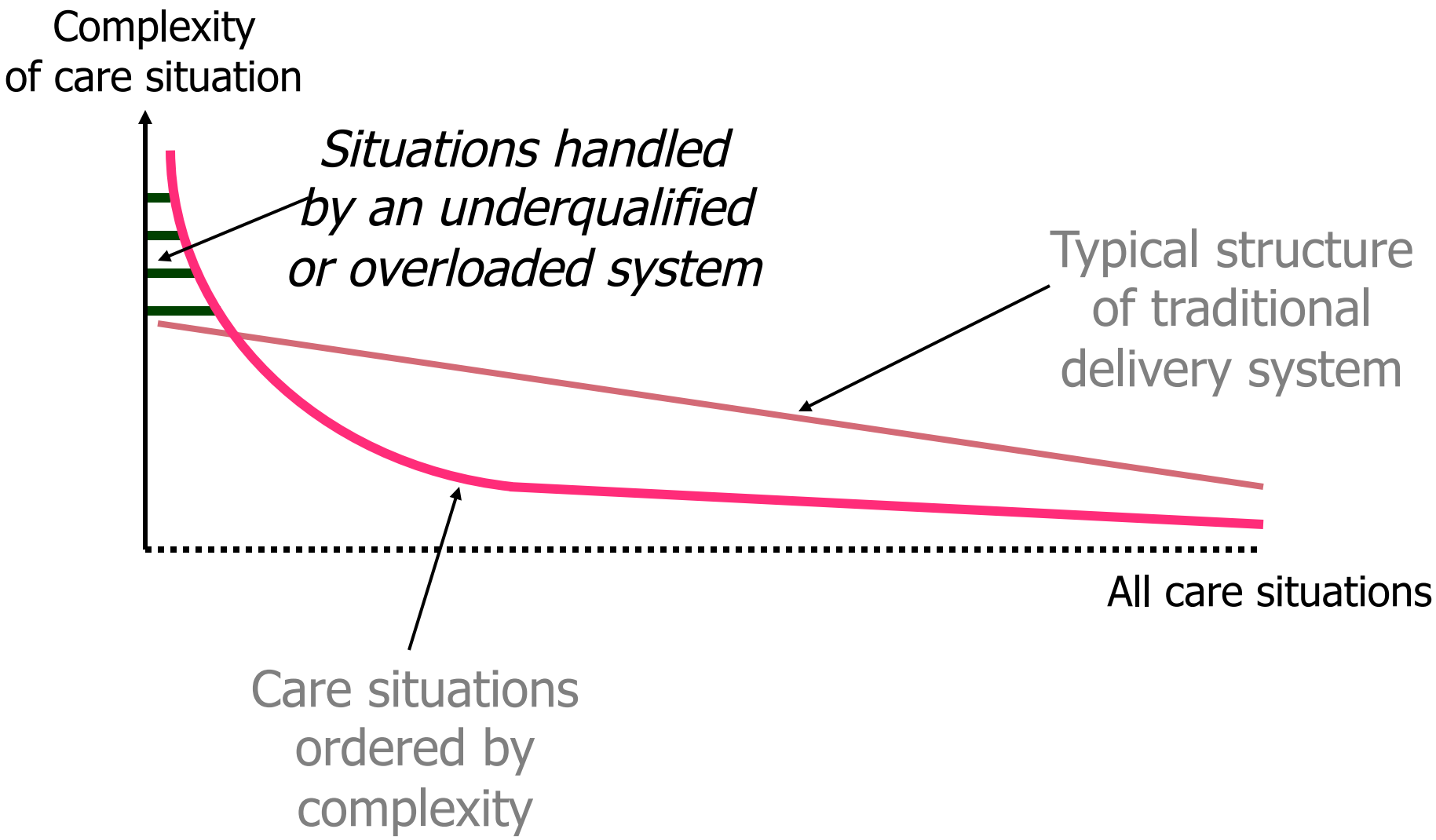

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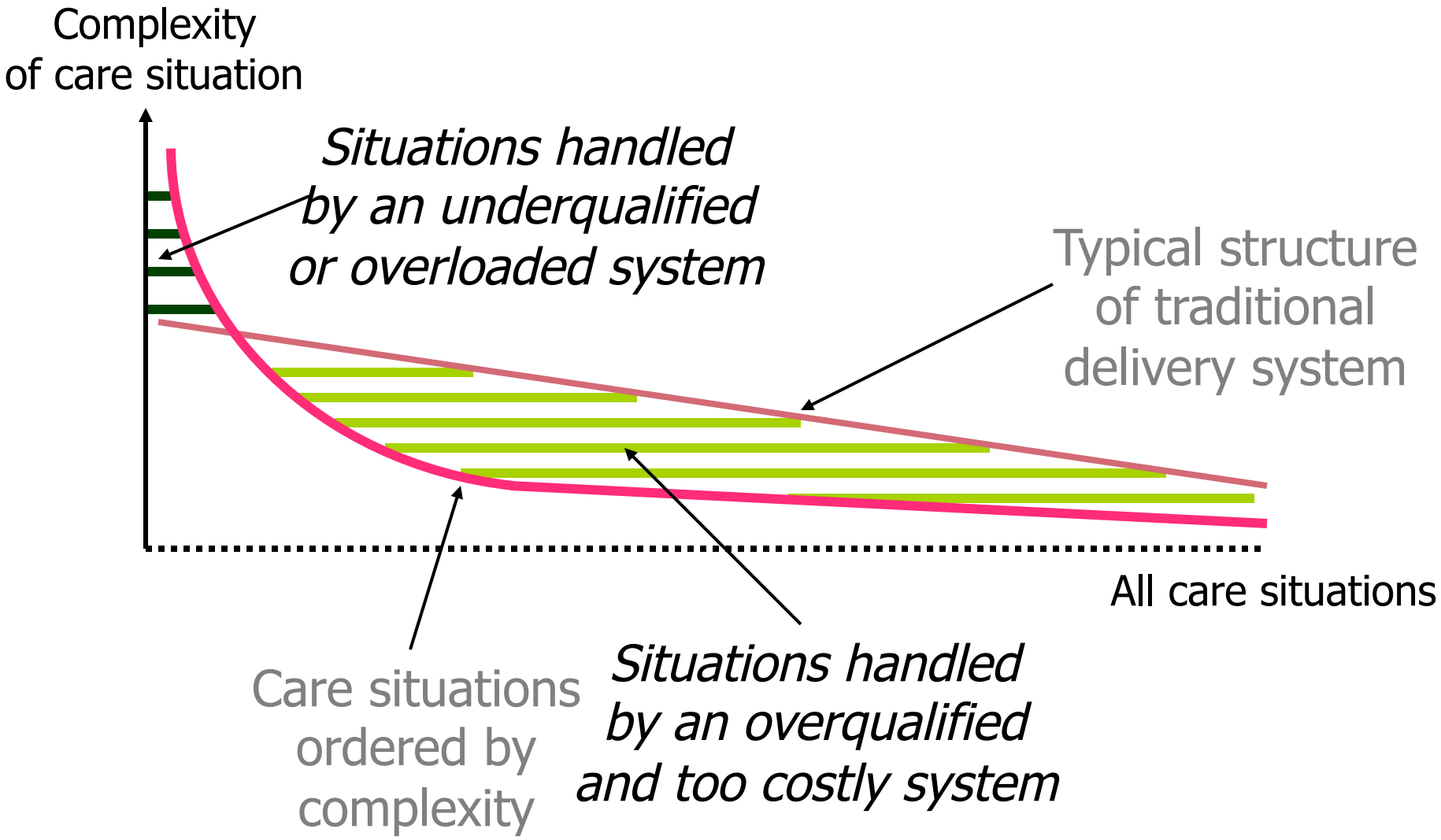

Match need to services

Develop the capability to deal with the complexity of patient needs and match these to services:

- Multidisciplinary teams including social care and mental health
- Capture the benefits of generalists and specialists
- Providing specialist advice more widely across the system
- Reduce care coordination challenges and hand-offs by multi-skilling professionals and care workers

Ensuring care is at the most appropriate level

Typically:

10-25% of admission could be cared for at a lower level of care

40-55% of bed days

Focus on flow

- Align the approaches of different parts of the system and the pace at which they work
- Match capacity to demand
- Separating different types of process flow from each other.
- Avoid the proliferation of holding, assessment & other units
- Focus on the interfaces, the transmission of information and standardisation of processes, equipment, communication, etc.
- Availability of senior decision maker at the front end of the process with access to alternative service choices
- Plan for every patient – make & execute decisions

Hospitals: Specialisation and generalism

Specialists need to make a very active contribution to the management of emergency patients

Rebalance specialism and generalism

Escalate quickly where necessary

Networks

Networks as a key organising principle – this has some profound implications:

- Staff working across organisational and sector boundaries with shared approaches to patient management
- Tiered services based on need and risk and easy transfer between parts of the network
- Focus on knowledge sharing and QI across the network
- Clear accountability for outcomes
- Focus on relationships more than structur

Artificial barriers

Break down barriers:

- Mental health and physical health
- Nursing & residential homes and the health services

Primary care

New approaches required:

- Longer appointments
- Care planning and case management
- Special focus on frailty and care homes
- Increased capacity, diagnostics & specialist support
- Standardisation
- Channel shifting – phone, web etc.
- This all requires increased scale

Rethinking the outpatient model

- Advice by phone and web
- E-clinics
- Hot clinics
- Tiered services, streamed clinics
- Integrated services e.g. MSK
- One stop models
- Multispecialty clinics
- Routing straight to diagnostics
- New approaches to follow up
- More intelligent approaches to consultant-consultant referral

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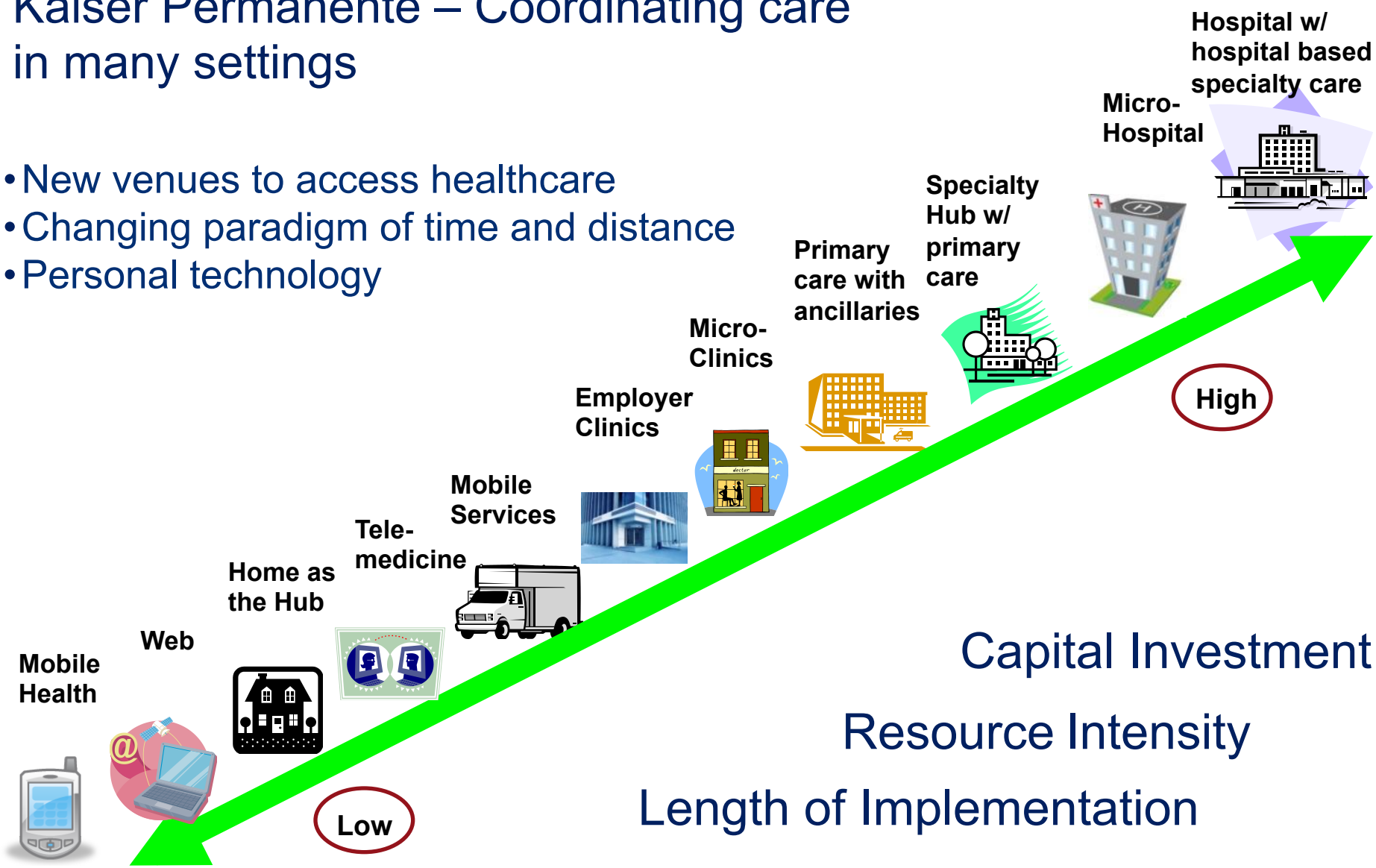
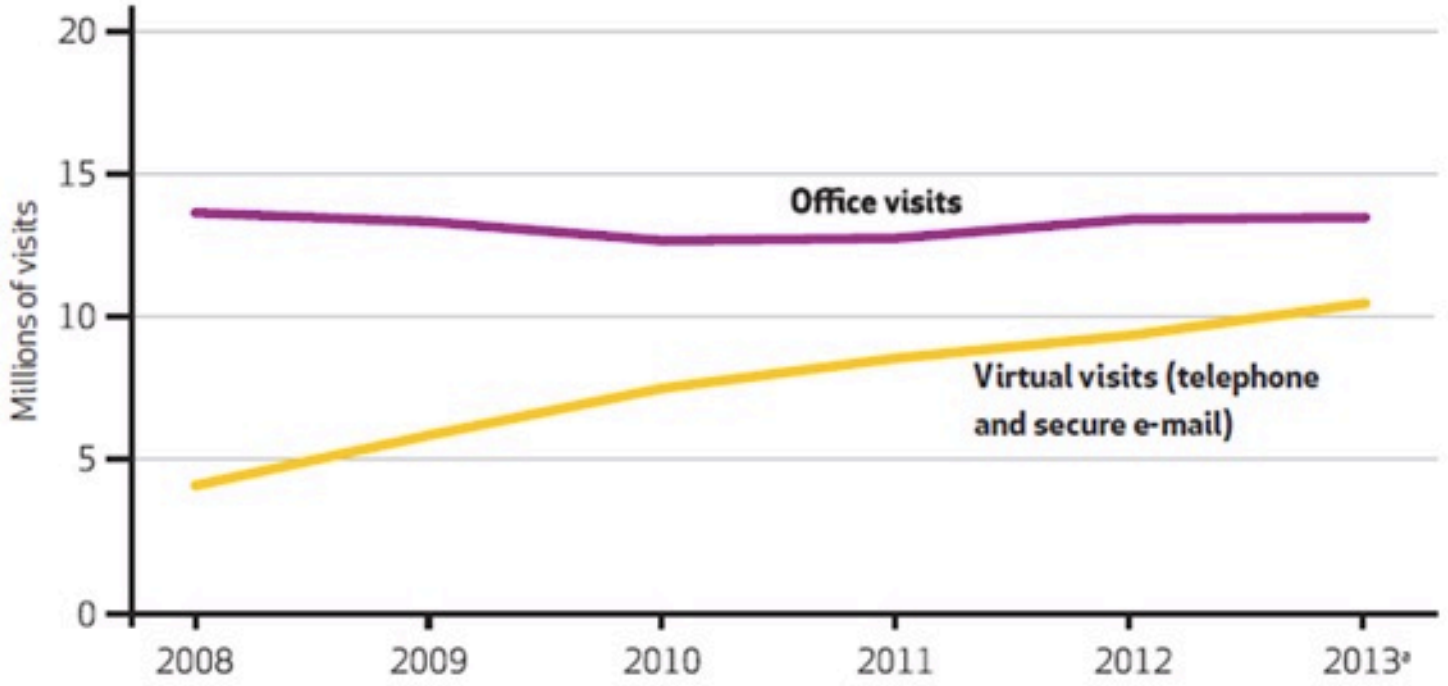
Kaiser Permanente – Coordinating care in many settings

- New venues to access healthcare
- Changing paradigm of time and distance
- Personal technology



Changing the nature of interactions

In-Person And Virtual Patient-Physician Visits, Kaiser Permanente Northern California, 2008–13



SOURCE Internal data from Kaiser Permanente Northern California. **NOTE** Virtual visits are encounters via telephone or secure e-mail; they do not include video visits. [a]Estimated values based on data for the first three quarters of the year.

Design systems where staff can flourish

- Control and mastery
- Manageable workload
- Human scale organisations
- Functioning teams
- Feedback on performance
- Tools to improve services

Plan for environmental sustainability

Carbon

Water

Communities

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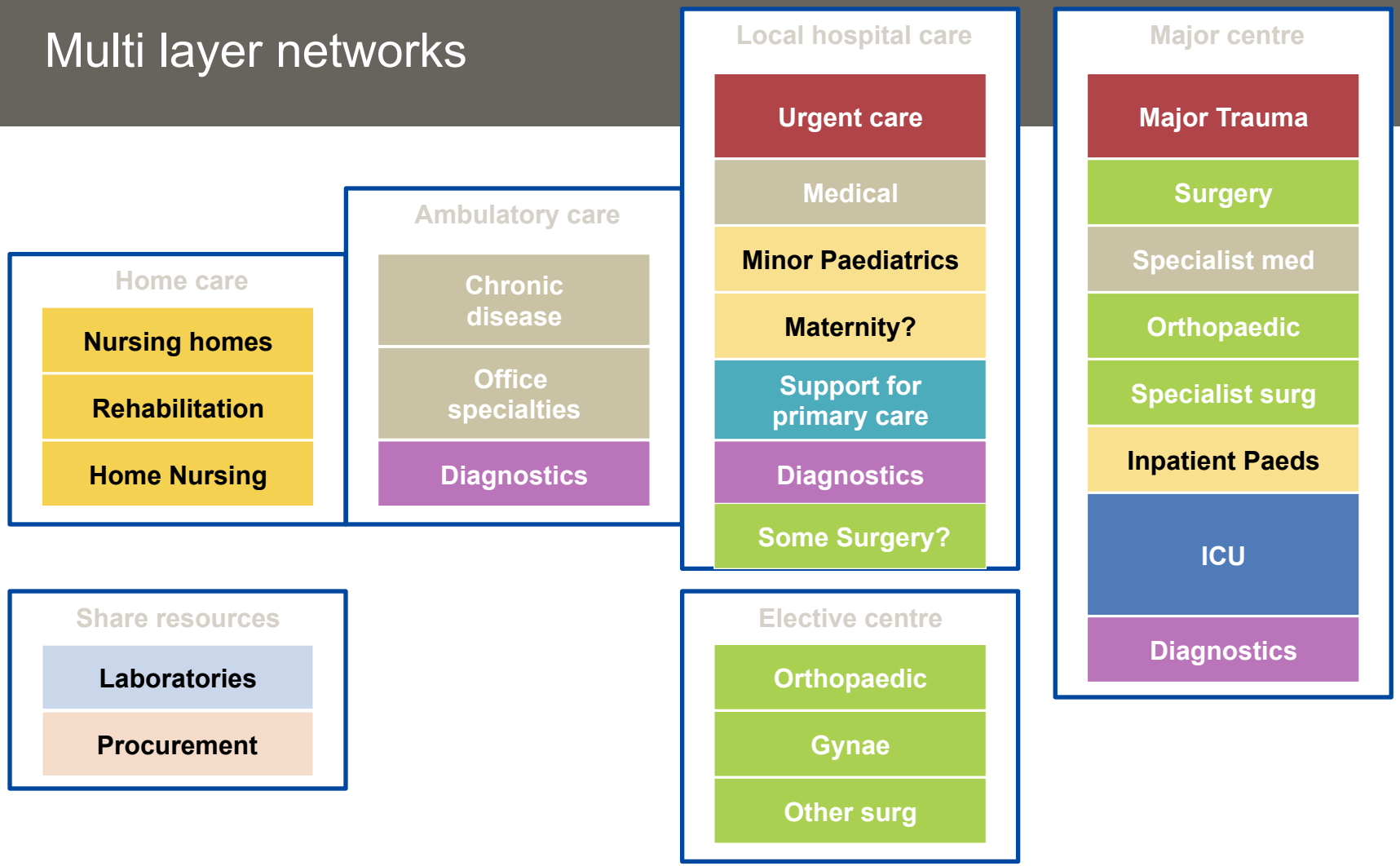
Multi layer networks



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