Thinking about outpatient / ambulatory care

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Outpatients in the 1920s
Why are we interested

- Large numbers of people use outpatients
- Lots of time, space and travel
- Poorly understood
- We have a suspicion that it is not adding value

Questions

- Did the patient need to come at all?
- What was the value being added?
- Could this be done in other ways?
What is the job to be done?

- Diagnosis
- Advice
- On going management
- Treatment
- Reassurance
- Follow up
- Get the patient out of the GP surgery

And when is it required?

"outpatients is not for the patient but for the GP"

Rethinking: before referral

- Referral management
- There has been a lot of focus on trying to stop referrals
- View that GP variation in referrals give a clue
GP referral – a difficult balancing act

It’s a balance between what I consider to be their needs, and what they consider to be their needs, and their wants and anxieties.

GP, case study site B

I think also it has to be cost-effective, so I think you need to have a slightly higher level view of why you’re referring rather than just necessarily pandering to the whims of patients’ requests... At the end of the day this is public money and it has to be spent appropriately.

GP, case study site C

Factors influencing referral decisions

- GP factors
- Patient factors
- Structural factors

A variety of approaches to GP referral management

Referral management centres
- All consultant-to-consultant and GP referrals to be subject to clinical triage process
- All GP referrals to be subject to clinical triage process
- All GP referrals to be subject to administrative triage process

Clinical assessment and triage services
- Specialty-specific clinical triage and patient assessment
- Referral to GPs with a special interest (GPwSI)

Peer review and audit
- Financial incentives
- Undertake peer review and audit; compare rates and compliance with guidelines

Use of clinical guidelines
- Encouragement to comply with guidelines, eg, Map of Medicine

Source: Imison & Naylor, 2010
Looks at a variety of factors

<table>
<thead>
<tr>
<th>Attribute of referral appropriateness</th>
<th>Key question</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Necessity</td>
<td>Should the patient be referred?</td>
<td>Could the patient be treated by GP rather than by a surgeon?</td>
</tr>
<tr>
<td>2. Destination</td>
<td>Where should the patient be referred to?</td>
<td>Could the patient be treated in a clinical assessment services setting rather than by a consultant level specialist?</td>
</tr>
<tr>
<td>3. Quality/process</td>
<td>How should the referral be carried out?</td>
<td>Have the necessary investigations been carried out?</td>
</tr>
</tbody>
</table>

Source: Blundell et al. 2010

Very mixed verdict

- Poor value for money
  - Referral management centres carry a large overhead cost that is likely to outweigh savings from any reductions in referrals.
  - Only 10/72 Clinical commissioning groups able to demonstrate any savings from referral management schemes.
  - Any strategy to reduce over-referral may also expose under-referral.
  - Reductions in referrals from one source can be negated by rises from other sources
  - Risks for patients and clinicians – especially when linked to incentives
  - Peer review and a number of other interventions might be better for patients and the system

Source: Imison & Naylor, 2010
Rethinking: before referral

- Referral management
- Relationship and education based approaches
- Advice and guidance
- Open access to specialists

New Care Models In Children – Design Principles
Imperial College

1. Focus on connections and relationships
2. Harness existing strengths: put GP practices at the heart of new care models - specialist services are drawn out of the hospital to provide support & to help connect services across all of health, social care and education
3. Include the whole population, (using segmentation to create bundles of care) to drive prevention and improve equity
4. Health seeking behaviours improve through peer-to-peer support
5. New approaches to care to be co-designed with children, young people, parents, carers and communities
6. Focus on outcomes that really matter to patients
7. Use education and development, for the whole multi-professional team, as a key way to build relationships and finding new ways to work together
New role for some specialists

- Co-producer of pathways and guidelines with patients and primary care professionals
- Keeping the system up to date with the science
- Educator and advisor
- Support to specialist nurses and care coordinators
- Dealing with the most complex and difficult patients
- Taking a population health view
  - Developing and running registries
  - Identifying the highest risk patients
  - Developing population health interventions
  - Understanding the context & social environment

Rethinking: New delivery models

- Virtual clinics
- Skill mix to allow different delivery models
- Telemedicine
- Hot clinics
- Multidisciplinary clinics for symptoms
- One stop diagnosis & treatment in one visit
PDSA cycle 1
One patient, one day

- Current system takes ~3 months from seeing GP to receiving a management plan
- Prediction: shorten this to under 8 hours in a single visit
- Completed in 3hrs 10mins
- Patient and daughter left with written management plan in hand
Some other approaches

- Active follow up of patients that did not attend clinic
- Follow up and on-going care
- Patient collected data
- Patient initiated follow up

Enabling this

- Methods to define value to the patient
- Payment systems
- Electronic record and portal
- Time and the ability to experiment
What are the principles?

- Match the delivery model to the problem the patient or the referring clinician is dealing with
- Move information rather than people
- Self service
- New relationship with patients
- New relationships with referring professionals
- Retraining staff and expanding job roles
- New methods for trust and communication
- Remove non-value adding time between referral and being seen
- Setting plans with patients
- Align payment & regulation
Together – for best possible health and equal care

Together – for best possible health and equal care
Perspective shift as a compass in the change

"Hälsa är att i glädje vara upptagen av sina livsuppgifter"  Gadamer, tysk filosof

Energi att leva livet
Tillsammans för bästa möjliga hälsa och jämlik vård

One size doesn’t fit all

Co-production - Patient contract

Mats Bojestig, Anette Nilsson
Vrigstad vårdcentral, filial Vrigstad

Förekomst av olika diagnoser

- Ångest
- Depression
- Diabetes
- Ischemisk infarkt
- Osteoporos
- Stroke/TIA
- Hjärtvikt
- Kol

Exempel Sävsjö vårdcentral, filial Vrigstad

Befolkning och segment

- Män
- Kvinnor

Öhönlse (antal dagar)

Utbildningslängd (%)

Åldersfördelning (%)

Examples of doing different - I choose myself based on situation!

Independent & Engaged
- Webbblad
- Självinspekt
- Läser i journal

Worried & Engaged
- Rådgivning
- Väntrumsvård
- Videomöte

Traditional & not worried
- Väntelista
- Reception
- Brev

Vulnerable & worried
- Uppringd
- Egen kontaktperson
- Ringer
Strategisk indelning

Vad är viktigt för dig & Kundsegmentering

Övergripande målsättning

Strategisk indelning

Malin
Sigge
Britt-Marie
Arne
Esther
Healthcafé
Create meetingpoints for people to support each other…

- Här ska personer med kroniska sjukdomar och deras närstående kunna mötas och bilda grupper som ger stöd och kunskap för att främja hälsa.
  - Hjärtats hus
  - Lev för att leva
  - Café hjärnkoll
  - Levande bibliotek
- 2017: utvärdering, utveckling av informationsstrategin och spridning av idéer till hela länet

Vårdmöten på nätet är bara början

- Slipp telefonkörer
- Välj tid
- Nytt meddelande
- Mina besök
- Min profil
- Logga ut
Together – for best possible health and equal care – from project to program

Challenges

Doctors or Nurses on demand or others?
Background.....

More and more needs care
We are going to bee older
We have more chronic diseases
We have moore knowledge about our health
We use new divesis
The environment develope faster and faster
(digital society)

Challenges.....

• How can we meet the citizen in the best way?
• How can we create the best meeting venues?
• How can we avoid unnecessary visits at the hospital?
• How can we avoid unnecessary hospital stays?
Some ideas........

• Meet where we are

A new option...........
A chance to choice

Doctor on demand – a pilotmodel

1. Trigger: SK on KM
2. Patient orders DSK
3. Patient visits VC
4. Patient gets advised virtually
5. Patient receives a text and a link
6. Patient contacts AN
7. Patient receives feedback

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2018-03-02

2018 02 25
För varje Vårdtjänst ingår en symtomguide i Min Doktor.

1. Urinvägsbesvär
2. Halsont
3. Hosta
4. Bihålebesvär
5. Ögoninflammation
6. Sömnstöning
7. Magbesvär – Övre
8. Magbesvär - Nedre
9. Hudbesvär
10. Födelsemärke
11. Huvudvärk
12. Mental ohälsa
13. Misstänkt Borrelia
14. Ryggsmärta
15. Ledbesvär
16. Övriga besvär
17. Erektionsproblem
18. Receptförnyelse
19. Ortopedi/Fysioterapi
20. Allergi (även astma)

Doctor on demand

• Homecare services a partnership together with the municipality
• Keywords – trust, security, support, decision
• Length of stay LOF
• Breakpoint call

(Microsystem festival)
2018 Jönings län
This is not the end, this is not even the beginning of the end, this is just perhaps the end of the beginning.

Winston Churchill

Care, Compassion, Confidentiality, Comfort & Customized!!

Homecare- Access for Healthcare services re-designed

Dr. Bishal Dhakal, MD
Founder/CEO
Nelson Mandela discharged from hospital, spends night at home

By The Associated Press

Former South African president Nelson Mandela, 94, was discharged from a hospital on Monday after being treated for pneumonia, the South African government said, adding that the ailing anti-apartheid leader remained in remission.

Mandela’s health has been of concern to South Africans since his return from 27 years in prison in 1994. He has been treated for diabetes, prostate disease and other ailments.

“His condition remains critical but stable and at times unstable,” said President Jacob Zuma in a statement.

Mandela has been treated in several hospitals over the past year and has received special care at his home, which is equipped with medical facilities.

His family and supporters have been under a strict media gag order, and the government has declined to provide updates on his condition.

Mandela was discharged from the hospital after receiving treatment for a lung infection and pneumonia.

Mandela has been a symbol of hope and resilience for many South Africans, and his legacy continues to inspire people around the world.

Still Critical, Mandela Ends Stay at Hospital

By The Associated Press

JOHANNESBURG — Nelson Mandela, the former president, was discharged from a hospital on Tuesday after spending six weeks there, the South African government said, adding that the ailing anti-apartheid leader remained in remission.

Mandela’s condition remains critical but stable and at times unstable,” said President Jacob Zuma in a statement.

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Testimonials

My god mother was diagnosed with abdomen cancer and after enquiring with a few people I was referred to Bishal Dhakal from health@home. Bishal’s company’s service and professionalism was great. Bishal was personally involved and would keep in touch with me monitoring regularly. I personally think that Health@Home is a great service for Nepal and thank Bishal for his initiative.

Mr. Gaurav Agrawal

Myths!!

- Homecare competes with conventional healthcare models!!
- Home care is inefficient service delivery models!!
- There is no protocol in Homecare!!
- Home care is equal to Nursing agency!!
- Home care is only for Geriatric patients and old age patients!!
- Homecare is only for rich and affording people!!
- Homecare is not needed in daily life!!
Homecare market scope theory !!

1. Pre hospital engagement
   A. Readmission reduction
   B. Containment of cost on travel, escort and companionship
   C. Outdoor visit and waiting time reduction

Post hospital engagement
   A. Rehabilitation
   B. Palliative and end of life care
   C. Chronic disease management
   D. Neurodegenerative disease management

During hospital engagement
   A. Nursing and Carer Placements

80% of human health care need can be served in Home environment

<table>
<thead>
<tr>
<th>Items/Service</th>
<th>Public Hospital ICU</th>
<th>Homecare</th>
<th>Comparison</th>
<th>Reduction</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed charge</td>
<td>5000 (24hrs)</td>
<td>2000</td>
<td>Carer provide one to one care round the clock</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>Doctor Visit</td>
<td>700+500+500 = 1700</td>
<td>1500</td>
<td></td>
<td>30-50%</td>
<td></td>
</tr>
<tr>
<td>Phlebotomy</td>
<td>1000+500</td>
<td>1000</td>
<td></td>
<td>30-50%</td>
<td></td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>1500 (500+500+500=1500)</td>
<td>800-1000</td>
<td></td>
<td>30-50%</td>
<td></td>
</tr>
</tbody>
</table>
Innovation in new market is possible (Nepal as an example)

Every country, community and citizens needs and deserves this model of service

Our achievements and organic expansion
What Services Do We Offer?

- General Nursing Care (Visit and placement)
- Caregiver training and placement
- Physiotherapy Visits
- Doctor Visits
- Lab Services (phlebotomy)
- Travel Support
- Appointment management
- Subscription or membership service (Expats, Travellers, Corporates, and Non Resident family care)

For hospitals:
- Decrease work load on human resources.
- Increase per patient care concentration or improvement on quality.
- Increase bed cycle and increase revenue
- Improve quality and care value
Steps of Health At Home Circa 2014
• New Web Tech Platform (Released in Beta)
• New Mobile Apps (Running Test)
• New Care platform (Digital Care Monitoring Ver 1.0)
• Cloud Based Software for care management (Test)

New DIGITAL Implementation

Providing home care for all!!

First health at home kid

Pregnancy care
• Complicated pregnancies
• Repeated cesarean section
• Caring neonatal babies with premature birth.
• Nuclear families with any such situations.
85 years old rimpoche/guru after 30 days of hospital stay!!

Brief history
• Was admitted in hospital with other issue.
• Was admitted in hospital without bedsore
• Was discharged with many big bedsore and critical situation.
• Was taken care at home and finally died in home in comfortable and quite environment.

Care and comfort optimization or customization.

Conventional solution

We offer almost for free!!
90 years old Sherpa lady with Cardiac failure treated at home!!

Cardiac failure management

- Was living in home in bedridden condition.
- Diagnosed with cardiac failure and liver congestion.
- Was managed with diuretics and close monitoring.
- Recovered in week time and now in independent lifestyle.

85 years old gentle man with respiratory failure, dependent living condition and 24 hr’s oxygen dependency!!
Case: Atrial fibrillation, Stroke-post craniotomy and evacuation of hematoma in comatose state!!

Critical care monitoring.

Parameters

- Oxygen level monitoring
- CVP monitoring
- Blood sugar monitoring
- Blood pressure monitoring
- ICP monitoring
- Pulse monitoring Dragger wi-fi enabled Afib monitoring

Diagnostics
For medical technologies (homecare is a new area of development)

HHPL can be independent model of healthcare service delivery in unique environment (home) complementing existing service and enhance healthcare reach and results.
Awarded best poster concept design in 2014 State Department Exchange Program
THANKS !!
www.healthathome.com.np
www.facebook.com/healthathome
+977-9818360166 (24/7/365)