



Faculty of Design

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Reevaluating the value of Primary Care using Design Thinking

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REEVALUATING

THE VALUE OF PRIMARY CARE USING DESIGN THINKING



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Primary Care in the United States
is at a **critical crossroads.**

The health care system is shifting from
Fee for Service to **Total Cost of Care**

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paid for sick care

paid for health

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paid for sick care

measured on volumes

paid for health

measured on outcomes and
patient experience

The health care system is shifting from **Fee for Service** to **Total Cost of Care**

paid for sick care

measured on volumes

difficult to bill for
non-physician services

paid for health

measured on outcomes and
patient experience

embraces team models

Moving from a system that was
never designed to one that is
more **thoughtful** presents us with
a **unique opportunity**.

The new system must:
attract and retain patients

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provide high value care

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provide high value care

have highly satisfying services

The new system must:

attract and retain patients

provide high value care

have highly satisfying services

better meet consumer needs

We must design to optimize:
coordinated care

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coordinated care

management of populations

We must design to optimize:

coordinated care

management of populations

management of chronic conditions

This shift is **not simple**.

We **can't** just **keep**
things as they are.

28% of patients could **list their medications**

37% could state the **purpose of their medication**

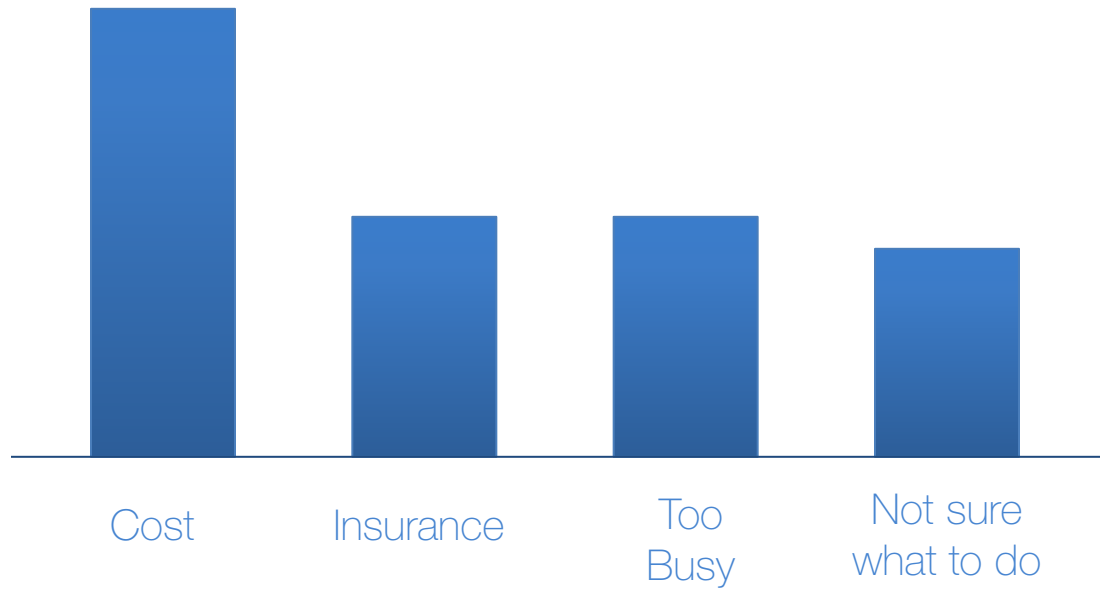
14% could state **common side effects**

42% could state their **diagnosis**

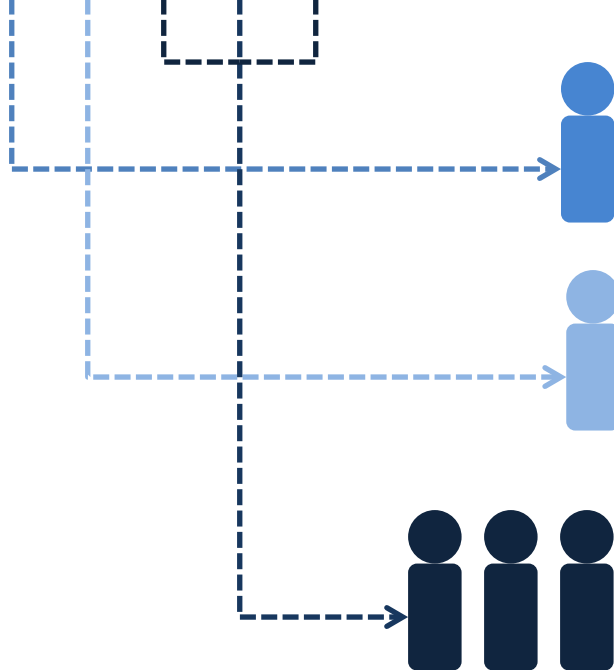
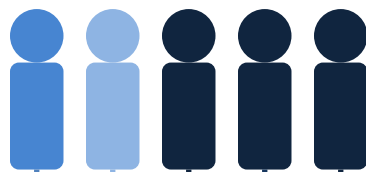
50% of all **prescriptions went unfilled**

50% of filled **prescriptions were taken improperly**

REASONS FOR NOT SEEKING CARE



Of every 5
patients seen
in the clinic
today



1 needs to see a
provider

1 could be served
with non-visit care

3 could be served
by a care team

The current healthcare system is in
the business of **doing things to
patients.**

(in fact, it overtly rewards providers for this)

The health care system cannot respond to the needs of the patient without **talking to them first.**

Consumers define health not as the
absence of disease but as the
**ability to function in their
daily lives.**

Consumers are looking for services that **support their health** rather than systems that rid them of disease.

We developed a system that helped patients get **what they needed, when they needed it, how they wanted it.**



CONVEYOR BELT CARE

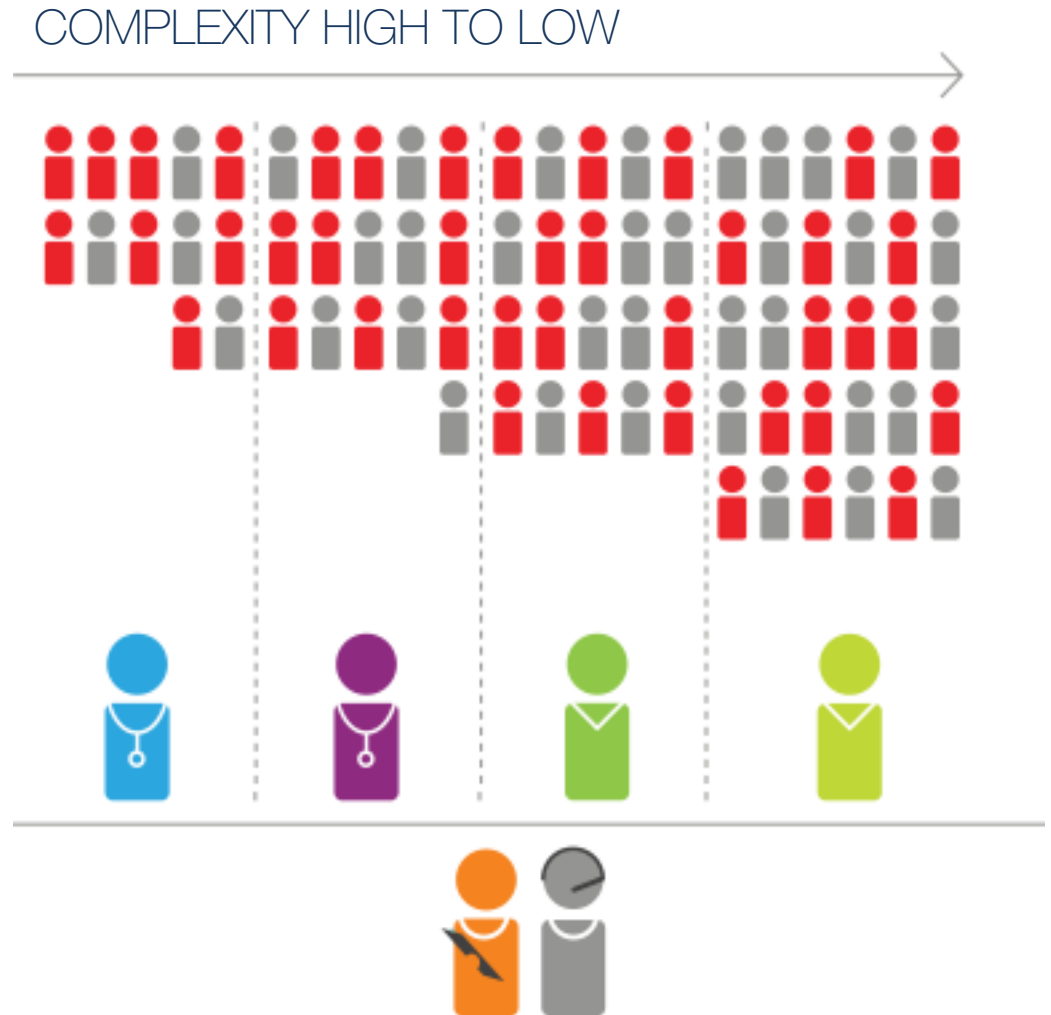


WRAP AROUND CARE



Sharing care responsibilities across the team means:

- Increasing nurse-only visits
- Improving the integration of allied staff members providing specialized services.
- Daily communication and coordination of patient care across the team.
- Increasing non-visit care options.



How is this Different from Previous Care Team Models?

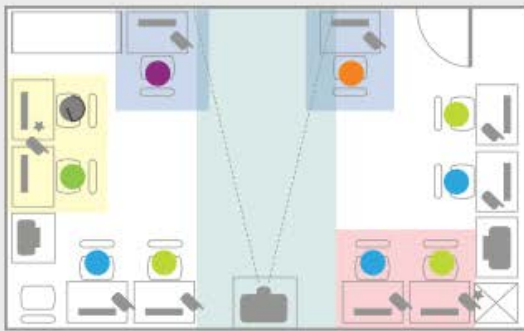
We are not simply emphasizing physician efficiency and maximizing individual physician productivity.

The Optimized Care Team:

- Establishes how each member of the team can add the most value to direct patient care.
- Emphasizes the delegation of care across disciplines.
- Diversifies the relationships patient's have with their clinic.
- Diversifies the access points patients have with their clinic.

7 weeks of experimentation

1300 patients seen



1. COLLOCATE IN A TEAM ROOM

A form titled "TEAM HUDDLES". It has sections for "PATIENT INFORMATION", "TEAM GOALS", and "TEAM MEMBERS". The form is designed to be filled out during team huddles to track patient care and team performance.



2. TEAM HUDDLES

A form titled "Visit Goals". It includes a section for "PATIENT INFORMATION" and a section for "VISIT GOALS". The form is designed to be filled out during patient visits to track goals and outcomes.

3. VISIT GOALS "HALF-SHEET"



4. NON-TRADITIONAL VISITS



5. WARM HAND-OFFS

BALDWIN TEAM MEASURES										
	1	2	3	4	5	6	7	8	9	10
1. Patient Visit to be by Working or On-call										
2. Patient Visit to be by Working or On-call										
3. Patient Visit to be by Working or On-call										
4. Patient Visit to be by Working or On-call										
5. Patient Visit to be by Working or On-call										
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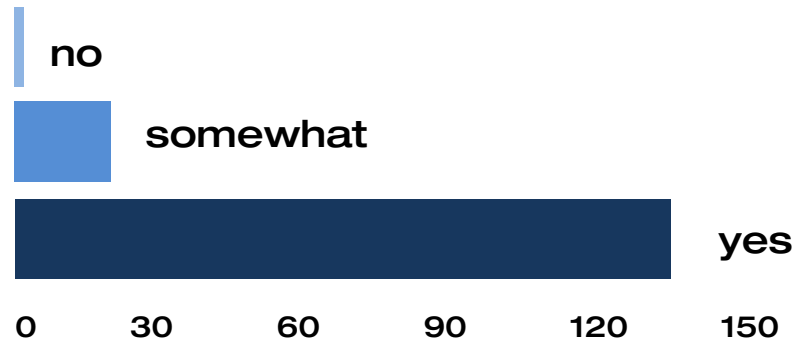
6. PROCESS MEASURES

“I’d rather come in for one very thorough 45min appointment where I see the whole team, than come back 3 times in 3 months.”

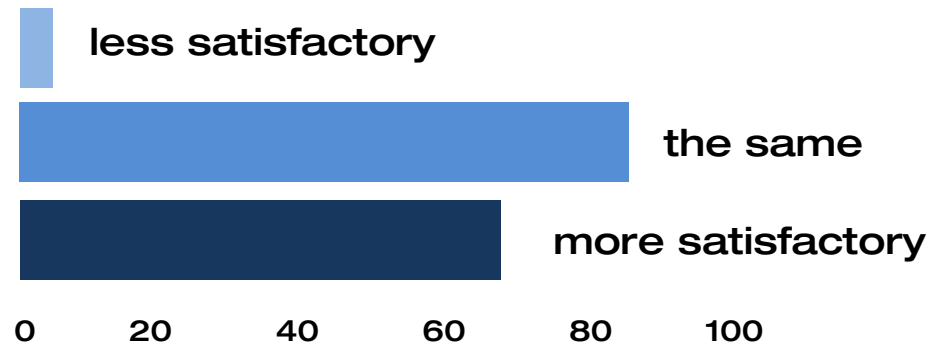
“Seeing the pharmacist was great. I pick up the meds for the family and I got to ask questions I otherwise would have forgotten.”

“I liked that everyone seemed to know about me.”

Did your care providers know your story and reason for visit?



Visit Satisfaction Comparison



Capacity Gained Actual Recorded vs. Potential



Utilization of Integrated Team

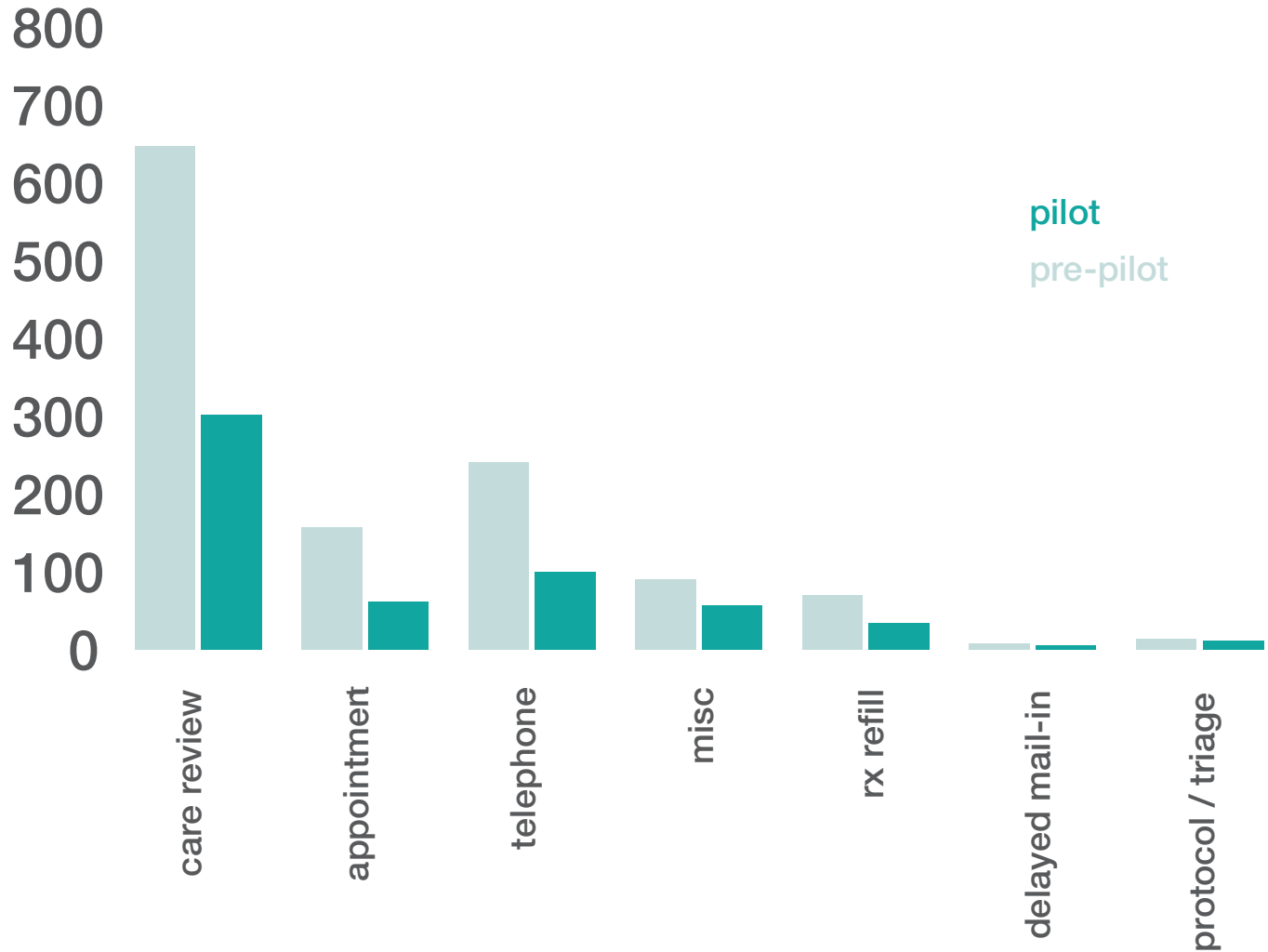


Nurse Visits



Non-Visit Care

Inbox Data: Pilot vs. Pre-pilot



It worked.

It worked.

Everyone agreed it was better.

It worked.

Everyone agreed it was better.

So why isn't it operationalized?

Culture

Physician Attitudes

Culture

Physician Attitudes

Allied Health Staff Confidence

Culture Tools

**Culture
Tools
Compensation**



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