RISE
Rapid-Improvement Support and Exchange

Redesigning care models through co-design
Snapshot of the webinar from 18 March, 2021

Click here to access the webinar recording

Core concept and principles

Step 2: Co-designing care models and service mix

Step 1: Segmenting for needs, risks and barriers

Step 3: Implementing and increasing reach

Step 4: Monitoring and evaluating

The four steps of population-health management (PHM)

Source: adapted from Population Health Alliance, 2012
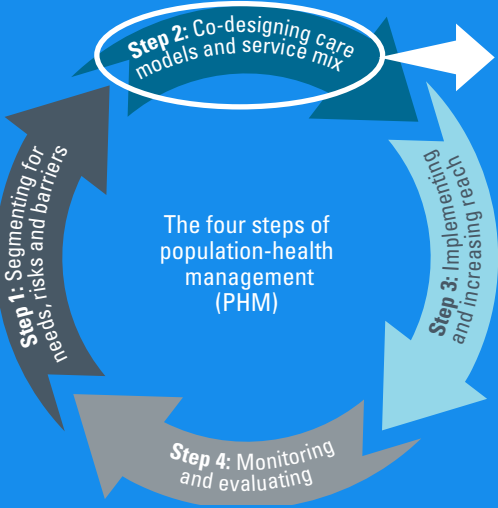
Consider five change components when designing care models:

- Delivery system redesign
- Clinical decision supports
- Information technology supports
- Self-management supports
- Community resources

Mental health providers · Primary care · EMS · Long-term care · Partners · Patients/Careivers · Home care · Specialty care · Acute care

Include **ALL** care partners including patients and caregivers

ALL redesign needs to

- apply an equity lens
- account for socioeconomic factors
- engage under-represented populations

Tools for engaging patients and caregivers in co-design

Virtual World Café: using interactive breakout sessions provide an opportunity to explore key questions, identify core components of care delivery models, and identify barriers and facilitators to implementation.
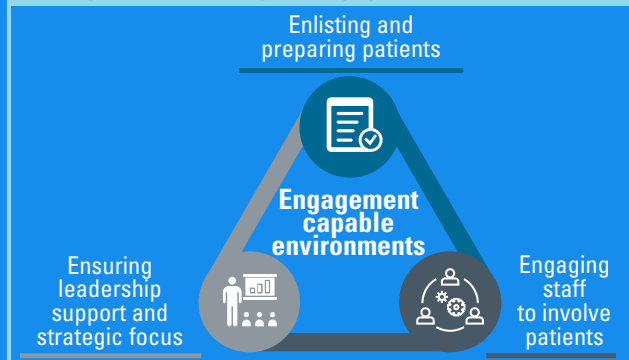
Click here for an example.

Vignettes: for each priority population, develop 2-3 "vignettes" to reflect a range of characteristics/needs; use them as a communication tool to spark conversation among your partners.
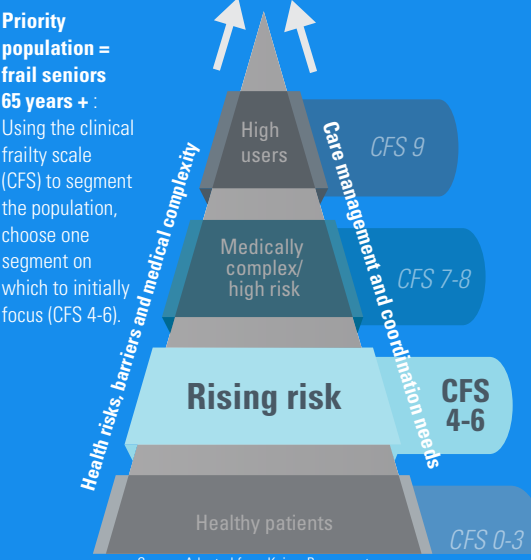
Click here for example one. Click here for example two.

This framework can be used as a checklist while you think about your engagement activities

Enlisting and preparing patients

Engagement capable environments

Ensuring leadership support and strategic focus

Engaging staff to involve patients

Hyperlinked source: Engagement Capable Environments Framework, Baker & Denis (2006)

An example of connecting the dots between segmentation and co-designing care models

Begin with one segment of a priority population → **Understand the segment** → **Characterize patient needs** → **Design care models/ programs/ pathways** → **Monitor care and outcomes**

Priority population = frail seniors 65 years + : Using the clinical frailty scale (CFS) to segment the population, choose one segment on which to initially focus (CFS 4-6).

Health risks, barriers and medical complexity

Care management and coordination needs

High users — CFS 9

Medically complex/ high risk — CFS 7-8

Rising risk — CFS 4-6

Healthy patients — CFS 0-3

Source: Adapted from Kaiser Permanente

Understand the segment

- If data are unavailable, co-design a case-finding process (i.e., identify and document all older adults CFS 4-6)
- Test and iterate a new process on a small scale (e.g., select providers with patient and caregiver input)

Characterize patient needs

- In a sub-set of the segment, create a registry of patients and engage with them to understand needs (e.g., complete geriatric assessment)
- Use quality tools to understand care gaps (e.g., fishbone diagram) and prioritize solutions (e.g., Pareto analysis)

Design care models/programs/pathways

- Co-design care models with partners (including patients) to meet needs
- Test and iterate new models and pathways

Monitor care and outcomes

- Link/share population health data (primary-hospital-home community) to monitor care quality and population health outcomes
- Monitor quadruple-aim metrics