Co-Production
A Global Collaborative

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#IHIFORUM
Session Objectives

- Paul Batalden, Paul Binfield, Dr. Navina Evans, Maggie Koch, and Andrea Werner today have no relevant financial or nonfinancial relationship(s) within the services described, reviewed, evaluated, or compared in this presentation.
Session Objectives

- Gather key insights about the benefit of co-producing healthcare.
- Understand how to apply the concepts of co-production in your organization.
- Learn different ways to gather lived experience and choosing measures.
- Developing ideas for strategic alignment to incorporate co-production into your organizational way of life.
- Make at least 1 connection with a participant in this session for future collaboration.
Old Question: What might we learn from those who regard never-ending improvement as an “enterprise-wide” effort?

New Question: How might we improve the value of the contribution that healthcare service makes to better health?
Making a service is fundamentally different from making goods, products. All service...at some level...is produced by professionals and those who receive the benefit.
Harvey Garn, et al; Elinor & Vincent Ostrom, others:

The coproduction of public services is an economical way of providing service, solving community challenges.
Goods
- cars
- furniture
- books
- clothing
- candy

Services
- teacher
- Doctors/Nurses

Math problems:
\[
\begin{align*}
5 + 9 &= 14 \\
8 + 5 &= 13
\end{align*}
\]
Community and society

Healthcare system

Co-execution

Co-planning

Civil discourse

Patients

Professionals

Co-produced high value healthcare service

Good health for all

M. Batalden, et al
A Healthcare Service

Relationship

Knowledge, skill
Habit, Vulnerability

Activity
Co-producing good services

System(s)

Co-execution (III)

Co-planning (II)

Civil discourse (I)

Patient/Client/TIFKAP

Professional

What might they do, contribute, invite, offer?

What might this mean?

What might they do, contribute, invite, offer?

What might systems do, contribute, invite, offer?
The interdependent work of users and professionals to design, create, develop, deliver, assess and improve the relationships and actions that contribute to the health of individuals and populations through mutual respect and partnership that notices and invites each participant’s unique strengths and expertise.
Situation

- Some suggestions that “co-production of healthcare service” offered opportunities for innovation and creative thinking, re-design.
- Diversity of settings interested.
- Realization that keeping “many different” avenues open might allow for more discovery.
- Questions were, “would ‘co-production’ help implement an organization’s strategy?” “what might leaders learn, do to help explore and discover how these various methods actually worked?”
Invited a Diverse Group of Settings

- A variety of geographic, healthcare system settings.
- A variety of populations, needs.
- All willing to learn with & from others.
- All settings might be called: “improvement adults”
Aim: Discover, explore ways of implementing system strategic plans in diverse settings by the redesign of service where professionals and patients meet, using a “coproduction” lens.
Our learning cycle:

1. Strategy
   - sr. leader short list
   - must do

2. Real work, real people, real connections
   - in/out locus
   - charter
   - front line/microsystem
   - people

3. Empathy w/ TIFKAPs
   - lived reality
   - assets
   - dx, rx burdens & mgmt
   - capabilities & interest
   - personae
   - anticipating enablers & barriers
   - pt/fam engagement
   - traumatic experiences

4. Current state assessment
   - “as is” process
   - process variability made visible
   - frequent failures noted
   - cycle times
   - descriptive data
   - internal scan
   - external scan
   - pt/fam engagement
   - modified patient journey mapping

5. Science-informed practice
   - literature-int/ext validity
   - local experience
   - measurement
   - illness/treatment burden
   - coproduction capability/possibility

6. Radical collaboration
   - relevant science, current state, & lived reality
   - shared aim
   - options/resources/value architecture
   - metrics of success/failure
   - pt/fam engagement

7. Science-informed rapid prototyping
   - service construction
   - testing
   - modification
   - pt/fam engagement

8. So what
   - stabilization/FMEA
   - generalizable lessons
   - pt/fam engagement

9. Now, then what
   - path for this dyad
   - implications
   - system value architecture/facilitation
   - improve context receptivity
   - technologic enablers
TIFKAP: aim, lived reality, social support, resources

As is system: journey, emotions, working/not-working

Science-informed practices: internal/external validity

Coproduced healthcare service

P. Batalden
Co-Production vs. Co-Design

What is the difference?
Co-Design and Co-Production

Co-Design. Process/service design implementation phase

Co-Production. Delivery of service/treatment

Co-Production. Evaluation and Monitoring
Co-Production Across the World

- Trauma Informed Care
- Workforce Diversification
- Community Building: Maternity and Pediatric Populations
- Mental health Peer Support
- Advance Care Promotion with Clinicians and Seriously Ill Patients
- Addiction/Opiate Use Disorder: Connecting People to Services
- Co-Producing Care of CHF Patients
- Reducing C-Section Rate
- Clinician Communication & Kindness
- Clinician Communication & Kindness
Voice of our Team

Jane Evans
Director, Quality Planning and Innovation, Corporate Services, Performance Excellence & Consumer Engagement
Eastern Health
Key Learnings from Co-Production

Paul Binfield
Maggie Koch
Capturing Lived Experience

- Variety of different methods to use
  - Background data
  - 1-on-1 Interview
  - Group Interview/ Focus Groups
  - Survey/ Questionnaire
  - Understanding Empathy v.s. Sympathy
  - Experience Mapping
  - Story Telling
  - Video Interviews

*Synthesizing Data – leading towards action
Empathy vs. Sympathy

**Empathy**

“I feel how you feel”

**Sympathy**

“I know how you feel”
Hi, my name is ____________.
I’m a patient here, and I’m helping the clinic on this project.

Thanks for taking some time to talk to me. This won’t take more than 10 minutes.
Let’s just go through your visit, and how things went for you.

Really important: this is anonymous, and I want to respect your privacy. So, please don’t tell me any personal information, or anything about your health - I don’t need to know anything like that.
Patients as the Interviewers

- In ELFT we have trained patients to carry out interviews and to gather feedback.
- They use tablets and surveys to gather more honest feedback.
- They carry out qualitative long form interviews on subjects such as the over-representation of BME males on mental health wards.
- Carry out research on the benefits of co-production for the patient (Academic paper).
Developing Measures

- Customer Satisfaction
- Reducing Readmissions
- Improving Quality
- Increasing Price

Better Quality of Life

Savings
Developing, Understanding and Sharing Measures

**Dialog** - quality of life measure (ELFT)  [https://dialog.elft.nhs.uk/](https://dialog.elft.nhs.uk/)

**GEM** - Collaborative database containing behavioral, social science, and other relevant scientific measures. [www.gem-beta.org/](http://www.gem-beta.org/)

**OHRI** - Hosts user manuals for measures developed for assessment of health care decision-making and evaluation of patient decision aids. [https://decisionaid.ohri.ca/eval](https://decisionaid.ohri.ca/eval)

**ICHOM** - Hosts Standard Sets for numerous conditions or health topics that list both consensus-derived outcomes and validated instruments for their measurement. [www.ichom.org](http://www.ichom.org)

**NQF** - Hosts a range of resources related to quality measurement, including the Quality Positioning System (QPS) searchable database of measures. [www.qualityforum.org](http://www.qualityforum.org)

**IPFCC** - Host a range of resources, tools, and checklists, including those for reflection and measurement of patient- and family-centeredness. [www.ipfcc.org/](http://www.ipfcc.org/)


**MUSC** - Provides lists of measures in a range of domains with information on reliability and validity and detailed notes on each. [http://academicdepartments.musc.edu/family_medicine/rcmar/](http://academicdepartments.musc.edu/family_medicine/rcmar/)
ELFT Case Study

ELFT- Mental Health Peer Support Workers

People with personal lived experience of mental health
Trained and recruited to support people receiving care and treatment
Provides a real link and the ability to share together.
Two Community MH teams have 4 each.
Now expanding into physical health- continence team etc
Over 30 posts across the trust.
MetroHealth Case Study: Empathy w/ Patients

Provider Assumptions
- Patients know how to navigate our system
- Patients will have a support system at home
- Knowing what the patients’ barriers are and what the solutions are
- Understanding of the patients’ goals

Patient Assumptions
- Providers know and understand their barriers
- Providers will tell them all that they will need to do and have to care for themselves when they go home
- Medications prescribed will make them better/fix their problem
MetroHealth Case Study: Empathy w/ Patients

Key Observations

- 50% of patients feel they were readmitted due to Shortness of Breath (SOB)
- 50% of patients did not know who is treating their heart failure
- Patients had differing perspectives regarding who they would reach out to if they had questions – e.g. PCP, Cardiology
- Patient goals are simple – they want to be able to care for themselves and do normal day to day tasks

Key Observations

- Patients generally receive all their care at MetroHealth
- Access to medications and resources were identified as key barriers to managing their health
- Inconsistent experience during the discharge process
What is limiting your efforts at co-production?

Take 5 minutes to discuss this with the person next to you
Senior Leadership Perspective

Dr. Navina Evans MBBS, DCH, MRCPsych
Chief Executive of East London NHS Foundation Trust

Andrea Werner, MSW
Senior Vice President
Bellin Health
“You have the right to be involved in discussion and decisions about your health and care, including your end of life care, and to be given information to enable you to do this. Where appropriate this right includes your family and carers.”

“You have the right to be involved, directly or through representatives in the planning of healthcare services, the development and consideration of proposals for changes in the way those services are provided and in decisions to be made affecting the operation of those services”
ELFT Philosophy

- A value based approach, grounded in a candid and robust dialogue with service users, carers and a wider community that results in improvement.
- It required a fundamental change throughout the organisation in how it perceives and therefore works with service users and carers as expert partners in their care – still working on this
- Has a focus on improvement
- A process that incorporates a whole range of activities
- Moving beyond the traditional Patient Experience to one of Participation (not just measuring how people feel about a service but how they can actively change it)
Some years ago, we in ELFT embarked on a journey of greater people participation. The rationale seems obvious; get service users to help you make them better. Simple, right?

In reality this has been more difficult to achieve than anticipated. There have been many barriers and concerns, e.g. issues of confidentiality, stress on the participants, fear of appearing tokenistic, governance issues, how to ensure ‘real’ representation, fear of reprisal.

Patients and carers also expressed additional concerns including lack of resources, lack of confidence and a fear of not being taken seriously, to name but a few. These shouldn’t stop us because with focused effort they can be overcome.

The benefits are definitely worth the effort.
MISSION
In partnership with the people of Northeast Wisconsin and the Upper Peninsula of Michigan, Bellin Health strives to improve the health and wellbeing of every person in our region while making healthcare quality, experience and cost the best in the nation.

VISION
People in our region will be their healthiest during every stage of their lives, and will be able to afford the services and products we provide.
Strategic Objectives

Objective 1: Optimal Customer Experience

Bellin Health creates and strengthens relationships to build loyalty with patients, customers and all members of our communities by seeking to understand what matters to them; *co-designing* services and products to meet their individual needs; and treating one another, patients and customers with the utmost dignity and respect in every encounter. Our services will be simple to navigate and our prices will be transparent.
High Performance Healthcare Model
Our Challenge to You

- What are the opportunities for shared learning?
- How might you bring together different groups to learn and address common challenges?
- Are there people in the room right now you can collaborate with?
Thank You

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