VIRTUAL AND PHYSICAL SPACE REINVENTION
— NEW CARE CENTERS OF THE FUTURE

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01 —

NECESSITY BECAME THE MOTHER OF INVENTION

IT IS ABUNDANTLY CLEAR THAT WE RELIED ON THE INCREDIBLE INGENUITY AND PRACTICAL THINKING OF OUR CAREGIVERS, LEADERS AND FACILITIES GROUPS.

Who would have ever predicted where we are today? We now think very differently about how we respond to change on so many levels, and no one is untouched by the recent healthcare crisis and the resulting impact on our daily lives.

Looking back, it is abundantly clear that we relied on the incredible ingenuity and practical thinking of our caregivers, leaders, and facilities groups to solve problems that demanded 24/7 innovation and attention to detail — just to operate and care for people.

And it could be argued that the need to protect patients and staff and adapt operational protocols and physical environment “on-the-fly” during COVID-19 has built a greater sense of confidence in experimentation in the health systems across the U.S. — more than we have ever seen before.

Unprecedented collaboration has helped us to solve problems in novel ways. We utilized the know-how of infectious disease doctors and other clinicians, environmental health planners, epidemiologists, academicians, health planners, facilities leaders, and the AEC professions to solve air flow and isolation challenges and provide just-in-time, safer environments for patients.

Some infection control and life safety solutions have been immensely practical; others have required some infrastructure investment to adapt quickly to crisis conditions. The reality is that providers have had to pivot quickly to protect workers and patients alike and reduce risk of infection. And a key lesson learned for all is that we can avoid shutdown of key services “next time” and be prepared.

VIRTUAL CARE AND TELEHEALTH ADOPTION HELPED MANAGE FLOW AND ISOLATION

Virtual care and telehealth engagement with patients ramped up considerably to manage access and direct patients to the care they needed in a time of crisis.

While we know that the jury is still out on the status and continuance of federal reimbursement for virtual care and telehealth, it appears that Reinvented Healthcare Encounters (RHEs, virtual or not) are part of the new norm. Data is being gathered quickly to document the effectiveness, case type, and volume of virtual care visits over the last few months and to rethink how patient encounters are being done generally in all settings as typical services ramp back up to Pre-COVID conditions.

We know that a growing element of care will continue to be delivered in virtual settings, with virtual technologies and monitoring devices supporting patient engagement and self-care management.

VIRTUAL CARE READINESS IS A REQUIREMENT FOR THE FUTURE.

LEVERAGING WHAT WE HAVE LEARNED

It has been said we need to treat patients where they are and not where we want them to be. Robust technology platforms will be essential to planning smart, flexible, and adaptive systems and locations of care in the future. The facility and operational implications of these simple, but predictive statements, are immense.

Now that necessity has spurred new thinking, the time is right to build on a new level of confidence and the best outcomes of the past few months to plan for future infectious disease events and care models to support them. While reactive planning worked this time because it had to, we do not want to suffer another similar onslaught without a proactive plan. New thinking is fundamental to preserving what has been learned.

While we may be somewhat smarter, there are still many unanswered questions and information that will continue to challenge us — daily and incessantly, as events related to the current pandemic unfold.

The time to plan is now. We need to bravely take some risks and leaps in thinking to imagine new ways to help, engage, and manage care to meet the needs of patients.

That said, it will be important to tackle the issues carefully to select from the magnitude of information and advice being offered.

WHILE REACTIVE PLANNING WORKED THIS TIME BECAUSE IT HAD TO, WE DO NOT WANT TO SUFFER ANOTHER SIMILAR ONSLAUGHT WITHOUT A PROACTIVE PLAN.

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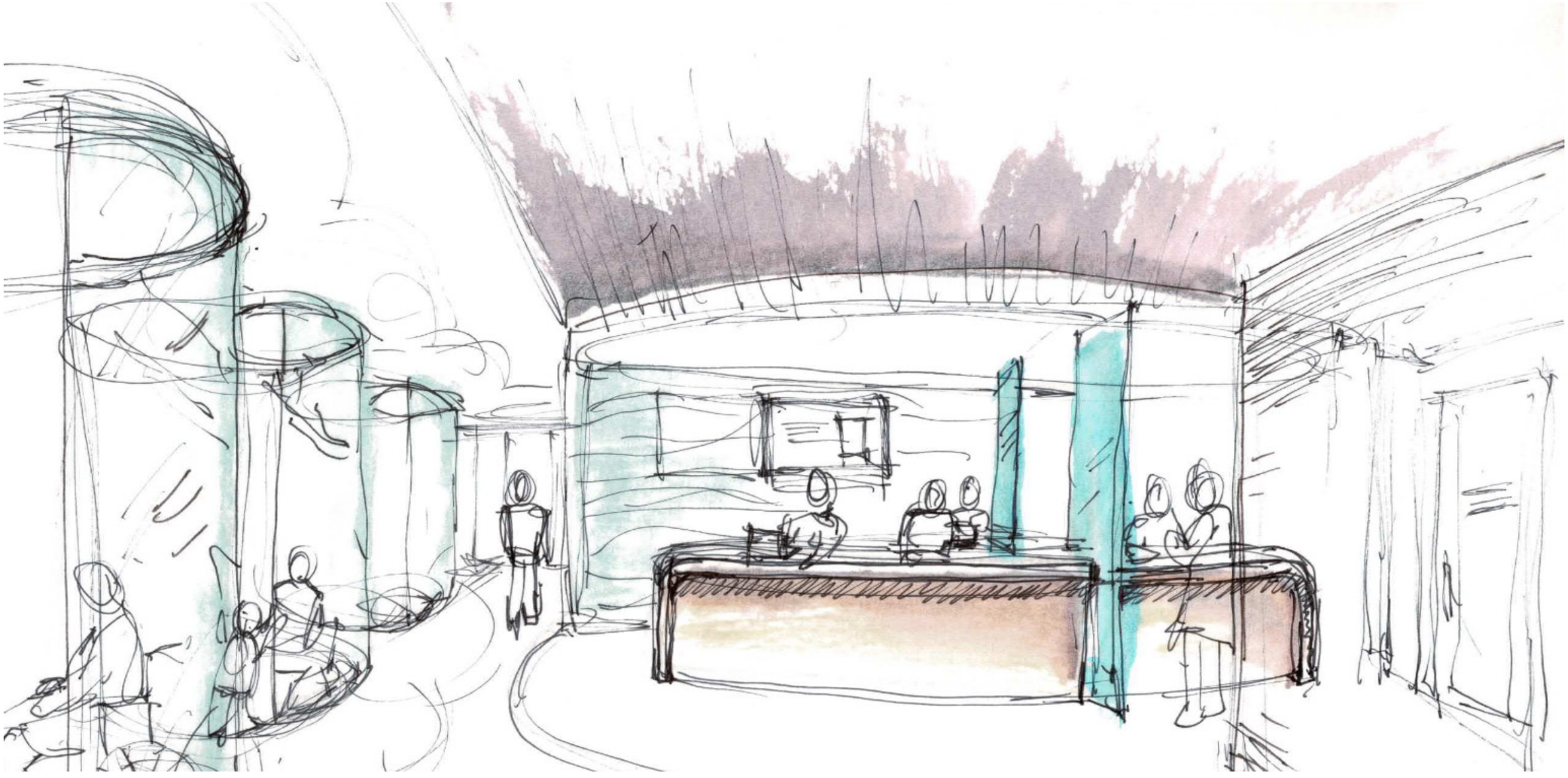
CARE CAMPUSES OF THE FUTURE—REIMAGINED:



RETHINKING HOW WE USE EXISTING SPACE — A UNIVERSAL CHALLENGE

How we rethink what we have done in the past, change behaviors, and convert existing physical space for new safety regimens is fundamentally challenging for all of us — whether we provide care or plan space for virtually any human interaction in the future. Planners are reviewing people and material flow, space capacity and density protocols, and air flow and infection control procedures for all buildings.

It is vitally important that future space plans are not only effective and forward-thinking, but cost-effective. And as plans unfold to support new safety regimens, it would be easy to start over, rather than reuse. It is vitally important that we do not leap to solutions that involve building new space. Instead we should be developing flexible, adaptable space conversion ideas that support changed behaviors and operational protocols.

On any campus, some buildings may be underutilized or best used by being converted to an alternate use. With a resource-constrained industry, we must provide ways to redo, convert, and make use of existing campuses and buildings.

In addition, the impact of work-at-home protocols will clearly impact square footage needs in the future. It is also likely that access points for health systems may change as existing building assets are redeployed post COVID.

WE SHOULD BE DEVELOPING FLEXIBLE, ADAPTABLE SPACE CONVERSION IDEAS THAT SUPPORT CHANGED BEHAVIORS AND OPERATIONAL PROTOCOLS.

QUESTION THE OLD ASSUMPTIONS

As we thought about the assumptions that are driving change, we challenged ourselves to question our current thinking about inpatient and outpatient campuses and how and where patients are currently treated:

- What patient care diagnostics can be done outside of a building in the future? And be completed before an actual in-person visit? Which encounters must be in-person?

- Are telehealth encounters and monitoring devices the new diagnostic tools that will reduce in-person visits?

- With remote monitoring and reliable devices for tracking vital signs before arrival, how is the entry and arrival protocol changed? How will we cohort/ segregate patients by type and severity on-site?

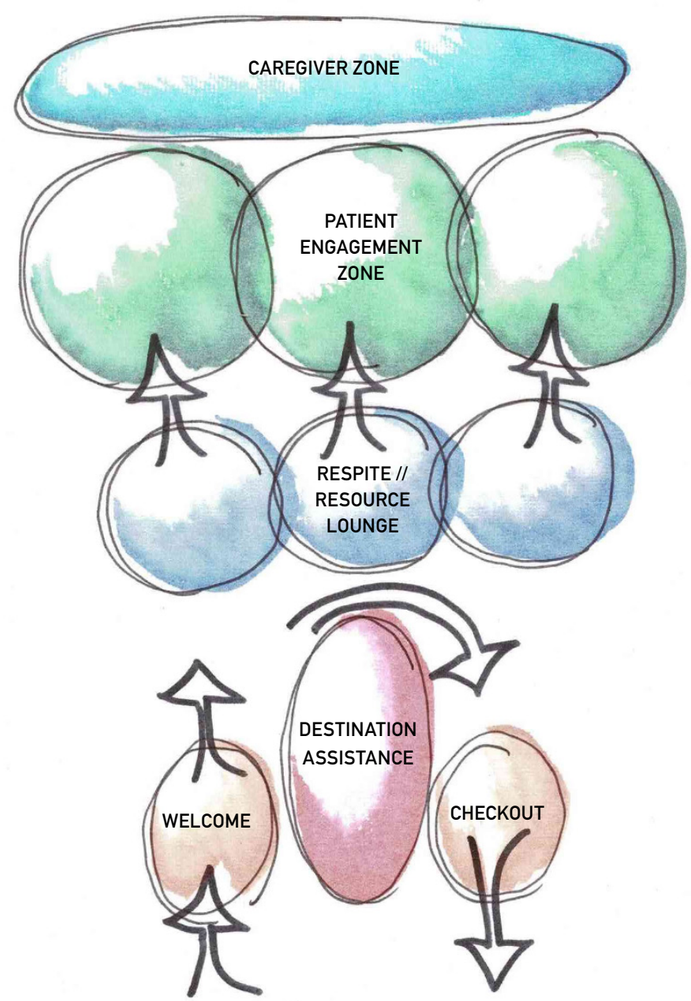
- Will protocols for the gold standard of face-to-face, physician-to-patient care encounters change with transition to telehealth visits? As more options for care encounters are tested, how will patients respond and have input?

- What services does the actual care environment need to serve and how is that affected by illness severity? Within inpatient and outpatient settings?

- How do we rethink how clinicians and providers use space? Where they need individual space? How they will collaborate through use of technology as a team and what physical environment supports their work?

- How will the technology and MEP infrastructure platform need to evolve for robust reliability and seamless interaction? For patients who use and access it? For providers who must be efficient and still feel close to their patients?

- How can spaces be flexible to overnight changes? What will be the different flows or protocols for the new normal versus another pandemic crisis? How can we keep medical facilities operational?



While there are many questions yet unresolved, there are some basic assumptions, or guiding principles, that could be applied to plans for Care Centers of the Future:

- New density norms are here to stay
- Reinvented healthcare encounters (RHES) are the foundation for all planning
- Convertible physical space is a must
- Robust technology platforms are essential
- Systems must find ways to minimize investment
- Acuity-specific sites may require new strategies and master plans
- Campus re-occupancy plans for campus-based and remote workers will influence future space use and space needs for hospitals and systems
- New disruptions to the care landscape are a given

PUBLIC HEALTH AWARENESS AND EXPECTATIONS HAVE SHIFTED.

OUR EYE IS ON CHANGE, AND THE OPPORTUNITIES IT OFFERS TO ALL

The assumptions and guiding principles provided a foundation for our team to think about space planning without being burdened by preconceived notions about what works and what does not. Or by believing that operational protocols will only shift over time.

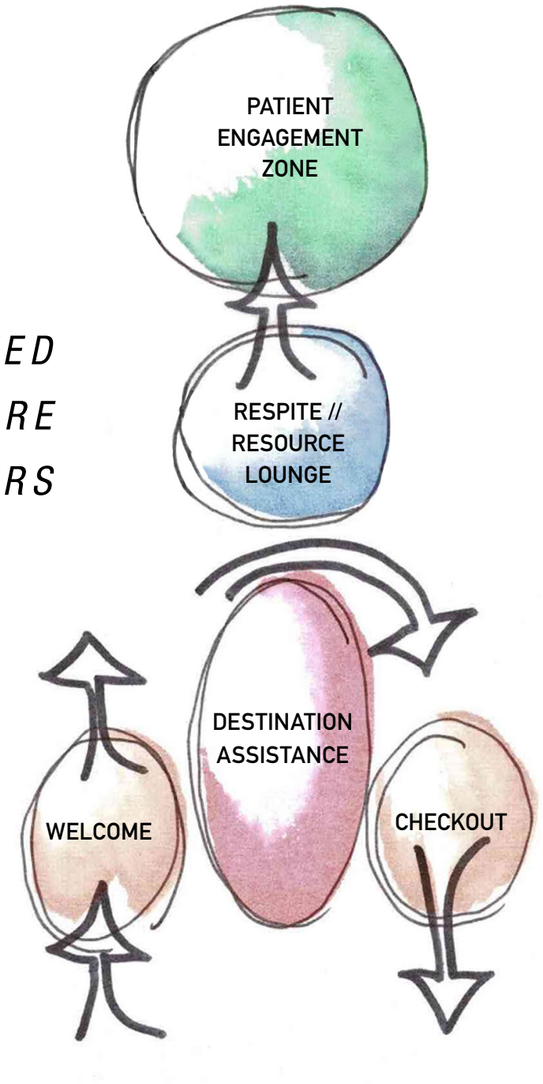
By assuming that some components of recent trial and error and temporary solutions to Reinvented Care Encounters would stick, we envisioned new types of engagement and experiences. We did not dive too deeply into the technical planning or try to answer all the practical questions. There are many trying to do just that, and sorting that detail will keep us all occupied for a long time.

The images and illustrations throughout this paper offer a glimpse into the future of what these spaces may look like and how they may support the needs of caregivers and patients. Our eye is on change and the opportunities it offers to all. Below are some ideas for how existing spaces may change or be planned differently.

- Interchangeable rooms and units of space that can quickly be converted for isolation or reuse
- Cohorted waiting — children, seniors, families, symptomatic, and asymptomatic
- Patient engagement and respite rooms that are sized for multiple uses
- Changed encounter protocols — diagnostic testing, telehealth visits, and consult types

- Technology and other education for seniors and select cohorts of patients at dedicated sites
- New space prototypes, modular, and prefab units that can be pre-stocked or pre-built with built-in isolation separations
- Group education for virtual visits and for chronic disease check-ins
- Home-space “devices” that support an interaction with a remote, virtual caregiver
- Video consult spaces: providers working alone, providers collaborating in one space, virtual patient engagement spaces, and comfortable viewing rooms for virtual group patient encounters
- Pre-fab observation areas where patients can be observed, treated, and released
- Routine and specialty diagnostics spaces

REINVENTED HEALTHCARE ENCOUNTERS



Caregiver offices, staff work areas and support / "Free-use"- convertible rooms / Telehealth triage / Clinical Exam rooms / Virtual Consult rooms / Cohorted Diagnostic and Testing spaces / Cohorted Waiting areas / Patient Education / Technology training / Check-in / Initial Patient evaluation / Checkout

IN A TIME OF UNPRECEDENTED CHANGE, MANY EXPERTS ARE RETHINKING HOW CARE WILL BE DELIVERED AND WHERE IT MAY HAPPEN.

Our mission for this article was to try to look beyond the moment and all the chaos. In a time of unprecedented change, many experts are rethinking how care will be delivered and where it may happen. Most agree there will be fundamental differences in care protocols as we plan for the next wave of infection and employ methods to avoid future shutdown of key services. And because we had to react so quickly there is debate about which new operational protocols will stay with us and what may be left behind. But lack of answers should not paralyze our thinking and planning to prepare with a forward view.

For those of us who have interacted with providers in non-COVID encounters, many changes implemented recently are already becoming standard. ***The notion of "Reinvented Healthcare Encounters" offers a practical baseline for rethinking how space can support new types of interactions and care standards in all settings.***

In the meantime, let's work hard to preserve, evaluate, and document "new care delivery" norms, so that facility planners can be a partner with providers as a new future unfolds.

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