PIP-OP

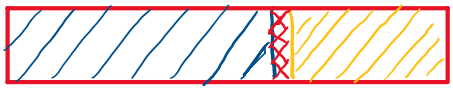
Tuesday, 11 August 2020 22.13

Pre- intra- and post-op

Surgery is identified with the surgical operation itself, but up to 99% of the surgical process is pre- and post-operative: Preparation and follow-up.
Preparation for surgery and follow-up thereafter are typically done by the same organization as does the surgery itself, but this isn't always the case, nor should it: An unknown amount of non-surgical time is realized as surgical costs, due to time and effort by surgery specialists and other physicians.

Surgical clinics tend to be rare, and therefore provide care for a wider community than the catchment area or the overall hospital organization that the surgical unit is embedded into.
The more intense or involved the surgical specialty, the fewer the number of units in a given area.

We visualize this Pre- intra- and post-operative time investment as the PIP Bar, or PIP:



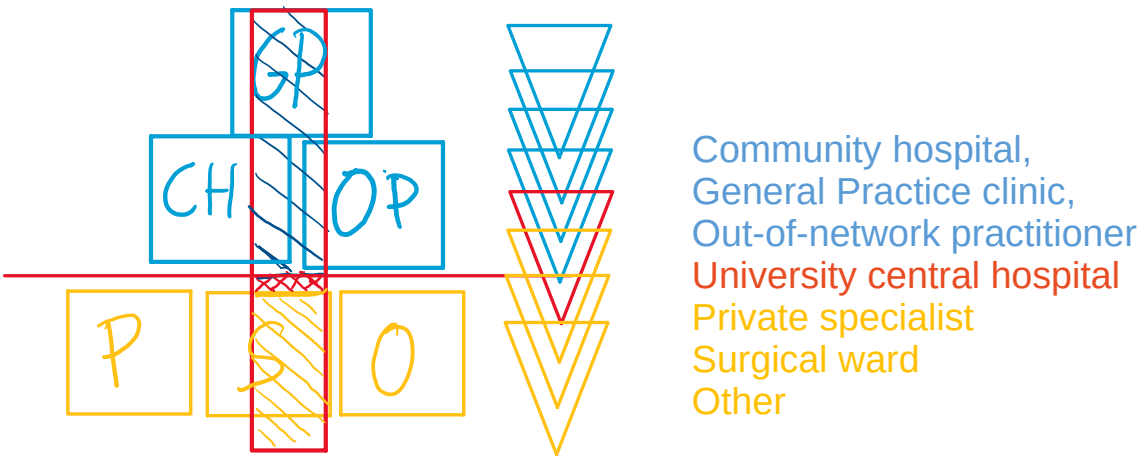
The blue hatched area is the preoperative, the small red slice is the intraoperative and the yellow hatched area is the postoperative part of the whole surgical process.

We do this chiefly for two reasons:

1. It illustrates how small the actual surgical footprint actually is in the overall surgical process.
2. As a 2-D construct it helps us visualize how a longer or shorter PIP requires inter-disciplinary and cross-organizational cooperation.

As patients move from one system or organization to another, their medical information is expected to flow as well. We call this a need for "inter-operability" or "interoperability"

As a general overview, it might look like this:



The Bar in this case shows that for any particular surgical procedure in a given area, a patient first sees a GP, who sends the patient to a specialist in a local intermediate hospital or directly to a tertiary surgical hospital where the diagnostic tests and investigations are done to confirm a diagnosis. Depending on the operation it is then done at either facility. After that, follow up can be done also at the same hospitals.

This means that since the ON is a part of the hospital housing the surgical unit, interoperability benefits and market share can be gained by the ON being used also by the local general practitioner GP, intermediate hospital specialists IH as well as the surgical hospital SH. As the partners do not themselves perform surgery, the version of Onesys Navigator can also be a less expensive and more streamlined variant.

What makes this approach different?
Apart from our novel approach, no one else sees these "non-surgical" partners as part of the overall process - not to mention inter-organizational discrete cooperation: When a physician sends a patient to a specialist, there exist **no structured information channels - these events occur tens of thousands or hundreds of thousands of times per year in a medium-sized organization, often multiple times per patient.**

The information must flow.