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The Esther approach to healthcare in Sweden: A business case for radical improvement

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Organisation: Director of the Esther Network

Country:

Level of government: Local government

Sector: Health

Type: Organisational Design, Public Service

Launched in: 2011

Overall development time: 1 year(s)

Link to the innovation's website

Description

The County of Jönköping in Southern Sweden with a population of about 330,000 transformed its healthcare system after patient experiences that made it very obvious that the health care system was built to fulfill its own needs rather than the patients. In the late 1990's, a more patient-focused approach to health care was introduced. Using the 'Esther approach', a shift was made from a traditional service provider-focused approach to one centered on the pathway of patients to health care.

Why the innovation was developed

- Esther lived alone and one morning developed breathing difficulties. After seeking advice from her daughter, who did not know what to do, Esther sought medical advice, was then seen by a district nurse and told to visit her GP. The GP said she needed to go to hospital and called an ambulance. After being admitted to emergency care she retold her story to a variety of clinicians at the hospital during a five and a half hour wait. In fact from first seeing the district nurse, Esther saw a total of 36 different people and had to re-explain her story at every point – which was made all the more troublesome by her breathing problem.
- This process caused Esther to become confused (which could, in a worst case scenario, have resulted in her being mis-diagnosed with dementia). After her long wait, a doctor finally admitted her to a hospital ward and treatment began.
- In light of this story, ‘Esther’ has become the generic name and character used to establish the Esther Network to help focus clinical and social care on the needs, expectations, priorities and fears of people entering the care system. An ‘Esther’ is usually described as an elderly woman (or man!) with one or more chronic conditions, who requires care from a variety of providers.

Objectives

Develop staff capacity, Improve effectiveness, Improve service quality, Improve social equity, Improve user satisfaction

- The key objective of this new approach was to create a network that would help patients feel confident, independent and secure by ensuring that they receive care in or close to home;
- Know where and who to turn to for care;
- See the healthcare system as an entity working together to provide their care;
- Have access to quality care across the whole region.

Main beneficiaries

Elderly people, General population

- Health care patients and the residents of Jönköping.
- Local health care service providers.

Results

Service quality

Responsiveness:

- The Esther Network for re-designing patient care has been crucial in delivering improved patients outcomes, whilst delivering resource savings. The success of the project became obvious very early.
- A total system wide redesign took place, from 2000-2001 onwards to focus energy and funds on caring for the patient at home. This resulted in a 20% reduction in hospital admissions. In 2003, the Esther Network won the ‘GotaPriset, Swedish national award for quality improvement.
- This project exhibited outcomes such as: Hospital admissions fell from approximately 9,300 in 1998 to an estimated 7,300 in 2003; Hospital days for heart failure patients decreased from approximately 3,500 in 1998 to 2,500 in 2000; waiting times for referral appointments with neurologists decreased from 85 days in 2000 to 14 days in 2003; waiting times for referral appointments with gastroenterologists fell from 48 days in 2000 to 14 days in 2003; the number of unnecessary days in hospital decreased from 1113 in 1999 to 62 in 2011.
- Unnecessary days in hospital: the measurement here is the amount of days the patient remains still in hospital although they no longer have a medical need for specialist care. This can occur for example if the homecare service or primary care does not have the capacity to look after the patient at home.

Development

Design

The Esther Network was initiated by the Chief Executive of the Medical Department in Eksjö, Mr. M. Bojestig, in 1997. It was triggered as a result of the experience of an elderly woman patient called Esther with the healthcare system.

Looking at the Esther experience from a patient perspective shows that limited value was created from Esther's interactions before and during her admission to hospital - in spite of the best efforts of healthcare professionals.

The episode highlighted significant wastage in the healthcare system because the links in the care-giving chain didn't fit smoothly together. Furthermore, Esther's lack of knowledge of what to do and who to contact when faced with her health issues created a delay in her treatment and added to the workload of the nurses that could have been prevented.

Following this event between 1997 and 1999, an analysis of patients' care journeys was undertaken to identify redundancies and gaps in the current system, and to develop an action plan to reshape the system.

Implementation

Tools used:

- The process consisted of over 60 interviews and several workshops with patients, staff, and government officials.
- A 'patient charter' was developed, establishing a new vision of the relationship between professionals and patients which developed in the Esther Network.
- A direct telephone line for complaints, whereby patients can talk with a person who will write down the complaint and give feedback to the involved partners.
- 'Quality time for Esther' sessions were introduced. This is personal time, usually a half hour period each week, in a social care environment that the patient uses to focus on activities which they prioritise themselves (often with nursing assistsance).
- Evaluations at every interaction between patients and healthcare professionals began to remove unnecessary contact points and improve efficiency.
- Organisations within the network improved telephone and email routines to create a speedy and seamless process.
- Staff and patient feedback have also resulted in the design of more effective prescription and medication systems. Medicine lists now follow patients through the chain of care.
- The speed of passing on information has increased through the creation of targets for transmission.
- A 'Virtual Competence Centre' has been created to enable the transfer of knowledge and improvement in the capabilities of practitioners involved in the care chain.
- Also, in 2006 the network established 'Esther Coaches' to embed the new approach throughout the network and promote continuous quality improvement.

Resources used:

- Today there is a small budget for the Esther organisation. Only 70 % is paid as coordinator function - all others involved in Esther accommodate this as part of their normal work.
- For activities like coach education, spread and new improvement projects the budget in 2015 was GBP 75 000.
- It is the continuous improvement work by staff at the front-line who create the results.
- The Esther Network also involves patients in improvement work and they get some flowers or other compensation 'in kind' but no other form of compensation.
- The budget is a problem, the Esther program gets some funding now and then but meetings and improvement work has to be a natural part of the daily work.

Lessons Learned

Lessons Learned

- Start by getting some patients and key actors from across the whole care chain in the same room to talk about improvements.
- Follow a patient story through the whole chain to get the same picture from different perspectives. From this, identify the key processes that are common to every patient journey. For example: The discharge process with an individual care plan and recommendations for further care.
- Use simple questions: What’s best for Esther? Who has to cooperate to make this happen?
- Train and trust your patient and the frontline staff to start small improvement projects.
- There must be space in the schedule to attend Esther meetings.
- Coaches can make a difference, find a way to engage doctors, and find a way to bring in stable funding over time.