

Empowering patients to need less care and do better in Highland Hospital, South Sweden

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Organisation: Highland District County Hospital, Eksjö, Sweden

Country:

Level of government: Local government

Sector: Health

Type: Organisational Design, Public Service

Launched in: 2001

Overall development time: 1 year(s)

Link to the innovation's website

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Description

In 2001, the unit of gastroenterology in the Highland Hospital in Eksjö (in the South-Swedish Highland with 115,000 inhabitants) had long waiting lists and therefore decided to redesign the care process. The unit looked carefully at the values fundamental to its work and came up with a set of innovative approaches to involve patients more intensively in their own care.

Why the innovation was developed

- We knew that the problems were deep-set in the system – indeed staff were just as frustrated as patients themselves, who were understandably dissatisfied at having to wait for treatment.
 - Moreover, making patients wait probably had adverse effects on their health, sometimes resulting in deterioration of their condition and causing worse flare-ups and longer hospital stays than would have occurred if care could be delivered at the proper time. Also patients experienced insecurity and uncertainty, further diminishing their quality of life and health experience.
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Objectives

Develop staff capacity, Improve effectiveness, Improve efficiency, Improve service quality, Improve user satisfaction

- The transformation process in the ward was triggered by the desire to empower and enable patients to be in control of their own lives and health.
 - The objectives were to diminish waste and to define which efforts created real value to the patients/customers/users, in the expectation that it would be possible to produce high quality care, with better outcomes, and with less effort.
 - In addition, there was a desire to cut waiting lists through providing more appropriate and cost-effective medical treatment.
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Main beneficiaries

Elderly people, General population, Government staff

- Patients
- Hospital

Results

Efficiency

- Availability: Referrals are registered in a computerised system and the number of patients coming for revisits in the ward is recorded manually – all data is presented once a week at the clinic review meeting.
 - The goal is to have no waiting lists for re-visits, less than 14 days waiting time for referral patients, less than 3 days waiting time for urgent visits and immediate availability for all phone contacts. In practice, there is now no waiting list for planned revisits nor for urgent visits.
 - Telephone availability is good – 93% of incoming calls are answered within 3 minutes. For referral visits, the average waiting time for nonprioritised referrals in 2006 was 23.5 days. (The first 7 days is taken up in handling the referral, before it is passed to the clinic, so the actual time taken from when the referral is made to the clinic until the patient actually visits us is only 16.7 days on average).
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Effectiveness

- Health condition: The patients self-assess their health on the Short Health Scale form, reflecting four aspects of their health - symptom burden, function, experience of anxiety and general condition.
 - Positive results are reported by the following proportions of our patients: symptom burden: 98% for ulcerative colitis, 96% for Crohns disease. Functionality in daily life: 96% for ulcerative colitis, 86% for Crohns disease. Anxiety: 94% for ulcerative colitis, 90% for Crohns disease. General health condition: 95% for ulcerative colitis, 95% for Crohns disease.
 - Medical quality: We have used as an important medical target that 95% of the patients should have a Hb > 120 – this has been achieved for 97% of patients with ulcerative colitis and for 94% of patients with Crohns disease. We know that the use of haemoglobin levels as a quality indicator is not widely accepted ; however, we know from several studies that anaemia frequently follows on from IBD – indeed, in some studies 30% of patients are anaemic. The number of patients with anaemia should therefore be an indicator of the unit's ability to discover and treat anaemia, so that being able to keep this number low is probably an indicator of quality.
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Service quality

Accessibility:

- Overall, the outcomes can be summarised as better access to information and treatment for all patients, high quality care for those patients in need of immediate treatment, lower morbidity for patients with flare-ups in their disease, satisfied and secure patients and satisfied staff, and lower use of health care system resources.
 - In many ways, these outcomes were unplanned – the original intentions were essentially to treat patients more in line with our values and give them a greater role in their care, while also reducing the waiting lists. We believed that we could achieve these things while maintaining the quality of patients' care.
 - In practice, quality has improved considerably, a much better result than we expected. Moreover, we have seen a substantial improvement in adherence to recommended drug regimes: 68% of patients with total ulcerative colitis have taken out from the pharmacy more than 70% of their prescribed dose, and for left-sided colitis the figure is 58%. These rates of adherence are considerably higher than those found in other investigations, where the adherence rates are as low as 30–50%.
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User satisfaction

- Satisfaction: Patient and staff satisfaction are measured by questionnaire. Both groups have reported high levels of satisfaction with the redesigned care system.
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Other improvements

- Adherence to drug treatment: Available international studies show that adherence to recommended treatment with 5-ASA-preparations (an important maintenance treatment) is as low as 30 – 50%. Our records show 68% of patients with total ulcerative colitis have taken out from the pharmacy more than 70% of their prescribed dose, and for left-sided colitis the figure is 58%.
- Medical: The number of hospitalisations of patients with inflammatory bowel disease decreased 48% during the period 1998 – 2005, compared to the nationwide decrease of 4% reported by the National Board of Health. The number of unscheduled visits of patients with flare-ups in their condition decreased from two a day in 2001 to two a week in 2005, mainly, we believe, because patients are taking more responsibility for their own care and therefore are contacting us much earlier when there is a flare-up in their condition, before they become really ill.

Development

Design

Given the waiting lists in 2001, we decided to undertake a fundamental review of the values behind the relations between our patients and the healthcare system. In particular, we analysed our service from a patient perspective. This analysis suggested to us that we needed to redefine the roles of the patients to give them greater personal responsibility for their health. As we redesigned the unit, we also had to find a way to monitor quality, as it was unacceptable to both patients and the hospital that quality should deteriorate and we realised that a shift in attitudes like this (which can be characterised as a paradigm shift) would be criticised. It was essential to us to prove that quality was at least preserved and hopefully improved.

Testing

- In order to ensure that this approach to treatment did not decrease the quality of care, an extensive performance measurement system was used, covering the medical results, the patients' health and illness experiences, waiting times for referral visits and waiting time for endoscopic procedures. T
 - hese involved questionnaire investigations of the patients' experience of care (both at home and as in-patients), and, in order to monitor medical results, use of our computerised medical register of diagnoses, simple biochemical markers and patients' experience of health. We also did one-off investigations, e.g. analysis of our pharmacy records to assess patients' adherence to recommended drug treatment.
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Implementation

Tools used:

- We decided that this had to be changed - we had to create a setting where the team and the patients are partners and where the patients are responsible for their own health.
- This view actually has a deep impact on the way we are working, as the care team has to negotiate with the patients instead of 'ruling' over them. So we designed a team where all participants, including the patient, would be involved, using their individual competences.
- We wanted each participant to feel in charge of at least part of the process. The patient is actually in the middle of two teams – the 'community team', made up of their family and friends and support system, and the 'medical team', the staff here in the hospital.
- The hospital team's role is to support the patient in his/her "real" team, where the patient expects to be a well functioning individual, with full control over their life.

Resources used:

- The key determinant of the costs of the unit is the size of the ward – the number of beds for in-patients. In the years after 2000, it seemed likely that the increasing number of in-patients would mean that the ward would have to be increased substantially in size.
 - However, this new way of working has made that unnecessary. In fact, the number of hospitalisations of patients with inflammatory bowel disease decreased 48% during the period 1998 – 2005. In consequence, the unit has been able to remain within budget since that time.
 - Not only have we saved the costs of expanding the ward but we have been able to devote far more of our staff time to helping those patients with chronic but non-acute conditions, so that their quality of life is substantially improved and their risk of flare-ups of the condition are reduced.
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Challenges and solutions

- The first thing we realised in the analysis was that it was essential to change the patient monitoring system. We therefore redesigned the unit to set up a team-based healthcare delivery system in which all participants, including our patients, put their individual competencies to use in a proper way.
- We were aware that many of the annual visits were of little use – at scheduled visits, we often found patients had no obvious health problems. These visits took up a great deal of our time on the ward, did not create any real value to the patients and, of course, were stressful and disruptive to the patients. Consequently, we moved to offering the group of patients with a stable condition (excluding patients on heavy medication, those with learning difficulties and those (few) patients who wanted to meet the clinician) an annual phone contact with a nurse and the opportunity to contact the surgery whenever they felt they wanted to discuss their condition.
- A further change we made was in the way we worked with in-patients. We realised that we seemed to apply a different set of values in the ways we treated in-patients compared to out-patients. We now invite each patient to come to our team room for a planning meeting, where we can put up the relevant charts, X-rays, etc. relevant to their case.
- We also realized that we were holding daily discussions on cases where it really wasn't appropriate – e.g. where there was an ongoing course of treatment with no sign of any problems. To monitor the patient's progress more appropriately, we started to use a "process control chart" – a white board with coloured magnetic dots, indicating where patients were in the treatment process and where it would be appropriate to have a planning meeting.

Lessons Learned

Lessons Learned

- What has made the project particularly successful is the fact that we have been able to improve care both from the perspectives of the patients and from that of the staff – indeed, all involved have been winners.
- Ensuring that this is the case has meant continuous monitoring of how the system is working. Every week, staff meet to plan the schedule for the coming weeks and to sort out any problems identified – this ensures that all staff are involved on a regular, systematic fashion, assuring the process and demonstrating their commitment to the philosophy underpinning it.
- Basically what we did was to change the way we delivered healthcare to a model which is consistent with our views on how anyone should behave toward a fellow human being. To avoid “dropping back” to the traditional repressive way of behaving, we had to discuss and agree the basic values we believed in amongst the staff. We also had to discuss with our patients how we wanted to change the “rules of engagement” – although, in practice, this proved to be a minor problem, as it turned out that they were very keen to work with us in this way.
- The most important lesson to us, in the end, was that patients do not cause the healthcare system to «overflow», when they are put in charge. On the contrary, patients are rational people, so they don't seek health care when their needs have been met. Basically, they use the system responsibly to improve their own health, and in so doing they decrease the unnecessary calls on the time of physicians and nurses. Actually, the results seem to be better when the patients are in charge than when we in the healthcare system try to force patients to do what we think they should.

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