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THE ESTHER MODEL: SWEDEN

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INTRODUCTION AND OBJECTIVES

The County of Jönköping in Southern Sweden with a population of about 330,000 transformed its healthcare system to respond to the bad experience of an elderly patient in the late 1990s and introduced a patient-focused approach to health care. […] 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.

This required the healthcare system to commit to the following principles of quality management (Vackerberg and Svensson, 2011):

- Staff commitment to the vision of the Esther Network.
- Increased competence across the whole care chain.
- Close working relations and support within the entire care chain to achieve the best for the patient.
- Efforts to continuously improve quality.

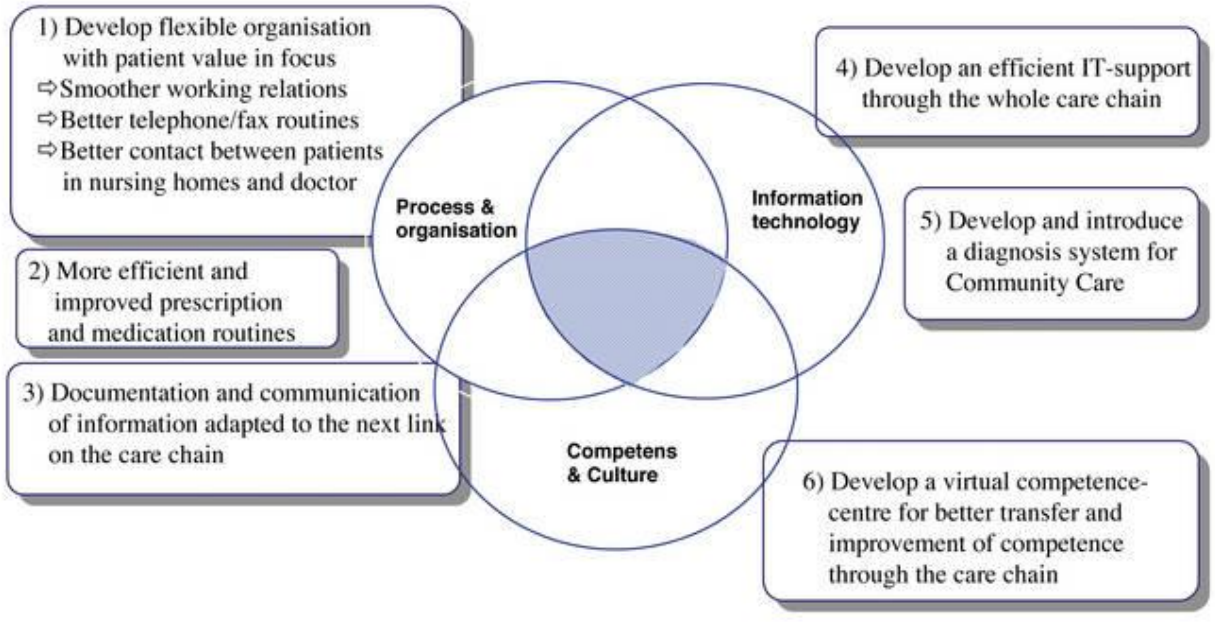
HISTORY AND FEATURES OF THE ESTHER MODEL

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. 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 misdiagnosed 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.

Looking at this 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 (Davies, 2012).

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. This process consisted of over 60 interviews and several workshops with patients, staff, and government officials (Carlsson, 2010). It identified that patients felt that healthcare personnel didn't have enough time to listen; and that too many people were involved in their care. It was also clear that individual work processes of staff in the care chain didn't fit together with the work of other colleagues, before or after their patient contact. This lack of coordination could mean, for example, that although a patient's social worker may have gathered information about their circumstances the patient would also be asked the same questions by their GP, nurse, and so on. This inadequate coordination causes considerable waste, redundancy and, in the worst case, medical errors.

An action plan was developed to redesign its system to avoid past errors and gaps.



Source: Projekt Esther & IBM—'Project 'Esther'.

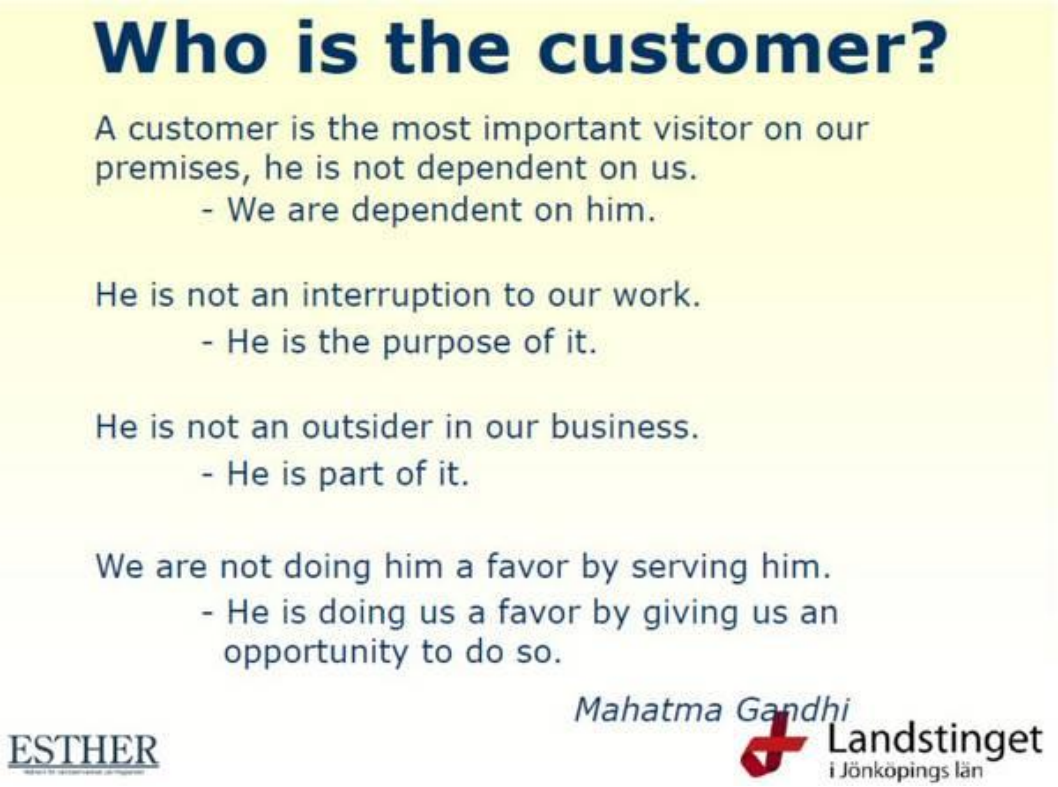
The thinking of healthcare providers and planners was therefore reshaped to focus on the aspects of a service that *patients, rather than clinicians and managers*, most valued – to create

'patient value'. In order to look at services through the eyes of a patient, providers and planners had to learn:

- what a patient needs or wants;
- what is important for them when they are unwell; and
- what is important for them when they leave hospital.

Staff discovered that most patients want to receive as much care in their home or as nearby as possible. If they have to go to the hospital, the patient prefers to leave as soon as is feasible, and have their continuing care needs met at home. This understanding led to a key part of the new system seeking to 'move responsibility to the patient'.

The 'patient charter' illustrates the new vision of the relationship between professionals and patients which developed in the Esther Network (Vackerberg and Svensson, 2011) – see 'Who Is The Customer' below. In addition, there is 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. This can also lead to improvement meetings with patients and staff where appropriate. Of course, every caregiver and provider makes their own promises in addition to this overall statement.



A simple, but effective way in which the network has tried to prioritize the patient's wishes has been through the introduction of 'Quality time for Esther' sessions. 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 prioritize themselves (often with nursing assistance). In 2010, 78% of users had made use of this opportunity (Vackerberg and Svensson, 2011).

Also, the Esther Network focuses on the patient's illness as a 'journey'—from illness, to treatment, and finally recovery. By evaluating every interaction with healthcare professionals, from the first contact point to the patient's recovery, professionals are able to remove unnecessary contact points and improve efficiency. Focusing on the patient journey also creates greater understanding amongst staff of the role of all other actors in the journey. This has improved cooperation between different professionals, who come from different departments and organizations to work together to meet the needs of the patient.

To further enable this action plan meant that organizations within the network improved telephone and email routines to create a speedy and seamless process. An example of this has been that GPs and hospital departments have improved their routines so that the hospital can now admit patients straight to the wards.

The Network has also improved contact between patients in nursing homes and their GP through measures such as establishing dedicated physicians at nursing homes, and regular visits by physicians to the homes.

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. This common list ensures all affected personnel have up-to-date information that helps avoid unnecessary changes to medication—although this process has still not been perfected.

The speed of passing on information has increased through the creation of targets for transmission. Documentation is also tailored to the needs of the next link in the care chain because each receiving care unit defines what they need from the preceding department. This has been further enabled through the improvement of IT systems to create an integrated and standardized system.

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. In particular, the competence center has (Project Esther and IBM, no date):

- adapted training to focus on fulfilling the needs of patients and moving efforts towards caring for Esther at home;
- educated personnel about different patient groups' needs;
- introduced multi-professional teams across Hospital, Primary Care, and Community Care;

- sought to improve the quality of meetings between patients and personnel.

In 2006, the Competence Centre received 12 million kronor (£1,138,279) to provide a two-year training program for members of the healthcare network in systems-thinking, communication, and IT development across the care chain. Following a system-wide survey assessing training needs of health care teams, the training was extended to include (Carlsson, 2010):

- medicine management;
- telephone advice; documentation;
- IT and communications.

Since its creation, over 700 people have participated in training programs. An evaluation of the training shows positive results. Staff feel that the project has helped to strengthen team-work, and establish better understanding of the different roles through interdisciplinary learning (Carlsson, 2010).

Also, in 2006 the network established 'Esther Coaches' to embed the new approach throughout the network and promote continuous quality improvement. Esther Coaches are members of staff—both clinical and managerial—who have the following tasks (Vackerberg and Svensson, 2011):

- support improvement projects in the frontline—by enabling staff to make the changes they want to see;
- catch improvement ideas and introduce new thinking to improve competencies;
- make the connection between daily work and the improvement of performance;
- inspire and motivate colleagues to improve, and celebrate improvements;
- keep the focus on the patient;
- introduce 'lean thinking'—getting the right things in the right place, at the right time, in the right quantities, whilst minimizing waste and retaining flexibility—to make workflows smoother;
- securing 'Quality time for Esther' to ensure patients can set the agenda.

To enable them to provide this role, coaches receive training on how to analyze problems in health care work and design improvements to address them. To spur innovations, Esther Coaches have to be solution-focused, encourage positive thinking, and be opportunistic. Esther Coaches receive no extra payment for their involvement and, despite being a major commitment; it is considered part of their job. In 2011, 102 members of staff had become Esther Coaches. Table 1 indicates the professions and their place in the network of the coaches as of 2011.

Profession	Municipality	County	Private practice
Nursing assistants	48	9	0
Nurse	4	16	0
Physiotherapist	4	3	1
Occupational therapist	4	3	1
Social worker	3	2	0
Administrator	3	4	0
Human relations worker	0	1	0
Chief	3	5	0

Currently, the Esther Network is made up of over 7000 members from health and social care services in the region. The network is non-hierarchical—although a coordinator works to maintain its success, it has no central budget or bureaucracy, and membership is voluntary.

To ensure the efficacy of the network, regular communication amongst members is encouraged. Workshops, training and site visits are held to bring different staff members together. Furthermore, every six weeks local network meetings are held between municipalities, primary care units and hospital staff and importantly 'Esthers' themselves—and patients also participate!. This enables staff to understand the challenges facing different professions and why different decisions are made. Annual 'strategy days' are also held that involve patients, staff, Esther Coaches, health care managers and local councillors which give the network a clear vision and develop action plans. These processes create a shared understanding and direction of travel throughout the network. This makes all members of the network understand that their performance is a link within the system as a whole – and that another department's problem is also their problem. It means that those involved in the chain of care consider the 'next provider', and that problems are not just passed on down the line. Since 2003 clinicians have also been encouraged to report when cooperation breaks down during treatment, irrespective of whether it caused a medical error or not (Carlsson, 2010).

"Everything was ready and prepared when I came home. I was astonished about how well everything was coordinated. I had my doubts when I was at the hospital."

—Eivor Jansson, 2012

"An Esther coach is a person with a deep and genuine interest to help fellow humans who are affected by the gaps in the health and social care system."

—Inge Werner, 2011