204: BALANCING QUALITY PERFORMANCE WITH CAPACITY MANAGEMENT: AN INTEGRATED APPROACH

Wollersheim H., Roumen E., Schretlen E., Feuth T.

Objective:

Mutual fine tuning between health care providers and managers in a systemic step wise approach may solve part of the conflict between budgetary restraints and shortages in medical and nursing personnel, and the drive to improve quality standards in patient care as shown in patients with deep venous thrombosis (DVT).

Methods:

First a well defined patient group is selected. Criteria for selection are respectively the preference in the policy document of the hospital, highly motivated care providers and managers who are able to cooperate, a central and de-central approved project management plan, a project group with a decision mandate, and the availability of sensitive and reliable quality indicators of the care process. Subsequently three models are applied and integrated:

1) A detailed multi-professional care plan is described on the care and on the organisational level. The plan consists of a guideline, the routing of the patient in steps; the localisation of activities, a description of an activity with its results, the executer(s) with the type and amount of personnel and materials necessary, the responsible persons for each step and for the whole, the type and amount of personnel and material necessary, the standard for the activity and the reference, possible problems encountered and possible solutions suggested;

2) Patient group quantifications. Care providers estimate how many patients in the selected groups in their department they need from the perspective of patient care (experience and registration conditions), research plans and education and teaching needs; while managers calculate from the care plan what one average patient routing costs;

3) Patient group steering. From consensus between care providers and managers a fixed number of inflow patients is agreed upon. Subsequently the doctor(s) that supervise the out patient clinic and first aid, regulate inflow and the start of the chain. They also negotiate with other neighbouring hospitals and with insurance companies about regional capacity and mutual adjustment. Two trained doctors and two trained nurses (one more supervising and one more executive, who can replace each other) take care of the patient and guide and monitor the applied care and routing.

Results:

Using the above-mentioned approach in patients with DVT (agreed number of inflow patients 100 yearly) we observed the following improvements if we compare the pre project year (1998; n=147 patients) with the post project year (2000; n=132 patients) Avoidance of admittance could be obtained in 72% versus 6% of patients, saving 331 hospital admission days. Protocol adherence to the right period of anticoagulation drugs and the proper analysis of trombofilia improved by 34 and by 55% respectively. The compliance of patients with wearing stockings improved from 34% up to 67%.

Conclusions:

The used plan-do-check method with combined multi-professional patient group care and organisation planning, patient group quantification and patient group steering, leads to improved transmural care, a better protocol adherence and more compliant patients. Due to the concentration of skills in a few hands the feasibility of the care plan is vulnerable during their absence (for example outside ordinary office hours). The preparation and realisation are quite an investment (0.4 fte) during the project phase although this should be far outweighed by the saving of hospital admissions. Yet objections to budget transfers and the inability to close one hospital bed (which was often filled with a sicker patient in need of more care than a DVT patient) threaten the gain in efficiency.

© 2002 Wollersheim H., Roumen E., Schretlen E., Feuth T. Reproduced as licenced to ISQua.