Multi-component intervention to transform (home)care for a sustainable future.

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BrabantZorg

BrabantZorg (BZ) is one of the largest (5000* employees and 2500* volunteers) Dutch regional healthcare organization for (home) and elderly care. 'Attention', 'comfort' and 'choice' are key in delivering healthcare services to approx. 4800 intra- and extramural clients. Services entail total package of residential, care and welfare services at 31 sites, across the Brabant province in the South of the Netherlands, with an overall turnover of EUR 200 million. BrabantZorg's aim is to make all client's lives as comfortable and easy as possible. See: www.brabantzorg.eu.
During the full length of the programme described here, were involved:

- board and management team (30),
- individual team managers (150),
- several hundreds of ancillary staff members, individual bedside health care team members and volunteers.

'Up to care!'

This program was supported by '*Up to care!*' (UtC): a nationwide Dutch programme to ensure sustainability of long-term care. UtoC's objectives are to: improve sustainability and transformation of long term care (LTC); support major transformations of LTC organisations; implement proven good practices; develop a learning sector. The UtoC transformation themes are: technology supported care; integrated care; empowerment of care workers / bottom up; opperational management (e.g. Lean). See: www.invoorzorg.nl. BrabantZorg was supported by UtoC with expert coaching activities for a period of 2 years.

Long term care in the Netherlands

- 600,000 service users
- 400,000 people employed
- 2,500,000 informal carers → 3,5 million people directly involved (= 1 out of 5 in Dutch population)
- 13 billion Euros = 18,5 billion US $

Challenges, vision and goals

While the ratio of people of working age to people over 65 will is expected to change from the current 3,5 to 1, to 2 to 1, over the next 40 years, there will be less (tax-based) governmental budgets to finance healthcare demands. Increasing relative healthcare personnel shortage, ageing population, less centralized and more open market healthcare policy press healthcare institutions to transform to more agile, flexible and client oriented organizations.
After merging of several organizations and streamlining its internal processes, between 2008-2011, BZ evolved into the triple-A status (2011). More importantly: BZ's structurally stable financial situation has created the necessary precondition to invest in further organizational development.

Vision and goals

Reflecting on the future, in 2009 BZ consulted nearly 600 clients and employees and defined its targets based on three vision pillars:

- **Attention**: Paying attention to clients by staff is priority throughout the organization.
- **Freedom of choice and 'in control'**: Clients have maximum freedom in choosing and organizing their care. Elderly are enabled to live, as long as they find possible, independently at home or in/nearby elderly homes, with healthcare services compensating for their growing physical and mental impairments.
- **Comfort**: More efficiency and less waste by decrease of all inefficiencies in work processes facilitating maximum attention for optimizing comfort for clients.

To meet with these corporate targets, each BZ professional is expected to engage in her/his work with a continuous focus on the client, on improvement and on reduction of waste. Such collective 'sustainable culture of continuous improvement' harnesses BZ to engage in challenges like:

- enduring national budget cuts
- broad IT-implementation (e-health and e-inclusion)
- integration of healthcare, social care and informal care (multi-disciplinary networks)
- quality (and safety) regulations
- demands for more client centered healthcare.

Bundle of change interventions

Over last 2 decades, healthcare quality improvement research and development have resulted in several methodologies and instruments. Primarily safety challenges in healthcare have fuelled these activities, predominantly in hospital settings. Increasingly, healthcare organizations are using these practice and evidence based improvement models, e.g.: Lean/SixSigma (Glasgow, 2010), Clinical Microsystems (Nelson, 2008), Planetree (Brady, 2008), 'self-managing teams'/social innovation, TeamSTEPPS (AHRQ/DoD)(Keijser, 2011).
Also, recent scientific reports suggest:
(1) proliferating overall effect of simultaneous implementation of individual programs (Dixon-Woods, 2011).
(2) several success factors of improvement initiatives (Greenhalge, 2004)(Dückers, 2011).

Based on current knowledge and experience BZ initiated a 5-year multi-component improvement program ('bundle of interventions'), combining these proven strategies: (a) process remodeling, (b) social innovation, (c) teamwork, (d) patient-/client-centered care and (e) leadership development, into an organization-wide program, entailing 3-branches (see Table).

Table – 3 branches

Branch 1 - Client-centeredness Program

Comprehensive intervention-toolbox to intensify client-, family-involvement and -feedback in (case)management.
Goal: To improve working in reply of clients, instead of organizations offers. Employees are expected to continuously keep in mind questions and wishes of clients which.

Branch 2 - Process redesign

Healthcare specific (LEAN)interventions.
Goal: Continuous improvement and waste reduction of work process increasing time / more attention for clients.

Branch 3 – Cultural development

Coaching/training interventions tailored to specific needs and competency-levels of individuals and care-teams. Interventions based on TeamSTEPPS™ curriculum (AHRQ/DoD) and 360°-assessment tools LifeStyleInventory (LSI – see Figure) and LeadershipImpact (LI)(Cooke, 1987).
Goal: Phased culture-program to improve leadership and multi-disciplinary teamwork (Skills, Attitudes and Behavior) towards a sustainable 'culture-of-continuous-improvement'.

Organization and dissemination

Program design and coordination tightly integrated to minimize time-investment staff/teams. Selection and training (train-the-trainer) of approximately 100 change 'ambassadors' and 'facilitators' and teamtrainers. Local thematic sessions and introduction of toolboxes (process redesign and team-training). Bottom up approach: designing *local* roll out tactics and executing *local* interventions profoundly based on input from and collaboration with *local* individual healthcare workers and clients.
Communication activities based on 'storytelling', also using internal media mix (print and online media). Various external dissemination activities, e.g. publications and co-hosting (with Ministry of Health) national conference on healthcare improvement.

Sustainment strategies

For long term sustainment of improvement efforts end effects, these strategies were followed:

1. Improvement cycles and monitoring effect

Structured and periodic improvement cycles at all levels (organizational, team and individual), e.g.:
- Quarterly management reporting;
- Individual development plans (teams and managers);
- Measurement instruments for
- teamwork-level (Baker, 2010);
- leadership (Cooke, 1987).

2. Social innovation & couleur locale

Active participation of clients, family and employees in design and roll out of improvement efforts. Improvement interventions tailored to needs and competence levels, at all organizational levels (no 'fit for all' design).
Dissemination of improvement expertise by active cross-level and cross-location exchange of experience, expertise and 'best practises'.

3. Improvement culture alignment

At all levels training of attitude and behavior focused on strategic goals. Mandatory participation in training and coaching for new employees.
After program completion (2014) all interventions embedded within local department and teams, in collaboration with and human resource division. Training and coaching 'from within' based on train-the-trainer/coach-the-coach curriculum, to minimize dependency of external trainers.

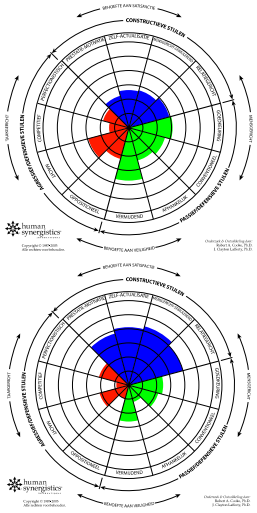
4. Up to date

Continuous development of improvement methodologies, toolboxes and instruments by:
- improvement officer (after program completion, 2014);
- monitoring external developments;
- experimental improvement initiatives (in collaboration with academic groups);
- structural improvement budget.

Measuring results

Effects of programs are measured within the following indicator domains:
a. Process redesign: quantitative process-outcome measurement (e.g. waiting times).
b. Client-centeredness: national customers satisfaction index (CQ-index).
c. Teamwork: teamwork attitude questionnaire.
d. Leadership: individual leadership assessment.
e. Cultural improvement: observational tool cultural shift (´Rhineland model´).
Prospective multi-method design: qualitative and quantitative measurement tools (Process: PDSA; Leadership: t=0 and t=1 year; Team effectiveness: t=0->3months and up).
April 2012: mid-term evaluation (Forum, 2012).

Figure - Behavioral Development.
Month t=0 and t=12 measurement management level behavioral styles (LSI-2).



Lessons learned and conclusions

Implementation of an improvement bundle organizational wide, has resulted in several lessons learned:

- Board and management staff continuously endorses initiatives and personal engagement in process of cultural shift.
- Identifying and facilitating internal 'champions'.
- Financial stable situation essential for cultural improvement.
- Continuous employee and client collaboration and feedback (social innovation).
- Need for extensive preparation period and program duration.
- External collaboration and investment (e.g. national exposure of hiring experts).
- Flexibility towards '*couleur local*' in phasing, timing and design (tailored).

Conclusion

To our knowledge, this is the first time that the combination of extensive improvement interventions in client-centeredness, process-redesign and teamwork and leadership has been deployed in a non-hospital setting.
Under optimal conditions, it is feasible to implement a 'bundle of improvement interventions' in large healthcare corporations and reach a sustainable 'culture of continuous improvement'. Requirements for success primarily concern having a clear vision and direction of organizational goals (three pillars) that appeals at all organizational levels and continuous focus on attitude and behavior in line with these goals.

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