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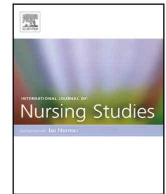

Patient assessment within the context of healthcare delivery packages: A comparative analysis

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A B S T R A C T

Background: Due to an increased focus on productivity and cost-effectiveness, many countries across the world have implemented a variety of tools for standardizing diagnostics and treatment. In Denmark, healthcare delivery packages are increasingly used for assessment of patients. A package is a tool for creating coordination, continuity and efficient pathways; each step is pre-booked, and the package has a well-defined content within a predefined category of diseases. The aim of this study was to investigate how assessment processes took place within the context of healthcare delivery packages.
Methods: The study used a constructivist Grounded Theory approach. Ethnographic fieldwork was carried out in three specialized units: a mental health unit and two multiple sclerosis clinics in Southern Denmark, which all used assessment packages. Several types of data were sampled through theoretical sampling. Participant observation was conducted for a total of 126 h. Formal and informal interviews were conducted with 12 healthcare professionals and 13 patients. Furthermore, audio recordings were made of 9 final consultations between physicians and patients; 193 min of recorded consultations all in all. Lastly, the medical records of 13 patients and written information about packages were collected. The comparative, abductive analysis focused on the process of assessment and the work made by all the actors involved. In this paper, we emphasized the work of healthcare professionals.
Results: We constructed five interrelated categories: 1. "Standardized assessing", 2. "Flexibility", which has two sub-categories, 2.1. "Diagnostic options" and 2.2. "Time and organization", and, finally, 3. "Resisting the frames". The process of assessment required all participants to perform the predefined work in the specified way at the specified time. Multidisciplinary teamwork was essential for the success of the process. The local organization of the packages influenced the assessment process, most notably the pre-defined scope of relevant diseases targeted by the package. The inflexible frames of the assessment package could cause resistance among clinicians. Moreover, expert knowledge

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was an important factor for the efficiency of the process. Some types of organizational work processes resulted in many patients being assessed, but without being diagnosed with at package-relevant disease.

Conclusion: Limiting the grounds for using specialist knowledge in structured health care delivery may affect specialists' sense of professional autonomy and can result in professionals employing strategies to resist the frames of the packages. Finally, when organizing healthcare delivery packages, it seems important to consider how to make the optimal use of specialist knowledge.

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What is already known about the topic?

- Healthcare delivery packages for assessment and treatment are used increasingly. Standardized tools, or packages, are introduced to create coordination, continuity and efficient pathways for patients, and to create cost-effectiveness.
- If healthcare delivery packages are to live up to the anticipated goals, they impose heavy demands on healthcare professionals and patients.

What this paper adds

- The local organization of the packages influenced the assessment process.
- Expert knowledge was an important factor for the efficiency of the process.
- The inflexible frames of packages can challenge the specialists' sense of professional autonomy and trigger resistance to the frames.

1. Introduction

In most countries, healthcare systems are being strategically reorganized to provide effective, systematic and optimal delivery of well-coordinated care services (Olejaz et al., 2012; Vanhaecht et al., 2010). The main method for planning the care process is to create "care pathways", defined as "a complex intervention for the mutual decision-making and organization of predictable care for a well-defined group of patients during a well-defined period" (Vanhaecht et al., 2010). In Denmark, there has been an increasing focus on productivity and cost-effectiveness in the healthcare sector since the 1980s (Obling, 2010). There has also been a growing emphasis on the quality of treatment (Obling, 2010; Olejaz et al., 2012). As a result, the focus in recent healthcare reforms has been on patient choice, waiting times and coordination of care, quality assurance and external accreditation (Olejaz et al., 2012), and on avoiding fragmented healthcare delivery (Ahgren, 2014; Olejaz et al., 2012). In 2012, the Danish government introduced a "waiting-time guarantee" for physical illnesses, guaranteeing all patients to be diagnosed within 4 weeks and treated within a maximum of 8 weeks (Ministery of Health, 2012). To match the economic and political imperatives, as well as a wish for high quality in care pathways, there has been an increase in large-scale specialized units offering cost-effective standardized diagnostic and treatment pathways for a range of diseases (Obling, 2010; Olejaz et al., 2012). This development can be characterized as top-down controlled healthcare (Ahgren, 2014).

Treatment and assessment healthcare packages belong to this highly structured mode of healthcare delivery, in which the specific course of healthcare interventions related to assessment and treatment is predefined and highly focused on timing and content. Clinical pathways (Vanhaecht et al., 2009) and care pathways (Bragato and Jacobs, 2003; Hunter and Segrott, 2008) focus on a wider segment of the patient trajectory than assessment packages, which include only the part of the trajectory that is situated before patients are diagnosed. However, they are comparable to the extent that they are standardized healthcare delivery models. Assessment packages are widespread and used in an increasing number of medical specialties (Vinge and Witzke, 2012; Vinge et al., 2012), and they are central to The Danish Healthcare Quality Program. The goal of the packages is to establish coordination, continuity and efficient pathways in which each step is pre-booked and has a well-defined content within a defined category of disease (IKAS, 2013). National packages were introduced in cancer diagnostics and treatment in 2007 (Vinge et al., 2012), in cardiology in 2010 (Vinge and Witzke, 2012) and in psychiatry in 2013 (Danish Regions, 2013). The political ambition for the future healthcare provision is to introduce packages for all major common diseases (Vinge and Strandberg-Larsen, 2010). In addition, there is an increasing number of locally initiated and defined packages.

There is some debate about packages in terms of their applicability, e.g. it is argued that some patients do not fit into any of the available packages (Agersnap, 2013); that packages do not allow individual pathways and diagnoses (Winding, 2013); that too many patients referred to packages should have been assessed differently (Heissel, 2014), and that there are problems related to the central role played by general practitioners in the referral process (Rasmussen, 2012). Another type of critique of these and similar approaches focuses on the extent to which they represent a managerial project whose effect may be a de-professionalization of traditional occupational and professional work, such as the work performed by nurses

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