Systems Change Using a Patient Centered Approach: The Esther Model



Aleece Caron, PhD

Professor of Medicine at Case Western Reserve University
Co-Director, Center for Health Care, Research and Policy at
The MetroHealth System



Mamta (Mimi) Singh, MD, MS

Director, Interprofessional Improvement Research Clinical Center
VA Northeast Ohio Health Care System
Professor of Medicine at Case Western Reserve University School of Medicine

U.S. Department of Veterans Affairs
Veterans Health Administration
VA Northeast Ohio Healthcare System

CASE WESTERN RESERVE UNIVERSITY
School of Medicine

MetroHealth
Devoted to Hope, Health, and Humanity

The Esther Model

"What is Best for Esther?"

A Person-Centered Approach to Integrated Health & Welfare Care

Aleece Caron, PhD

Co-Director, The Center for Health Care, Research and Policy, The MetroHealth System

Mamta (Mimi) Singh, MD, MS

Director, Interprofessional Improvement Research Education Clinical Center, VA Northeast Ohio HealthCare System

What brought you here today?

(write it down on the sticky note)

Learning Objectives

Define

Person-centered care

- Shift from provider-driven medical models to honoring individual preferences, values, and lived experience.

Describe

The Esther model and its origins

- Examine how a 1997 Swedish care crisis led to a world-class network for dissolving organizational silos.

Apply

The lens across roles

- Align clinicians, social workers, and administrative teams under one shared core question.

The Esther Story

Esther is an 88-year-old woman who lives alone in a small apartment. Over the past few nights, her breathing has worsened, and her legs have become so swollen that she cannot lie down, so she sits up all night.

She calls her daughter, who tells her to call her home nurse. The home nurse visits, assesses her, and determines she needs to see her primary care physician, but Esther lives on the third floor and cannot manage the stairs.

The home nurse calls an ambulance, which takes her to the physician, who then sends her to the hospital by ambulance. Three hours have now passed.

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. Esther saw a total of 36 different people and had to retell her story at every point, while having problems breathing.

This process caused Esther to become confused. (In a worst-case scenario, she could have been misdiagnosed with dementia). After her long wait, a doctor finally admitted her to a hospital ward and treatment began.

The Problem: Fragmented Care

Key System Challenges

- **Lack of Coordination:** Silos between hospital, primary, and home care.
- **Incompatible Systems:** Fragmented documentation tools.
- **Medication Discrepancies:** Risks during care handoffs.
- **Overcrowding:** Long waiting lists & emergency pressure.

The System Question



Think-Pair Share

Repeated examinations, long waits, and a parade of unfamiliar faces: this is Esther's care experience, and it raises one simple but powerful question — **"What is best for Esther?"**

What is the Esther Model?

A long-term **Quality Improvement (QI) strategy** was launched in 1999 in the Highland area of Region Jönköping County, Sweden.

> "A collaborative approach to improve the quality of life for persons with complex healthcare needs, their families and professionals."

- Started at Highland Hospital with 6 municipalities and primary care.
- Covers persons of any age with complex healthcare needs.
- International reach: Spread to Singapore, UK, Denmark, and Austria.
- Recognized by CNN (2014) & European Prize for Social Innovation (2017).



The Esther Project: History & Outcomes

From a single patient's story in Höglandet, Sweden to a globally adopted model of coordinated elder care

HISTORY

1997

An elderly patient (“Esther”) sees 36 people over a 5.5-hr ER wait. Mats Bojestig launches the project at Höglandet Hospital.

1997–99

Interviews & workshops map care journeys across hospital, primary, and municipal care; the persona and HPR method take shape.

2000s

Qulturum (Jönköping County's learning center) formalizes Esther coaches, cafés, and a countywide improvement network.

2010s–today

Model spreads internationally — UK, Singapore, Toronto, and beyond — adapted for non-elderly and non-healthcare settings.

OUTCOMES (Höglandet / Jönköping County)



9,300 → 6,500

Annual admissions to Höglandet Hospital's medical dept.

1998 to 2013



17.4% → 15.9%

30-day readmissions, age 65+ (12.1% in Tranås with “Welcome Back Home”)

2012 to 2014



19.2 → 9.2 days

Average rehab length of stay (surgery: 3.6 → 3.0 days)

2009 to 2014



Global spread

Adopted in the UK, Singapore, Toronto & beyond as an international model

2016–present

What is the Secret Sauce?

Source: Commonwealth Fund, “Sweden’s Esther Model” (2016); Care Management Matters, “The Esther Project” (2020)

"What is best for Esther?"

‘AÄÖÇCČBÄDĎBĎĎĆÁÇĒÄĒBÁĎĆĎĆBBÄÇBĒĎÇÄBÁĎOĒĒÁĒBÄ

Person-Centered

Unified purpose across all providers

Co-Production

Esther's actively shape care redesign

Global Impact

Sweden, Singapore, UK Denmark, Austria

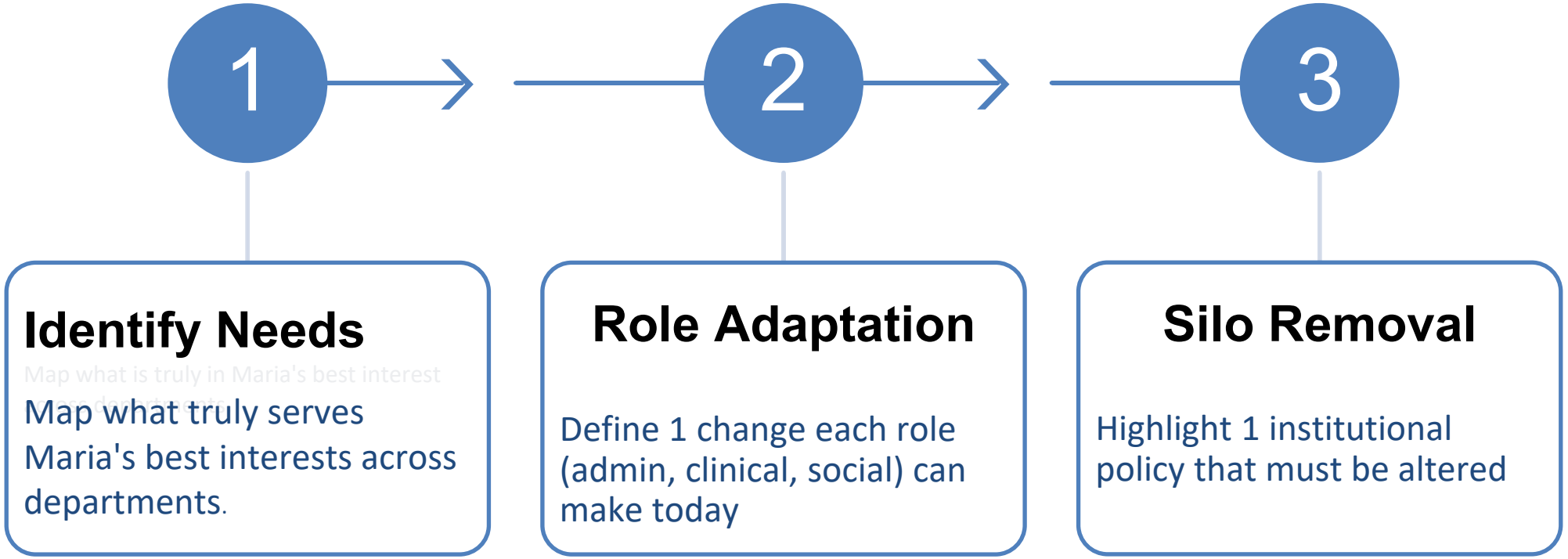
Interactive Case Breakout: Meet Maria

Maria is 52, has Type 2 diabetes, works two jobs, and is on Medicaid.

She skips her metformin when has side effects and when she can't afford the copay. Her A1C has been above 9% for two years. Three providers have given her three different messages about her diet.

She takes four buses to get to your clinic. She has to make appointments up to 6 months in advance due to access but cannot keep them due to her changing work schedule.

Table Exercise



3 QI Dimensions

1. Systems Thinking

Asking "What is best for Esther?" opens a holistic, boundary-spanning perspective.

Simple rules > detailed routines

2. Psychology of Change

Esther's story builds emotional engagement and passion, fostering psychological safety.

Intrinsic motivation > financial incentives

3. Co-Produced Learning

Iterative learning by doing through PDSA cycles and patient co-design.

ESTHER coaches build internal capacity

Key Takeaways: 3 Simple Rules

Rule 1: Ask "What's Best for Esther?"

Use the individual's needs as the sole compass for every decision.

Rule 2: Own Your Step

Ensure smooth transfers without making the patient restart.

Rule 3: Manage Together

Cross departmental borders to solve systemic roadblocks.

Key Lessons Learned

For Healthcare Systems

- **Develop QI Cornerstones:** Practice improvement both strategically and daily.
- **Center the Person:** Unwavering focus on care recipient needs.
- **Break Silos:** Foster multidisciplinary, boundary-spanning dialogues.
- **Build Support Roles:** Esther coaches ensure long-term sustainability.

The Three Simple Rules

(tested & proven effective during the COVID-19 pandemic)

1. Best for Esther
2. Take responsibility for your step in the care chain
3. We manage together

Personal Commitment Activity

Write down 1 concrete practice you'll start tomorrow.

Tomorrow, When_____, instead of_____,

I will ask ”what is best for_____? and_____.

Closing

Did we get to what brought you here today?

THANK YOU!!!