Conducting an Empowerment Evaluation Project in the Area of Health Care Services: An Innovative Methodology

Evaluación de proyectos de *empowerment* en el área de los Servicios de Salud. Una metodología innovadora

Monika Bobzien*

Abstract

Empowerment evaluation, as a core concept in the fields of community psychology and health promotion, refers to the ways in which individuals, groups and/or communities gain influence over the activities in which they choose to work, and over the decision-making processes that these entail, augmenting the capacity to self manage their lives.

This article explores the concept of empowerment as a framework for managing projects in the health care services. The case study shows a two-year pilot project conducted in Hamburg, Germany, outlining an innovative approach towards combining experiential and professional expert knowledge in the field of clinical practice.

We analyze and discuss the ways in which patient participation can be strengthened by making public the criteria or standards by which hospital treatment is oriented; we also discuss the implications of such a turn. “Quality standards for self-help-friendly hospitals“ were developed, implemented and evaluated in collaboration amongst hospitals and patient organizations for those who suffer chronic diseases, and lead to a qualifying certificate (“Self-help-friendly Hospital“) awarded to those hospitals which succeeded in their performance.

Keywords. Empowerment, project management, health services, patient organizations, patient focus, participation, quality standards.

Resumen

La evaluación del empowerment, como un concepto central en el campo de la psicología comunitaria y de la promoción sanitaria, se refiere a las formas en que los individuos, grupos y/o comunidades ganan influencia sobre las actividades en las que eligen participar, y también sobre los procesos de toma de decisión que éstas incluyen, aumentando así su capacidad para autogestionar sus vidas. Este artículo explora el concepto de empowerment como marco para gestionar proyectos en los servicios de salud. Este caso de estudio muestra un proyecto piloto de dos años de duración que se llevó adelante en Hamburgo, Alemania, sentando las bases para un enfoque innovador que combina conocimiento de profesionales y de aquellos quienes han ido aprendiendo por su experiencia en el campo de la práctica clínica. Analizamos los modos en que la participación de los pacientes

* Monika Bobzien, Dipl.-Psychologin, OrgLab – Organizational Development Laboratory (http://www.orglab.de/), University of Duisburg-Essen, Germany (monika.bobzien@arcormail.de).

puede ser fortalecida al hacer públicos los criterios a través de los cuales se orientan los tratamientos hospitalarios. También presentamos una discusión crítica de las implicancias que tiene dicha orientación. Como resultado se han desarrollado Standards de Calidad para Hospitales Amigables, que se han implementado y evaluado en colaboración entre los hospitales y las organizaciones de pacientes que agrupan a quienes sufren de enfermedades crónicas. Esta implementación llevó a producir y entregar certificados de calidad a aquellos hospitales que cumplen con los stándards.

Palabas clave. Empowerment, gestión de proyectos sanitarios, organizaciones de pacientes hospitalarios.

Empowerment is a popular word and often subject to misperception. In the field of organizational consulting, empowerment means a top-down management tool for the improvement of individual and team performances to achieve better business objectives. Employees must initially be in a (high-leverage) position to take advantage of empowerment programs.

In community psychology, however, empowerment is an enabling and emancipatory tool most commonly associated with political power and decision-making processes geared towards people outside the mainstream of economic and social power.

> Central to the empowerment concept is the importance of individuals and communities having influence and control over decisions that affect them (Israel *et al*., 1994, p. 3).

Characteristics of empowerment tools are the exchange of information, spreading of (bottom-up) knowledge to promote networking and to build capacity for theory, research and practice. This may also include international cooperation within the most relevant domains of intervention (e.g. health promotion and prevention, poverty and oppression, violence and drug problems) in areas of social change and betterment in local, national and global politics (Rappaport, 1986; Stark, 1996).

The work of Fetterman and Wandersman (1996, 2005) served as foundation for conducting the empowerment evaluation project. According to Fetterman's and Wandersman's theories empowerment evaluation is defined as

> An evaluation approach that aims to increase the probability of achieving program success by (1) providing program stakeholders with tools for assessing the planning, implementation, and self-evaluation of their program, and (2) mainstreaming evaluation as part of the planning and management of the program/organization (2005, p. 28).

The publication of Fetterman's Ten principles[1] of empowerment evaluation coincided with the start of the two-year pilot project "Development, implementation and assessment of quality standards of 'self-help-friendliness' into hospital routines" (Bobzien, 2006), which started in 2005. The objectives of the project were defined in a flexible way, and the publication of the 10 principles gave us defining parameters upon which to base the project. As a result, the description of our methodology will apply Fetterman's 10 principles, even though this frame was not used systematically to conduct the study.

Introduction

We will start by providing a short overview on the institutional and political background on health care reform legislation. We shall also describe patient organizations with experience in empowerment. It is important to note that from the start we encountered favourable conditions that were a prerequisite for the success of this project. The coming together of different elements such as sponsors, knowledgeable project managers, and the physical environment, including personnel, need be optimal to design the project and to achieve the desired success. Our analysis of the case study presented in this piece will focus on the following phases that were necessary to get all parties together to begin the collaboration:

- Development of quality standards for 'self-help-friendliness' in hospitals.

- Implementation of quality standards in standard operating procedures (SOP) of hospital treatment, especially in routine delivery of health care and in the institutional organization involved.

- Development of criteria for institutional self-assessment, and the conduction of external tests to evaluate the integrity of the self-assessment protocol. Success in the entire process qualified the institution for a quality award.

1. The Ten principles of empowerment evaluation are: Improvement, Community ownership, Inclusion, Democratic participation, Social justice, Community knowledge, Evidence-based strategies, Capacity building, Organizational learning, Accountability (Fetterman & Wandersman, 2005, p. 30).

Special attention will be given to the phases of the project where a maximum of stakeholders' participation was involved, which basically entail the development of quality standards and the development of evaluation criteria into a quality management system while carrying out the assessments.

In all phases support to non-professionals and professionals[2] was provided in way of expert consulting and training, by the project manager. In other phases a more process-oriented, support-like coordination, summarizing, communication and information flow were provided.

Advocating successfully for patient participation within a highly hierarchical, structured and expert oriented professional system like a hospital is an empowerment process by itself, since it fosters the taking of responsibility by the patients and self-determination instead of being dependent and passive. In order to implement some small participatory changes within that environment we had to work with the whole system.

The article will close with an analysis about the benefits and implications emerging from participative assessments and lessons learned applying the principles of empowerment evaluation to the processes and outcomes of our project. Conclusions will refer to opportunities and perspectives of patient focus in professional health care that have been generated by this seminal project.

Background

The overarching idea of the pilot project stems from the fact that patients should be the focus of health care delivery and treatment in health care policies. Various scientific studies and political programs have dealt with improvements in collaboration between patient organizations and professionals in treatment and care, although rather in a more theoretical and normative way (Borgetto, 2001; Matzat, 2003; Rosenbrock, 2001) but had little impact on strategies for implementation and on processes for practical use.

Field studies showed also that professionals in hospitals were interested in collaborating but did not know how to get the process started (Slesina, 2007). On the other hand, patient organizations complained about being put off or misunderstood when it comes to serious negotiations with hospital professionals. In fact, they felt that their contributions and ideas were not being acknowledged and appreciated. Instead, hospital staff saw their presence as an opportunity to pass on to them some of their unwanted menial tasks. In few cases where good relationships had been established between a head physician and a leader of a patient organization, collaborations often broke off as soon as either of them retired or left the institution (Bobzien, 2003). Achieving an optimal treatment and health care delivery mechanism is important both for patients and hospitals, and thus policy makers have wanted to further research how collaboration between patients' groups and hospitals may play in the entire healthcare delivery system.

- Baseline: empowerment experience

Empowerment evaluation is designed to share decision-making power. It is a participatory and collaborative approach to the evaluation; it requires that all participants be committed to actively engage in the process, from beginning to end. An important effect stated by Fetterman and Wandersman (2005) is the emerging psychological power that goes along with it:

> The ability of a group to achieve their goals as members of a learning community, improving their lives and the lives of those around them, produces an extraordinary sense of well-being and positive growth. People empower themselves as they become more independent and group problem solvers and decision makers. It is a liberating or emancipatory experience (Vanderplaat, 1995, 1997). Empowerment evaluation is about helping people help themselves (2005, p. 10).

This statement is consistent with the philosophy of mutual aid groups as a whole, and also specifically congruent with the aims of patient organizations[3] who suffer from chronic diseases (Bobzien, Hundertmark-Mayser & Thiel, 2006). Members of patient organizations affected by certain psychological, social, or health problems seek mutual aid and support in every-day life or even a new sense of life when diagnosed with a chronic illness or a fundamental life changing event. As patients, or immediate family members, people try to learn more about the implications of that specific problem.

Patient organizations of people suffering from chronic diseases (cancer, rheumatic diseases, diabetes, relatives of Alzheimer patients, only to name some) usually get up-to-date with latest research results, methods of therapy and medication. As a result of their experiences during multiple stays in hospitals and rehabilitation clinics, members of patient organizations gain substantial knowledge about best practices and treatment methods through contacts with physicians, medical practitioners

2. This was organized in two working groups – an evaluation team and at a given milestone a survey team as a sub-team and a *consulting committee*.

3. Other terms may be used in this article as self-help group / self help organization / mutual aid group. The character of those groups is that all members will participate voluntarily and seek for mutual aid for a similar problem, e.g. suffering chronic disease. Patient organizations / self help organizations in general have small "branches" like local self help groups that offer easy access to patients and / or family members.

and professionals. This knowledge often forms the basis for recommendations about best practices, and referrals to better clinics and treatment facilities. As nonprofit organizations they collaborate with health research, health care institutions and lobby the pharmaceutical industry to invest more in research of more effective medicine. They also provide first-hand services to other patients and professionals.

In the sense of Antonovsky's concept of salutogenesis (1987) people in mutual aid groups experience a sense of coherence, which empowers them and makes them feel less vulnerable to the effects of their illness. They build up capacity to take charge of their environment with the resources available to them. As they become more self-determinated and aware of collective resources they also establish a more critical attitude towards professional help. It is an empowerment process in which people typically know their own problems and are in a good position to generate their own solutions.

This exactly is the role and specific contribution of patient organizations in health promotion as defined in the Ottawa Charter for Health Promotion (1986): "Health promotion is the process of enabling people to increase control over, and to improve their health" (p. 1). If health promotion is applied to improve quality in hospitals, it increases the results of outcomes and has implications for hospitals´ structures and processes. Following the more explicit quality philosophy of hospitals, the outcome concept of hospitals already has expanded to include, in addition to clinical outcomes, health-related quality of life and patient satisfaction as well.

The concept of empowerment stresses the necessity that individuals take control over their health -which means in the context of the hospital that patients are not only seen as objects of interventions but also as active participants of these interventions. This kind of empowerment cannot be achieved by the clinical interventions themselves, but by communicative interventions and shared perspectives with patients and patient organizations / mutual aid groups.

- Implications in the "Globe" that fostered the project idea

Some important changes in health care policy, research, quality control and the health care industy have influenced policy makers and statutory health insurances to think about useful and sustainable approaches in health promotion. An important stimulus came from the German laws and regulations which became effective in 2000. These regulations intended the overall modernization of the health care system. They affect almost every aspect of the health care system, from health promotion to after-care, and strengthened patients' rights by providing them the rights to participate in shared decision making in medical treatment and patient care.

Regulations require quality control in health services and mandate hospitals to provide evidence in quality. Their reports are published on the homepage. Quality reports are an important aspect of competitiveness in the market place, and hospitals implement quality management and undergo assessments by accredited certifiers in order to stand out from the crowd in the healthcare market.

National and international economic constraints are creating a competitive and shareholder dominated healthcare market. This triggers changes in traditional patterns still prevailing in institutional treatment and patient care. Instead of exercising a paternalistic attitude towards patients the climate became more customer-focused but at the same time more profit-oriented as well.

Hospital stays have become shorter due to budget control that refers to Diagnosis Related Groups (DRG)[4]. This often results in the fact that a patient cannot recover from treatment adequately before being discharged. On the other hand, hospitals are obliged to manage the interface between hospital care and after-care, for instance in rehabilitation, or to ensure ambulatory or family care. This situation may also give patient organizations an important role in after care.

In the recent past, many hospitals have become unprofitable; as a result, have either shut down, merged or have sold shares to private investors. During the project period one of the "test hospitals" in the project was bought out twice and with every new owner, there was a new mission and a turnaround in organization. However, being more efficient and being highly ranked can also be an impetus for best practice in hospital management and patient care. It is assumed that this new development would create the environment to "listen to the patient" -or to the general patients' needs.

From the beginning, the pilot project attracted good reviews in professional healthcare circles and self help groups. Articles about the core idea of the project as well as about intermediary data of collaboration between patient organizations and hospitals were published in local, regional and professional journals. It was acknowledged that these activities supported sensibilization and created acceptance, which in turn led to interests and inquiries from other hospitals and patient organizations all over Germany for the outcomes of the project, and, or the possibility for participation in the project.

4. DRG – Diagnoses Related Groups is an internationally developed classification system on which a prospective payment system for hospitals is based upon.

Fig. 1. Definition for Self-help Friendly Hospital

Project framework

The idea and concept of the project "Self-help-friendly Hospital" (see Figure 1 for a summary of its characteristics) came from the Kontakt– und Informationstelle für Selbsthilfegruppen – KISS Hamburg (the regional non-profit clearinghouse[5] in Hamburg) and the Department of Medical Sociology at the University Medical Center Hamburg-Eppendorf (UKE).

To promote the idea of a self-help-friendly hospital, KISS and the Department of Medical Sociology put together a group of stakeholders, including the patient organizations and the hospitals to collaborate across. The Bundesverband der Betriebskrankenkassen – BKK BV (The German umbrella association of Employees Health Insurances) funded the project. However, BKK's role in the project was not only financial, but also instrumental in establishing contacts and networks of organizations important for the project.

Clearinghouses, overall, have close connections to patient organizations. In various presentations during regular meetings organized by KISS Hamburg, we had the chance to discuss the project idea and were able to invite patient organizations to participate in the development of quality standards and in the evaluation processes. Although there were only a few organizations that felt ready to participate in a working group, all patient organizations interested in the progress of the project were regularly informed by the project management in overall meetings and through press releases.

KISS Hamburg hired the author of this article as project manager. Part of the project manager's job was to be liaision to the relevant stakeholders and to select the project teams (evaluation team and consulting committee). With the exception of the project manager all other members of the project teams worked on a voluntary basis for the pilot project, which was especially true for the participants of patient organization. The other stakeholders or participants in the project, such as hospital personell and other health care professionals contributed their work time to the project.[6]

- Project Design

The project goals were defined as to

- develop and portray customized quality standards as a model of good practice in collaboration between hospitals and patient organizations;

- identify hospitals ready to participate in the pilot project and to implement the quality standards into their daily standard operationg procedure (SOP);

- take part in the process leading to the qualification for the "Self-help-friendly Hospital" award.

To achieve our goals, we strived for a broad representation of all stakeholders to be included into strategic development of the project. The idea was that the benefit of establishing consensus on views, sharing expert knowledge and investing time

5. Clearinghouses professionally connect people to self-help, lobby for the idea of patient focus in professional health care services, advocate resources and offer expertise to and about peer-run groups and organizations that serve people who have been diagnosed with similar disease or share the same problem. Funding for these non-profit-organizations in general is obtained from a local government health or social department and from locally-based government health insurances.

6. It is not generally expected in Germany that people either volunteer their time and efforts or use their work time to support unpaid projects, so the fact that we had a mix of volunteers, paid, and unpaid workers in the same project created a very delicate working environment.

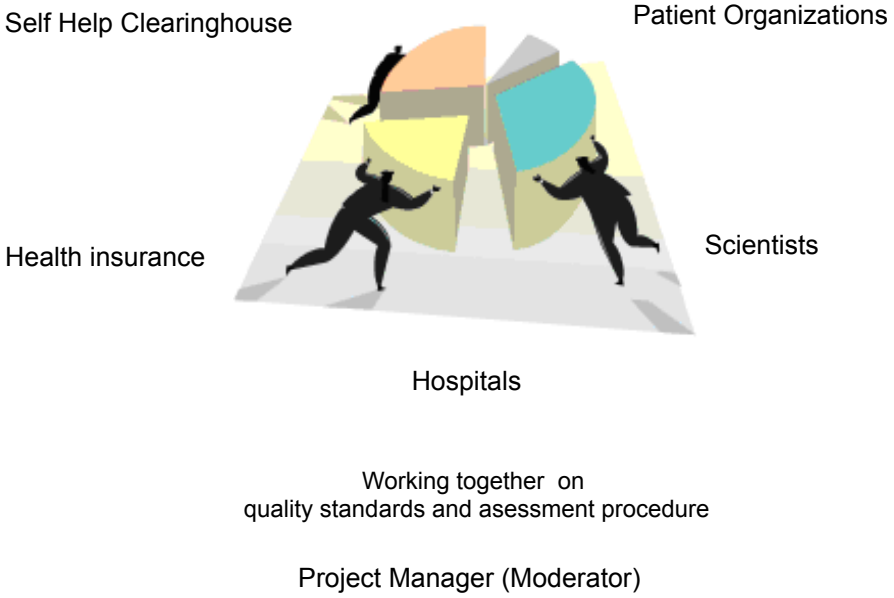

Fig. 2. Collaborating in the Project

togetherwould result in a return on the outcomes (see Figure 2 for a representation of this idea).

Interventions by stakeholders based on mutual understanding and respect for one another's contributions tend to produce sustainable results, because each participating stakeholder is able to take responsibitly for the outcome of the results. Team building and mutual support is the key to empowerment evaluation process -and result-based accountability, as Wandersman notes (2003), "the stakeholders are intertwined in a triple helix of accountability to one another to obtain results" (pp. 227-242).

For this purpose we first put together an *evaluation team* representing hospitals, patient organizations and clearing-houses. Evaluation teams were composed by quality managers representing in turn three large local hospitals (each with more than 1000 beds for acute care), representatives from patient organizations of chronic diseases (breast cancer, mental disorders, chronic eye diseases and progressive muscle disease) and of two professionals from local clearinghouse.

We next created a *consulting committee* representing the same stakeholders as in the evaluation group, scientists from the field of medical and social sciences, a certifier of quality management systems in hospitals and the health insurance to support the evaluation group with strategies and ressources.

Both project teams met regularly as was needed to exchange ideas and brief each other on the progress of the project. Everyone was committed to working as a team and sharing experiences with everyone else, regardless of position or who brought what to the table.

Development of quality standards for "self-help-friendly" hospitals

We used the principles of standard development (Fig. 3), as outlined by the international society for quality in healthcare (ISQua[7]) to develop the quality standards for self help. At our disposal we had the results of a literature review and an already completed quality survey done by three hospitals in Hamburg. Thus, we did not have to start from ground zero to develop a standard.

The findings of the survey indicated that, besides the benefits for the patients, clinical staff assumed that collaborating with patient organizations may help optimize treatment and care, but they also showed that clinical staff in general were not very familiar with working with self help groups. Other studies conducted in Germany have also shown the same results (Findeiß, 2000; Slesina, 2007; Stark,

7. ISQua, The International Society for Quality in Health Care, is a non-profit, independent organisation with members in over 70 countries. ISQua works to provide services to guide health professionals, providers, researchers, agencies, policy makers and consumers, to achieve excellence in healthcare delivery to all people, and to continuously improve the quality and safety of care.(http://www.isqua.org).

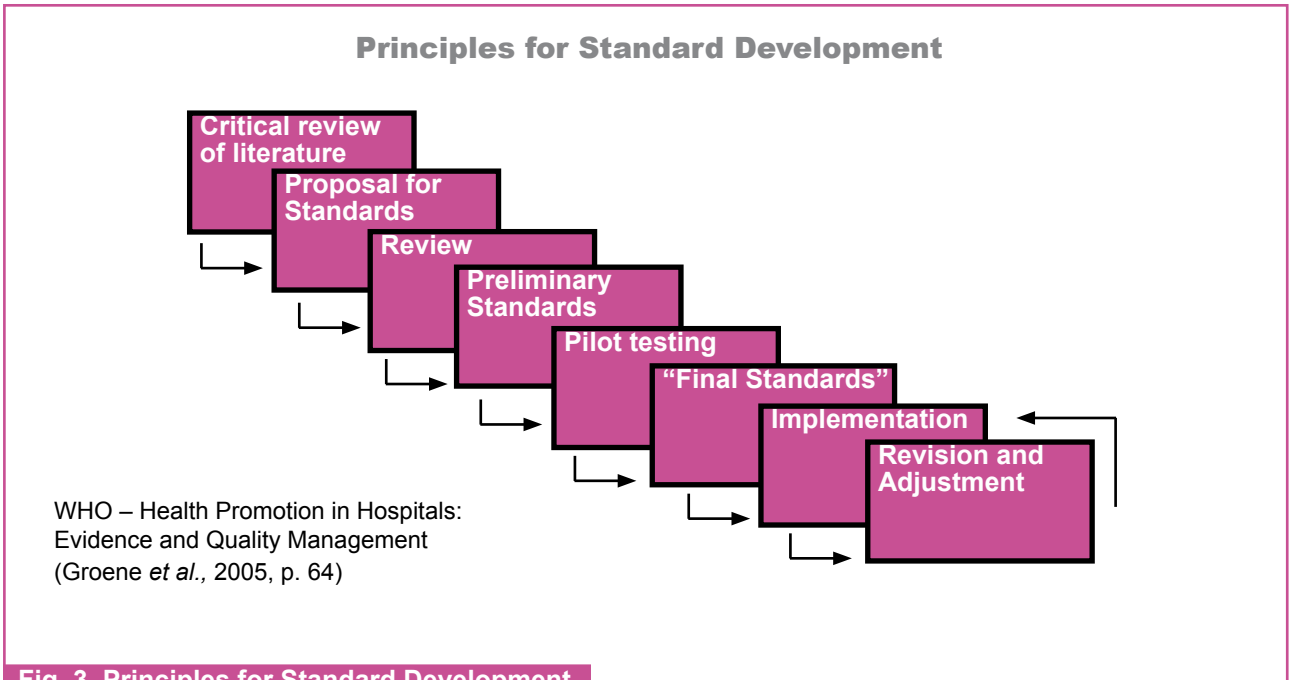

Fig. 3. Principles for Standard Development.

2001; Trojan, 2004).

The evaluation team supported the idea to start a country-wide survey with the assistance of the Department of Medical Sociology at the University Medical Center Hamburg-Eppendorf (UKE) - a project stakeholders. Addresses were provided to us by NAKOS, an umbrella organization of German clearinghouses as well as by BAG Selbsthilfe, an umbrella organization for patient organizations of chronic diseases, both important stakeholders in the project, too.

The survey aimed to investigate the current situation of collaboration between hospitals and patient organizations and to ask for the patient organization's point of view. The questionnaires contained similar questions to those contained in the quality surveys done by three hospitals in Hamburg, as well as proposals for standards. The survey participants were asked to make comments and suggestions on the standards proposed based on their experience.

Fifty-eight percent of the patient organizations invited to participate in the survey considered the matter of introducing quality standards to be meaningful and some organizations felt encouraged to attach individual reports to the questionnaires returned, showing examples of good practice as well as of bad experiences in collaboration with hospitals (Werner, Nickel & Trojan, 2006).

The data collected offered a valuable basis for the evaluation team to reflect on mutual expectations and community constraints[8]. We generated 16 preliminary standards and following several reviews and discussions, we finally agreed on eight core standards based on criteria and indicators that had priority to the stakeholders (Fig. 4. Quality Standards).

The quality standards were understood as "guidelines" to provide orientation to the hospitals as well as to patient organizations and clearing houses with respect to creating successful collaborations. The results of the quality standards were published in professional journals for hospitals and became pivotal for the upcoming steps in the project.

Implementing the quality standards in hospital SOP

Most of the previous collaborations in the hospitals were on ad hoc basis, nothing as systematic as what we were proposing. Based on anecdotal evidence, it was evident to the hospitals to go forward to incorporate our proposals in their SOP for example:

> A hospital may make presentation space available to self-help groups and would, in most cases, also make information flyers available to interested patients or relatives, under the belief that this is all that was needed. However, in fact, reality surpasses this description. We found that unless it is some one´s task to be responsible for giving out information, for example, the situation could worsen to the extent that patient organizations complain that nobody is informed when flyers run out, the hospital staff complains that run out flyers are not timely replaced. Patients complain that they cannot find material

8. It is important to note the due to the fact that this project involved working with people whose family members were personally either caregivers, family members of caregivers or sick people, most of the discussions and meetings, especially discussions of results of surveys were sometimes emotional.

Quality Standards for a Self-help-friendly Hospital – an Overview

- Provide room, infrastructure and space for presentation to self-help groups
- Provide regular information to patients about self-help
- Support public relation work of self-help groups
- Create a position that will be responsible for coordinating self-help in the hospital
- Regularly exchange of information and experience between self-help groups and professionals
- Implement self-help as part of qualification programs for hospital staff
- Self-help groups to participate in quality circles, ethic commissions etc.
- Formal commitment and documentation of collaboration

Fig. 4. Quality Standards.

because they are not placed in an easy to find places. Sometimes the clinical doctor or the hospital nurse would pass on a flyer but at another time may forget to do so, etc.

In order to ensure that an SOP is implemented, the responsibility and commitment for this issue should cover duties and competences assigned by the hospital management. A self-help coordinator enhancing the implementation of quality standards in a structured and systematic way may act like a "bridge" between hospital and patient organizations in the process of collaboration.

- Aiming for Continuity and Sustainability

Today in Germany, most hospitals have to adapt to patients' expectations of care, and a certain professional manner in regards to medica treatment, based on empirical evidence and research. Patients' rights are also becoming an increasing part of hospital-patient-relationships. Several customized quality management systems and accredited certifiers refer to the current situations under which hospitals and patients have to deal with one another.

Kooperation für Transparenz und Qualität im Krankenhaus (KTQ) is one o the leading German certifers in the area of quality management system (they certify about sixty percent of all German hospitals). The hospitals collaborating in our project also use the KTQ quality management system.

The KTQ model is influenced by EFQM and other quality management models such as ISO and JCIA.

The core element in certifying the process is a structured self-assessment process conducted by the hospitals and is intended to help in identifying weaknesses in work processes. It allows the hospitals to determine whether accreditation can be achieved the first time round and to determine what improvements, if any, are necessary. Self-assessment is based on the assessment catalogue, which the hospital can follow in order to fulfil the required criteria; it is not linked to subsequent certification and can thus be carried out by a hospital independently of certification. If a hospital chooses to participate in certification, the results of the self-assessment are used in preparation for an external survey.

The subsequent external survey is conducted by a team of professionals on the basis of the Anglo-American concept of "peers". In addition to medical, nursing or management qualifications, the surveyors must possess comprehensive knowledge of quality management. External assessment has an educational function: the surveyors are supposed to advise their colleagues during the surveys and also learn about the hospitals' problem solving and trouble shooting mechanism. In addition, interviews are conducted with patients, family members and hospital staff. The quality report represents the performance achieved by the hospital and is published by both the certified hospital and KTQ. (see also http://www.ktq.de)

We also needed to create a mechanism for transparency and to find an effective tool to control the implementation of the quality standards into regular hospital working processes.

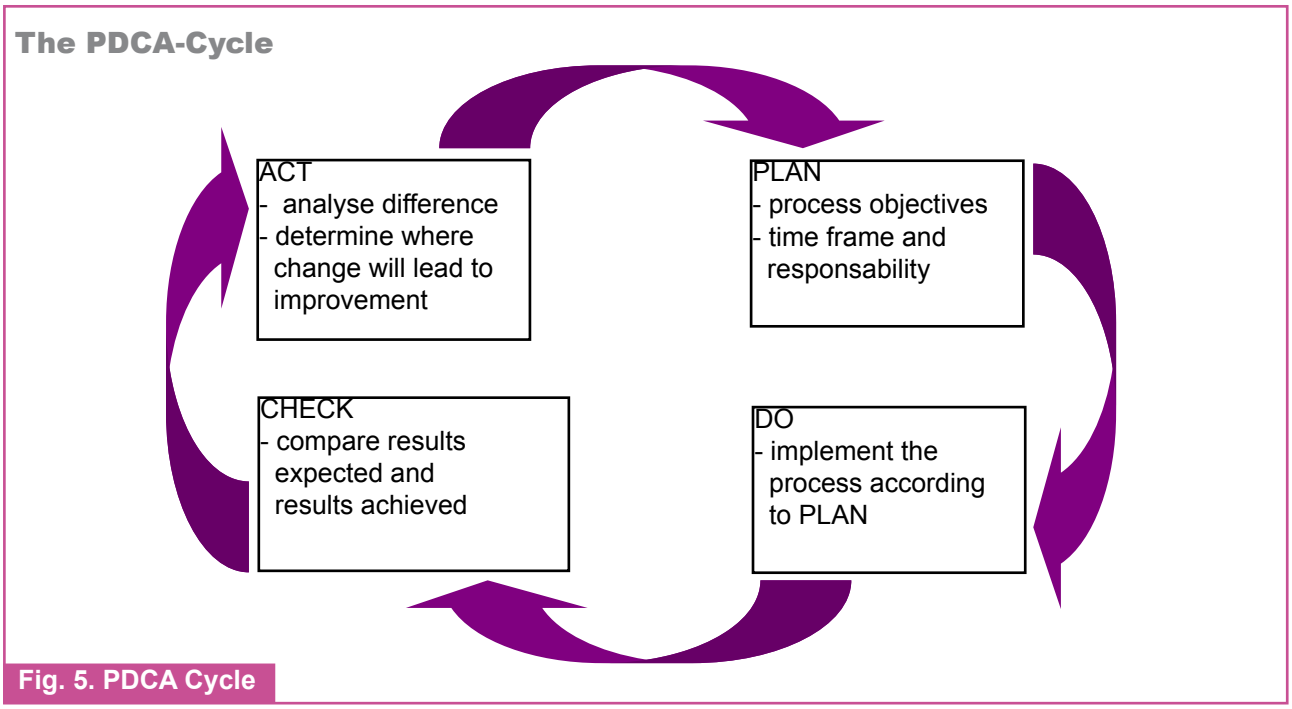

Fig. 5. PDCA Cycle

The creation of the position of a self-help coordinator (as provided in the quality standards) showed the commitment of the top management to the project. This was a milestone in the project since for the first time, the project goals and objectives became integrated into the everyday working of the hospital.

Then the pilot project gained approval from top management of the hospitals to assign clinical departments that were ready to act as "test departments" for conducting self-assessments and external assessments on the topic of self-help-friendliness according to their regular assessment procedure of the quality management system already in use in the hospital.

We revised and augmented five major categories of the quality management system -patient focus, employee focus, Information and communication, leadership and quality management- with additional questions that would form part of the hospital working processes subject to quality control, thereby enhancing the implementation of quality standards for self-help-friendliness.

A questionnaire was generated by the evaluation team for a "trial run" and after optimizing it, the department leaders of seven clinical departments in two hospitals were encouraged to take the chance of evaluating with their staff the situation of fulfilment as a "present state" analysis.

Participatory assessment processes

We established two *survey teams* out of the *evaluation team*, each consisting of five persons: three representatives of patient organizations, one representative each from a hospital (quality manager), a self help clearinghouse in Hamburg.

Our task was to survey seven clinical departments in two hospitals. In order to avoid biased results, quality managers and patient organizations should not evaluate their hospital but rather have mutual insight. With quality managers as part of the survey team a cross evaluation process was arranged. This required another commitment between the surveyors and the management of the hospitals to ensure that patients' data to which the *survey teams* may have access to as well as to insights experienced during the external assessments are handled confidentially.

To ensure that the survey will be completed as planned, we invited ten additional members from patient organizations of similar background as in the *survey teams* as extras.

All participating patient organizations went through two training sessions before finally committing to taking part in the survey.

Especially supportive to the training was the expertise the quality managers of the collaborating hospitals brought into the *survey teams.* Self assessments had been conducted already in their hospitals and not only did they impart know-how about running an assessment day, they also could give good advice as to time schedule and logistic preparations.

The first training session focused on communication skills on how to conduct interviews with hospital staff[9]. The second training session focused on

9. A surveyor should have a thorough know how about hospital work processes and have an open-minded attitude, i.e. he / she should not refer to his or her personal experience with the hospital whether good or bad, but should always remain neutral.

how to evaluate and interpret results using the Plan-Do-Check-Act (PDCA) technique (see Fig. 5)[10].

We used the PDCA-cycle as a base testing tool and augmented it to suite our purposes. We then applied the augmented PDCA-cycle to the categories in the self-assessment manual of KTQ. Every process with a step in the PDCA-cycle was given a maximum score. How many points each step received was based on the degree of completion of that process.

With the numeric score system elaborated the survey team was able to judge the degree of performance, i.e. how quality standards were fulfilled in a coherent and consistent way.

The numeric parameters represented the fulfilment of quality standards in the following level: 0 = did not meet requirements; 1 = met requirements rudimentarily; 2 = requirements fulfilled in some areas (about 50 %); 3 = requirements completely fulfilled.

At the end, we developed indicators like

- targets of activities exemplified;
- expected results in a given time frame;
- scope of responsibility;
- documentation and
- structured methods of controlling

for analyzing whether and how the quality standards had been implemented into the clinical work processes of seven clinical departments.

We examined the results of the self-assessment reports of the seven clinical departments and gave a written report to the heads of the clinical departments on the status quo of implementation of the quality standards.

- Qualifying for the quality award self-help-friendly hospital

Qualifying for an award requires an external assessment and the results from the self-assessments formed the basis for the preparation of the external evaluation. The participating hospitals were highly interested in qualifying for the award. The findings documented in the self-assessment reports of the clinical departments were broadly discussed in the hospitals across all levels of hierarchy and in adjacent clinical departments. This was a motivating factor in getting hospital staff and management to comply with the quality standards and provided an impetus to the staff to win the award.

The department heads used the period between self-assessment and external assessment for improvements to further fine-tune the processes. Performance in the external assessment had to achieve at least fifty-five percent of the total scores to be attained per category.

The hospitals and the *survey teams* agreed on a date for the external survey to begin. The hospitals assigned the clinics and departments and provided us access to visit facilities and inspect documentation relating to the results of the self assessment.

At the start of the survey, the *survey team* presented the project and asked questions that emerged from the results of the self assessment and what changes, if any were implemented between the end of the self assessment and beginning of the external assessment. At the end of this dialogue phase, we moved on to the individual clinics and departments to check the documentation process and to ask hospital staff about specific processes.

At the end of the survey, we presented the results of our findings to the hospital staff. The reports include highlights as well as well recommendations for further improvements.

The last step in the certification procedure requires that a quality report be written by the survey teams together with the clinical departments. In addition to statistical data such as how many beds the hospital has, how many doctors, etc, from the hospital, the quality report provides an overview of the categories evaluated as to the implementation of the quality standards of self-help-friendliness. All processes representing the implementation of the quality standards are described. Since the quality report is generated in collaboration with the hospital and the pilot project based on the documentation provided by the *survey teams*, it is an important document in the certification procedure.

Certification is successfully completed when the quality report is published on the Hospital's home page as well as on the homepage of the pilot project.

Finally, in August 2006 seven clinical departments in two hospitals were certified and qualified for the award "Selbsthilfefreundliches Krankenhaus – self-help-friendly hospital". The award ceremony was a reason to celebrate with all stakeholders of the pilot project and with hospital staff of the clinical departments assessed and also promoted the image of the hospitals in public media.

10 The PDCA-cycle originally elaborated by E. Deming is an iterative four-step problem-solving process employed in business process-improvement. It was also adopted by the KTQ quality management system for evaluating the fulfillment of quality criteria.

Benefits and implications of assessments

The set of quality standards were highly accepted by the hospitals as well as in patient organizations as they give orientation to both sides as to what has to be achieved.

The findings of the self-assessment and of the external assessment showed, that the hospitals complied only moderately with the standards. This was not a surprise for the patient organizations participating in the project, however it was disappointing for the hospital staff. Although the quality standards as suggested by the project were accepted in general by the clinical staff as innovative, they still claimed that they have been implementing them all along. This contradictory view was true in one aspect: Many of the criteria showed good scores in the parameter of “Do” of the PDCA-cycle and a plenty of the activities gathered seemed to relate to the requirements. However, few of them complied with the requirements in “Plan” or in “Check”, because activities and results often turned out to be an accidental occurrence. This led us to conclude in the external assessment that there was considerable room for improvement in closing the gaps.

Since hospitals already have a systematic way of controlling clinical tasks due to their existing quality management system it was clear that the task of collaboration with patient organizations had to be implemented and carried out in a systematic way, as well.

The hospitals put much emphasis on the responsibility of leadership and the role clinical staff played during the assessment processes. It seemed that during the external assessment an old practice sometimes disregarded in SOPs should be revived the personal communication between health professionals and patients as a major factor in their relationship and an important factor to meet the requirements of a patient focused treatment and care. The hospital staff acknowledged that they received valuable inputs from from patient organizations surveyors during the external assessment, since they had personal experience as real patients with knowledge about hospital and clinical processes and documentation.

The hospital management were inspired by the results of the assessments to set new goals in collaboration with patient organizations. They were committed to various improvements in clinical tasks that will have positive effects on internal communicative processes since it initiated dialogue between clinical staff and management.

Lessons learned

Empowerment evaluation is a collaborative, participatory and a user-friendly evaluation mechanism.

As stated at the beginning, the ten principles of empowerment evaluation

- Improvement
- Community ownership
- Inclusion
- Democratic participation
- Social justice
- Community knowledge
- Evidence-based strategies
- Capacity building
- Organizational learning
- Accountability

were not used as explicit guidelines for the evaluation process project. As a result, the case study does not describe the set of principles as postulated by Fetterman and Wandersman (2005). However, the principles could —and did— act as a guide for conducting an evaluation process guided by ethical standards.

A comparative analyses of the pure empowerment evaluation principles (eight out of ten principles)[11] with our project process as applied at the time of the project highlights the deviations from Fetterman’s and Wandersman’s principles in some areas but showed wide agreement in approach. This was a surprising result, given that we did not have the benefit of the guidelines at the inception of the project.

- Improvement

According to Fetterman and Wandersman, empowerment evaluators use the methods and tools of empowerment evaluation to help programs, organizations and communities achieve results:

> This is in contrast to traditional evaluation, which values neutrality and objectivity and wants to examine programs in their “natural state” in order to determine a program’s effect without the influence of the evaluator. Many funding (agents) are interested in empowerment evaluation because they are tired of receiving evaluations that show no results and would like evaluation to be helpful to grantees in achieving results (Fetterman & Wandersman, 2005, p. 30).

11. Except from the principle of social justice and the principle of community knowledge, that will not be considered in this context due to the particularity of the project. The project itself strived for social justice and viewing the community members (stakeholders) as experts on their own community was a prerequisite of the project idea.

All stakeholders and the grant provider health insurance sought improvement in patient focused health treatment and care. The project turned out to be a successful intervention to improve collaboration between hospitals and patient organizations.

The quality standards defined best practice in collaboration. The standards were in a way attractive to all stakeholders. The quality standards were a good fit to the quality management system of hospitals and provided a structured approach to improving collaboration processes.

Some improvements in the hospitals' processes, like the assignment of a self-help-coordinator were particularly noteworthy. All clinical departments that took part in the assessments commented on their collaboration with patient organizations and provided links on their homepages to patient organizations.

At the end of the project, the hospitals as well as the patient organizations suggested the continuation of the process of implementing the quality standards by conducting quality circles to be moderated by the clearing-house.

One of the project's greatest accomplishments was that the quality standards for self-help-friendliness were adopted as a SOP by an accredited certifier for hospitals and closely connected to the categories in an updated version of the self-assessment manual.

- Community ownership

> Empowerment evaluators believe that the community has the right to make decisions about actions that affect their lives. (..) Program stakeholders have the responsibility of making critical decisions about the program and the evaluation. This commitment to community ownership is in contrast to typical traditional evaluation approaches, where decision-making power regarding the purpose, design, and use of evaluation results is held by the evaluators and the funding agent (Fetterman & Wandersman, 2005, p. 31).

The health insurance as grant provider of the project understood the idea of empowerment evaluation. They showed respect for community ownership exercised by the participants of the evaluation team and the consulting committee. The pilot project itself turned out to be a collaboration process, and was a test of the motivation and ability to improve mutual relations and team building of all parties involved.

A great challenge for all participants was to learn to respect each others realms of personal and institutional resources as well as to tolerate distinct points of view that emerged from functions, roles and experiences. The entire decision making process during the project was based on consensus. This helped form a bond between the project team and the stakeholder.

- Inclusion

To collaborate in diversity is a strong characteristic in empowerment evaluation projects.

> Empowerment evaluators believe the evaluation of a program or organization benefits from having stakeholders and staff from a variety of levels involved in planning and decision making. (...) Not being inclusive can be counterproductive to empowerment evaluation and often results in poor communication, undermining behaviour, and a lack of human resources for stakeholders to help one another in improving practices (Fetterman & Wandersman, 2005, p. 33).

From the beginning the key stakeholders were invited to share their knowledge and participate in the project. Because they came from differing backgrounds, it may create tensions, false expectations and skepticism. Subject matter or expert knowledge often lead to prejudice and misconceptions among the collaboration partners. Unequal resources may result in misunderstanding as well.

The project was characterized by the fact that professionals from hospitals and clearing-houses are in the position to contribute their paid-working hours to the project, whereas representatives from patient organizations worked as volunteers. Sometimes participants were unable to attend meetings due to illness or because of to much workload outside of the project, nevertheless their commitment was valued. Addressing those "cultural" differences helped a lot to avoid misunderstandings and unrealistic expectations.

- Democratic participation

> Democratic participation also (1) underscores the importance of deliberation and authentic collaboration as a critical process for maximizing use of the skills and knowledge that exist in the community and (2) emphasizes that fairness and due process are fundamental parts of the empowerment evaluation process (Fetterman & Wandersman, 2005, p. 33).

When the project was proposed, some stakeholders had the expectation that they could exercise institutional power in relation to other stakeholders. We were concerned that working with

diverse partners –profit, public and non-profit– could create a non-appropriate power issue within the group. To discourage this, we made it a priority and our goal solicit all stakeholders' opinions in all levels of planning and decision-making. We also made sure that everyone was equally represented in the working groups and carried their own weight.

Democratic participation contributed to reasonable judicious making when conducting the assessments in the hospitals.

- Evidence-based strategies

> This value of using existing knowledge is part of the commitment to avoid reinventing the wheel and to build from existing literature or practice (Fetterman & Wandersman, 2005, p. 35).

Ours was a seminal project, and we did not have set frameworks from where to build our strategies. The evaluation team as well as the consulting committee sought out the best practices in strategy and practical steps; every adopted tool and strategy had to be adapted to the needs of the project.

- Capacity building

Evaluation capacity was developed by conducting the assessments when provided with the necessary conditions in the organizational environment of the hospitals and with appropriate tools (e.g. outcome measures). Every one learned that evaluation is an ongoing integrated process. The participants acquired new tools to plan, implement, evaluate and produce results.

> "Empowerment evaluation helps people help themselves and in the process acquire new skills and knowledge." (Fetterman and Wandersman, 2005.105)

This approach helped to demystify evaluation and the participants became more self-sufficient.

After many years of experience in hospital stays a member of a patient organization is often familiar with hospital processes, language usage, idioms and medical acronyms used in treatment and documentation protocols. Hospital professionals and patient groups gained new insights into one another's thinking when it became clear that both really understood each other's language. This provided a breakthrough and mutual respect between both parties.

- Organizational learning

> "Argyris (1999) concludes that in order for organizational learing to occur organizations must do the following:
>
> 1. Support learning and not just be satisfied with business-as-usual (i.e., organizations must be open to change).
>
> 2. Value continuous quality improvement and strive for ongoing improvement.
>
> 3. Engage in systems thinking. Organizational learning involves inquiring into the systemic consequences of actions rather than settling for short-term solutions that may provide a temporary quick fix but fail to address the underlying problem.
>
> Promote new knowledge for problem solving (Fetterman & Wandersman, 2005, p. 36).

The clinical departments participating in the assessments used the evaluation feedback to create activities in various organizational areas and to provide resources that would improve collaboration with patient organizations. Implementing the quality standards in the quality management system of the hospital probably shows long term positive and sustainable effects.

The evaluation team and the consulting committee representing the key stakeholders were encouraged to form a learning community working together, although the stakeholders had competing political agendas.

The open structure of the pilot project and project processes by itself encouraged the participants to acquire, apply and master new tools and methods to improve the collaboration between patient organizations and hospitals.

- Accountability

Although the pilot project placed a high priority on process accountability, it also focused on the final outcomes to be achieved.

> A description and assessment of program processes enables program staff and participants to create a chain of reasoning. This helps establish mechanisms for accountability on both process and outcome levels (Fetterman & Wandersman, 2005, p. 37)

The goal of the project was to create a set of processes with guidelines and parameters that when applied in hospital settings, adjusting for particularities in each situation will yield results similar to what was observed in the project.

Linking the quality standards of self-help-

friendliness to the quality management system applied by the hospitals may augment the chance for sustainable effects. To this extent, we are able to say that we have achieved the goal to provide for continuous improvement in collaboration within the two-years project period. Thus more longitudinal studies still have to be made to find out whether and to which extend the interventions were suitable to activate changes in hospitals as well as in patient organizations.

Conclusions

The development, implementation and assessment of quality standards of self-help-friendliness in hospital processes was a seminal project involving patient organizations, clearing-houses and hospitals – all key stakeholders from the healthcare system in Germany.

The project management played a key consulting role in identifying and selecting critical elements to achieve the project's goals in two years. To the extent that the project management team was committed to working within the time and budgetary constraints of the grant provider, certain activities of the evaluation team and the project management were restricted. Further more, it was not always easy to obtain timely approval from hospital top management for necessary steps during the inception and development of the project.

In discussions with the entire stakeholder team, we all realized how important to us all it was to achieve positive results in the pilot project first time round. Not backing the project was not an option for any one since it would have been difficult to encourage the key stakeholders to participate in further projects.

The interdependence of the grant provider BKK, project management and other stakeholders was instrumental to the fact that the project was widely accepted by the relevant communities. The results of the project urged the health insurance BKK to continue to support hospital treatment and programs with patient focus. It has continued to fund other studies in self-help friendliness in other hospitals in Germany.

The transparency and the structure of documentation of the assessments made it possible to trace the scores received in the selected criteria and made outcomes credible. As a result, the certifier KTQ - one of the stakeholders -, implemented the quality standards for self-help-friendliness as a standard format in their assessment manuals, revised and edited in 2009. All stakeholders involved in the project were satisfied with results of the project and approved the use of the project evaluation results. The implementation of the quality standards and the assessment criteria into a widely deployed quality management system for hospitals would enhance the goals of the project - to achieve a sustainable, structured and systematic patient focused collaboration in hospitals.

Not only did the patient organizations participating in the pilot project in Hamburg benefit from the outcomes, but they also gained a higher acceptance from hospitals in other regions. In addition patient organizations to be more confident in their abilities and effectiveness as a voice for change in patient's treatment and care.

The clearing-houses also realized their value as coordinators and a bridge between patient organizations and hospitals. The clearing houses have intensified their role as "match-makers" between hospitals and patient organizations. They also showed interest in working together on future projects.

References

Antonovsky, A. (1987). *Un-ravelling the mystery of health*. London: Jossey Bass.

Argyris, C. (1999). *On organizational Learning.* Malden, MA: Blackwell Business.

Bobzien, M. (2008). *Selbsthilfefreundliches Krankenhaus. Auf dem Weg zu mehr Patientenorientierung*. Praxishilfe. Bundesverband der Betriebskrankenkassen (Eds.) Essen: BKK BV.

Bobzien, M. (2006). Die Zusammenarbeit zwischen Selbsthilfe und Krankenhaus unter Qualitätsgesichtspunkten fördern: Modellprojekt Qualitätssiegel Selbsthilfefreundliches Krankenhaus. In S. Werner, M. Bobzien, S. Nickel and A. Trojan (Eds.): *Selbsthilfefreundliches Krankenhaus. Bundesverband der Betriebskrankenkassen. Gesundheitsförderung und Selbsthilfe*, Bd. 16. Essen: Wirtschaftsverlag NW.

Bobzien, M., Hundertmark-Mayser, J. & Thiel, W. (2006). *Selbsthilfe unterstützen. Fachliche Grundlagen für die Arbeit in Selbsthilfekontaktstellen und anderen Unterstützungseinrichtungen.* Berlin, NAKOS (eds). Bd. 1.

Bobzien, M. (2003). Kooperation von Selbsthilfekontaktstellen mit dem professionellen Versorgungssystem – den Wandel mit den Akteuren initiieren. In DAG SHG (Eds.): *Selbst-hilfegruppenjahrbuch 2003,* pp. 72-83, Gießen.

Borgetto, B., Troschke, J. V. (Eds.) (2001). *Entwicklungsperspektiven der gesundheitsbezogenen Selbsthilfe im Deutschen Gesundheitswesen*. Bd. 12. Deutsche Koordinierungsstelle für Gesundheitswissenschaften, Freiburg: German Coordinating Agency for Public Health.

Fetterman, D., Kaftarian, S. J., Wandersman, A. (1996). *Empowerment evaluation. Knowledge and tools for self-assessment and accountability.* Thousand Oaks: Sage Publications.

Fetterman, D. M. & Wandersman, A. (2005). *Empowerment evaluation principles in practice.* New York: Guilford Press.

Findeiß, P., Schachl, T. & Stark, W. (2000).

Abschlussbericht des Projektes C 2 Modelle der Einbindung von Selbsthilfe-Initiativen in das gesundheitliche Versorgungssystem. Bayerischer Forschungsverbund Public Health – Öffentliche Gesundheit, München.

Groene, O., Jorgensen, S. J. & Garcia-Barbero, M. (2004). *Self-assessment tool for pilot implementation of health promotion standards and indicators in hospitals*. WHO Regional Office for Europe. Copenhagen.

Israel, B. A., Checkoway, B., Schultz, A. & Zimmerman, M. (1994): Health education and community empowerment: Conzeptualizing and measuring perceptions of individual, organizational, and community control. *Health Education Quarterly, 21(2),* 149-170.

Matzat, J. (2003). Zur Kooperation von Selbsthilfe und Rehabilitation. Bemerkungen aus der Selbsthilfekontaktstellen-Perspektive. In *Kooperation von Selbsthilfekontaktstellen und Rehabilitationskliniken,* Berlin, NAKOS-EXTRA, 69-77.

Official Site of The International Society for Quality in Health Care. ISQua, in: http://www.isqua.org

Official Site of the Cooperation for Quality and Transparency in Healthcare, KTQ, in: http://www.ktq.de

Ottawa Charter for Health Promotion (1986). Geneva, World Health Organization, in: http://www.who.int/hpr/NPH/docs/Ottawa_charter_hp.pdf

Pelikan, J, Dietscher, C., Krajic, K. & Nowak, P. (2005). Eighteen core strategies for Health Promoting Hospitals. In O. Groene & M. Garcia-Barbero (Eds.), H*ealth promotion in hospitals: Evidence and quality management.* WHO Regional Office for Europe, Copenhagen.

Rappaport, J. (1986). Collaborating for empowerment: Creating the language for mutual help. In: J. C. Boyte & F. Riessman (Eds), *The new populism. The politics of empowerment.* Philadelphia: Temple University Press.

Rosenbrock, R. (2001). Funktionen und Perspektiven gesundheitsbezogener Selbsthilfe im deutschen Gesundheitssystem. In J. Borgetto & J. V. Troschke (Eds.), *Entwicklungsperspektiven der gesundheitsbezogenene Selbsthilfe im deutschen Gesundheitswesen*. Bd. 12. Freiburg: 28 – 40.

Selbsthilfefreundliches Krankenhaus, in: http://www.selbsthilfefreundliches-krankenhaus.de

Slesina, W. & Knerr, A. (2007). Zusammenarbeit von Ärzten und Selbsthilfegruppen – Formen, Nutzen, Wünsche. Bundesverband der Betriebskrankenkassen (Eds.). *Gesundheitsförderung und Selbsthilfe*, Bd. 21. Bremerhaven: Wirtschaftsverlag NW.

Stark, W. (1996). *Empowerment – Neue Handlungskompetenzen in der psychosozialen Praxis.* Freiburg/Breisgau: Lambertus Verlag.

Stark, W. (2001). Selbsthilfe und PatientInnenorientierung im Gesundheitswesen-Abschied von der Spaltung zwischen Professionellen und Selbsthilfe? In: Borgetto, B., Troschke, J. (eds.): *Entwicklungsperspektiven der gesundheitsbezogenen Selbsthilfe im Deutschen Gesundheitswesen*. Bd. 12. Deutsche Koordinierungsstelle für Gesundheitswissenschaften, Freiburg: 7– 66.

Trojan, A. & Estorff-Klee, A. (2004). *25 Jahre Selbstilfeunterstützung – Unterstützungserfahrungen und –bedarf am Beispiel Hamburgs. Soziologie: Forschung und Wissenschaft,* Bd 10. Münster: LIT-Verlag.

Trojan, A., Werner, S., Bobzien, M. & Nickel, S. (2009). Integration von Selbsthilfezusammenschlüssen in das Qualitätsmanagement im ambulanen und stationären Versorgungsbereich. Bundesgesundheitsblatt Gesundheitsforschung – Gesundheitsschutz, Ausgabe 52, S. 47-54. Berlin: Springer Medizin Verlag.

Vanderplaat, M. (1997). Emanicipatory politics, critical evaluation, and government policy. *Candadian Journal of Program Evaluation, 12(2),* 143-162.

Wandersman, A. (2003). Community science: Bridging the gap between science and practice with community-centered models. *American Journal of Community Psychology, 31* (Nos. 44), 227-242.

Werner, S., Bobzien, M., Nickel, S. & Trojan, A. (2006). *Selbsthilfefreundliches Krankenhaus – Vorstudien, Entwicklungsstand und Beispiele der Kooperation zwischen Selbsthilfegruppen und Krankenhäusern. Bundesverband der Betriebskrankenkassen. Gesundheitsförderung und Selbsthilfe,* Bd. 16. Bremerhaven: Wirtschaftsverlag NW.

Werner, S., Nickel, S. & Trojan, A. (2006). Ergebnisse einer bundesweiten Befragung zum Status quo der Kooperation von Selbsthilfe und Krankenhäusern. In: S. Werner, M. Bobzien, S. Nickel & Trojan, A. (Eds.), *Selbsthilfefreundliches Krankenhaus. Bundesverband der Betriebskrankenkassen. Gesundheitsförderung und Selbsthilfe*, Bd. 16. Bremerhaven: Wirtschaftsverlag NW.