

Posterwalk 4 – PRO

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CHIROPRACTORS' USE OF RESULTS FROM A DANISH SURVEY OF PATIENT EXPERIENCE AND SATISFACTION

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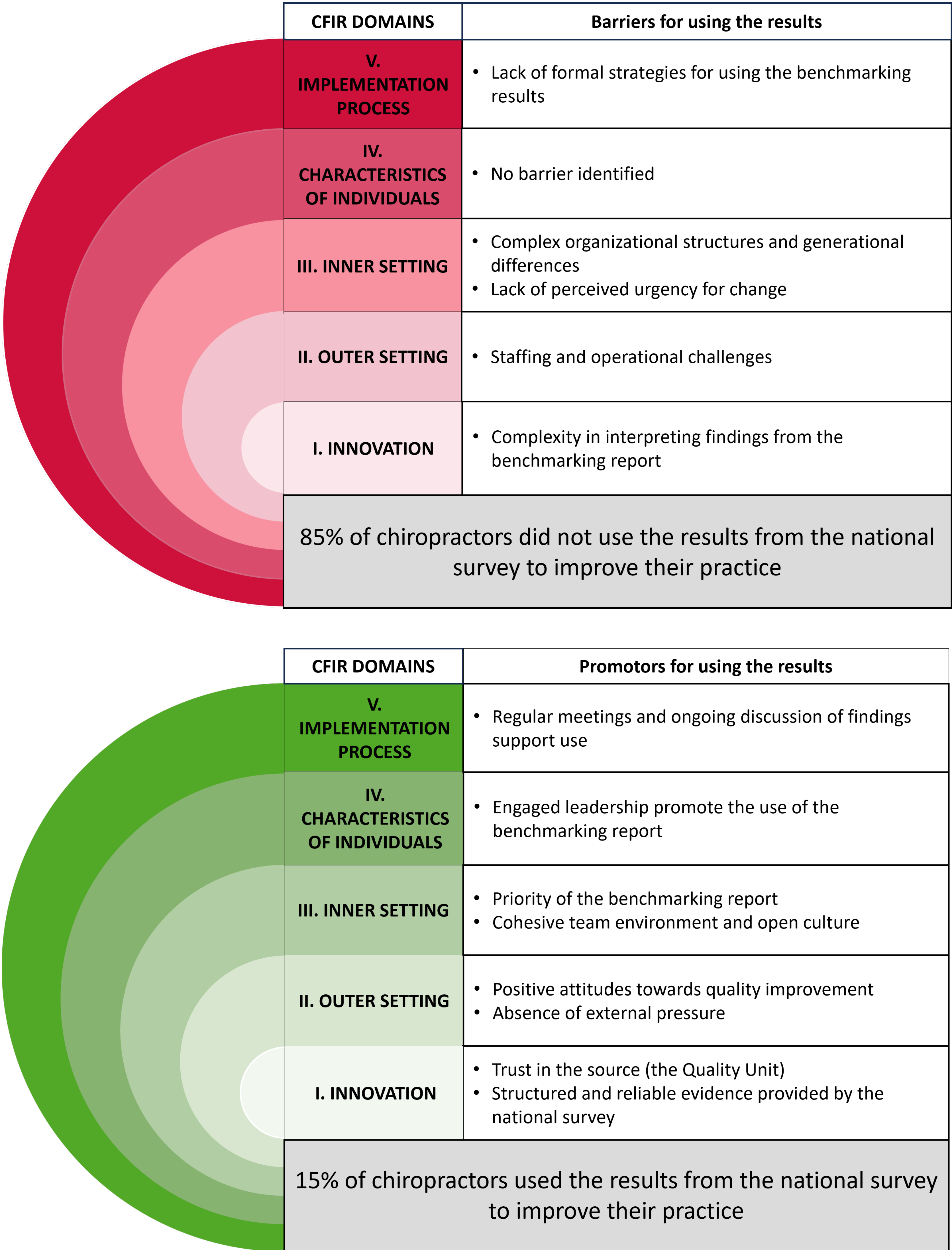
RESULTS

- Positive patient experiences and high **patient satisfaction reduced the need for change** in chiropractic care.
- The results offered an opportunity to **reflect on practice**.
- Chiropractors **used the results to improve their practice**, including: waiting time and efficiency, patient communication and information, clinic access and facilities, improved collaboration between professions in the clinic and staff recruitment.
- To optimise the clinical use of the survey, **improved support for interpretation** of survey results and **action planning** was suggested.
- Identified **barriers could inform future quality improvement** initiatives.

AIMS

1. To explore chiropractors' use of benchmarking results from a national survey of patient experience and satisfaction with chiropractic care.
2. To identify barriers and promoters for using benchmarking results to improve chiropractic practice.

Illustration of joint display analysis integrating quantitative and qualitative results



CFIR: Consolidated Framework for Implementation Research.

METHOD

A national survey of patient experience and satisfaction with chiropractic care was conducted in 2023.

This study was a three-phase mixed-methods study.

- Phase 1: Surveying 331 Danish chiropractors (response rate 46%)
- Phase 2: Interviewing 6 Danish chiropractors about their use of benchmarking results from the national survey.
- Phase 3: Integrating results using joint display analysis.

Qualitative data were analysed using the Consolidated Framework for Implementation Research (CFIR) to identify barriers and promoters for use of benchmarking result to improve practice.

Collecting patient-reported outcomes after major lower extremity amputation: balancing efficiency and inclusivity

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BACKGROUND

Patient-reported outcomes (PROs) are important for evaluating treatment and rehabilitation from the patient perspective. However, systematic PRO collection can be challenging in vulnerable populations. Patients undergoing major lower extremity amputation (MLEA) are generally older, have substantial comorbidity and functional limitations, and receive postoperative care and rehabilitation across different healthcare sectors. Consequently, feasible methods for collecting PROs independent of healthcare setting are needed. Increasing digitalization provides opportunities for efficient data collection but may also introduce selection and exclude vulnerable patients.

AIM

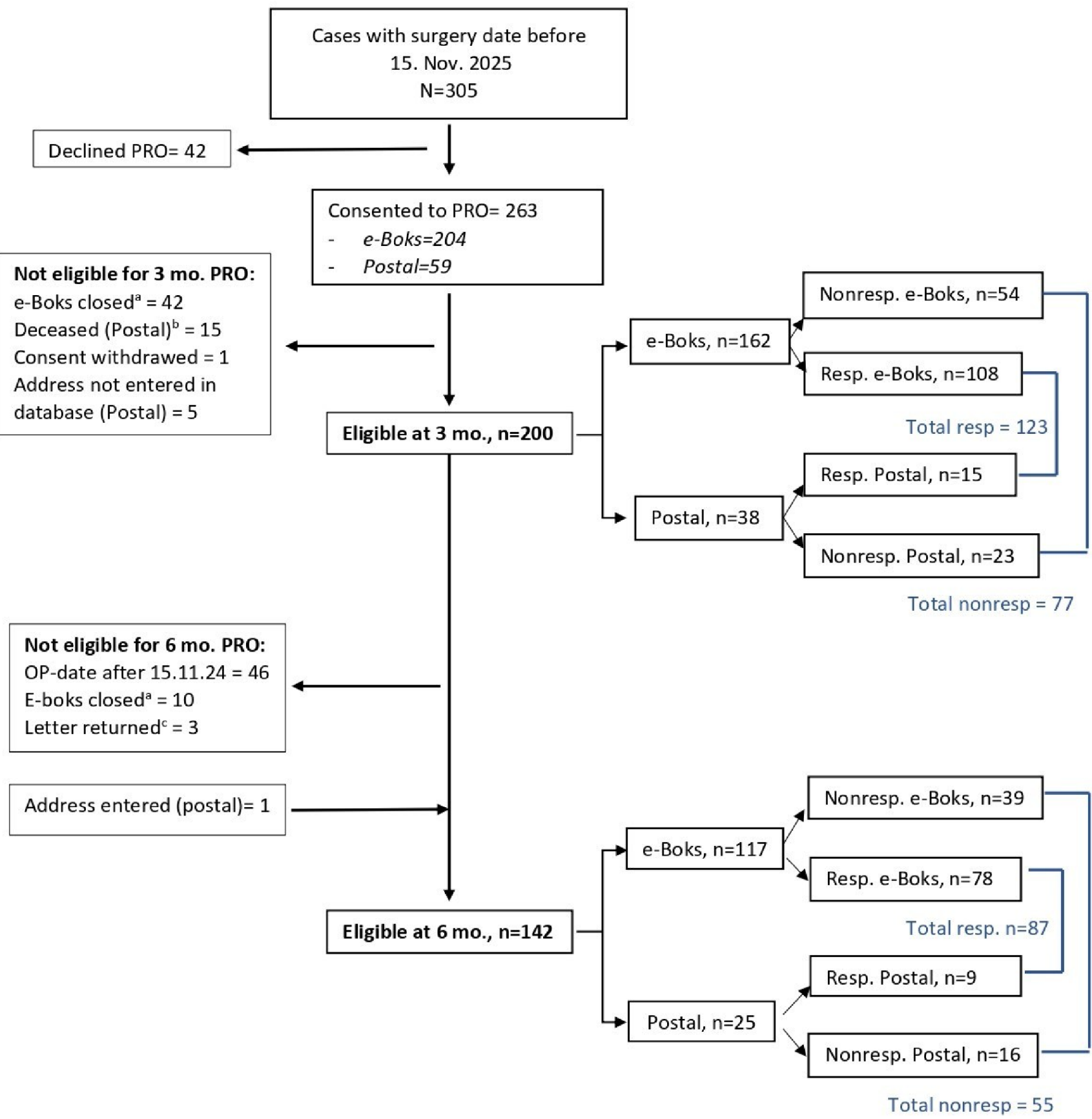
To evaluate two methods for collecting PROs following MLEA: digital distribution via e-Boks and postal mail. The evaluation compared response rates, respondent characteristics, distribution costs, and explored patient-perceived barriers to responding.

METHODS

A mixed-methods study was conducted within the research database DanAmp (the Danish Amputation Database). 12 orthopedic departments across Denmark are reporting to the database. PRO questionnaires were distributed through e-Boks (the Danish national digital mail system) or by postal mail to patients not using e-Boks. Data on response rates and patient characteristics at 3- and 6-month follow-up were analyzed descriptively, with between-group comparisons using appropriate statistical tests. Costs were calculated per questionnaire from a distribution perspective. To explore reasons for non-response, semi-structured telephone interviews were conducted with a subsample of non-responders and analyzed using content analysis.

RESULTS

Figure: Flowchart of participants



Response rates

Among 263 patients consenting to PRO follow-up, 78% received questionnaires through e-Boks and 22% by postal mail. Overall response rates were 62% at 3 months and 61% at 6 months. Response rates were higher among e-Boks recipients than postal recipients at both 3 months (67% vs. 39%) and 6 months (67% vs. 36%). Complete responses were more frequent in the digital group.

Respondent characteristics

Responders were younger, less likely to have atherosclerosis, demonstrated better in-hospital mobility, and were more frequently discharged home compared to non-responders at 3-month follow-up. At 6 months, age differences were reduced, possibly reflecting attrition among the oldest and most vulnerable. e-Boks responders tended to be more mobile and more often lived at home before amputation compared to postal responders.

Costs

The cost of distributing questionnaires via e-Boks was 1 DKK per questionnaire. The cost of distributing questionnaires via postal mail was 172.28 DKK per questionnaire, covering both administrative time and materials.

Patient –perceived barriers

16 interviews were conducted. The average age of participants was 67 years, 6 women and 10 men; 6 transtibial and 10 transfemoral amputations. Only few participants remembered receiving the questionnaire.

The interviews identified barriers related to perceived relevance, questionnaire format, life disruption following amputation, and limited competencies. Although digital communication was familiar to many participants, digital challenges remained for some, while others suggested telephone-assisted completion as an alternative.

"That's fine if it can help with the development of something, then that's good. Yes, if it can help the researchers and so on, then that's fine." (ID15)

"My life has been completely turned upside down, so there has been an overwhelming amount of things to deal with—of all kinds—and it's been pouring into my e-Boks and email. And yes... yes, I haven't even made it through all of it yet." (ID14)

"And then there's this thing about deciding what... because I also think that there's often a lot coming into e-Boks. And then what is it that you... well, of course you deal with what seems most important, right?" (ID8)



CONCLUSION

Digital distribution provides a feasible and resource-efficient approach to PRO collection after MLEA in a highly digitalized healthcare system. However, efficiency must be balanced against inclusivity. Reliance on a single distribution method, risks underrepresenting frailer and digitally excluded patients, potentially introducing systematic bias into PRO-based evaluations. Multimodal approaches, including telephone-assisted collection, should be explored to improve representativeness while maintaining feasibility.

FUNDING

- The Independent Research Fund Denmark (grant ID: 10.46540/3165-00053B)
- Region Zealand and Region South Denmark Research Fund

CONTACT

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Reference Hulsbæk, S., Kristensen, M. T., Hansen, R. L., Hallett, M. F., & Madsen, U. R. (2026). Collecting patient-reported data among patients with major lower extremity amputation. *Int J Orthop Trauma Nurs.* 2026 Aug;62:101315. doi: 10.1016/j.ijotn.2026.101315.



PRO i kommunal kræftrehabilitering



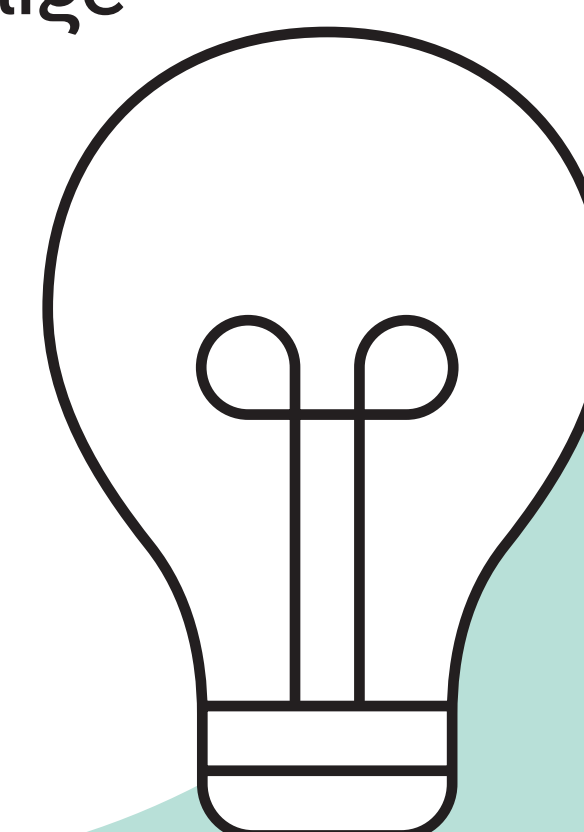
8 års erfaringer med brug af PRO i behovsafdækning, kvalitetsudvikling og forskning

Baggrund

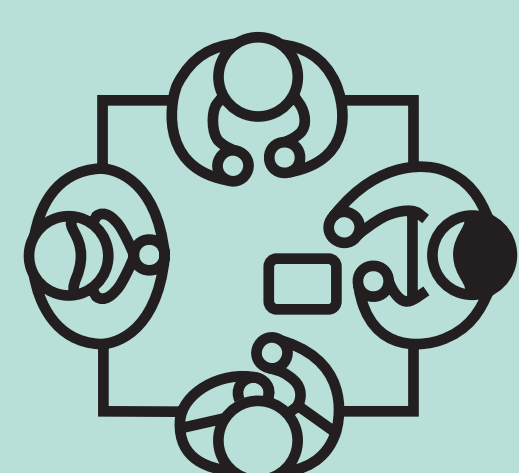
Der er behov for viden om hvordan patientrapporterede oplysninger (PRO) kan integreres i klinisk praksis, så det er anvendeligt på flere niveauer.

Take home

Det kræver meningsfuld anvendelse, tydelige arbejdsgange og ledelsesmæssig forankring.

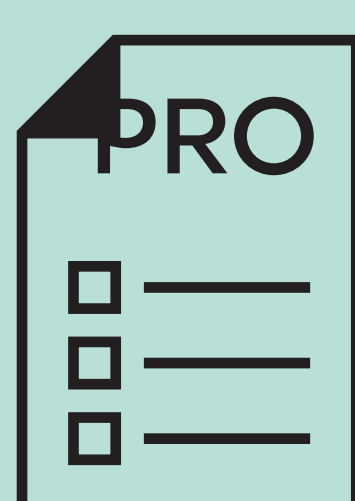


Hvad skal der til?



Inddragelse

Inddrag borgere og medarbejdere i arbejdet med PRO



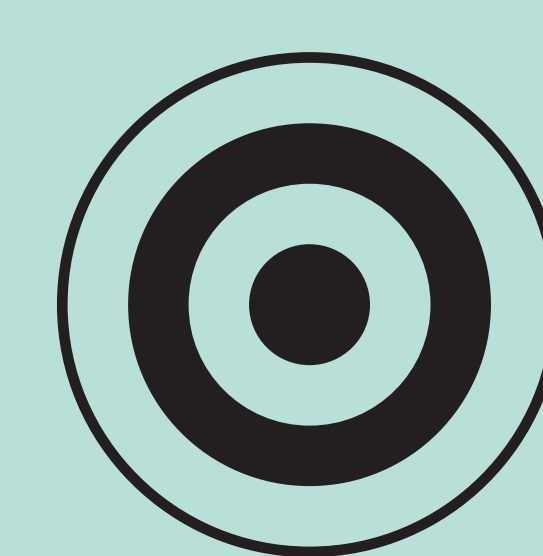
Tilpas PRO til praksis

Gør PRO meningsfuldt og nemt at anvende



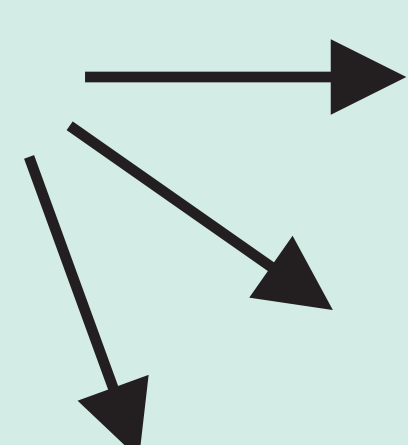
Faglig fortolkning

Kobl PRO-svar til indsatser eller handlinger



Følg op

Sæt mål for PRO-svar og brug data



Kvalitetsudvikling



Forskning

PRO i mødet med borgeren

- Reflektere over egne behov
- Fokus på det vigtige
- Understøtte dialogen
- Identificere og prioritere behov

Det hjælper mig med at få sagt det, der er svært



PRO i kvalitetsudvikling

- Identificere forskelle i behov mellem målgrupper
- Følge udvikling over tid
- Målrette og evaluere indsatser



PRO i forskning

- Skabe ny viden
- Borgere med størst behov får størst indsats
- Borgerne har forbedret livskvalitet efter endt forløb
- Åbne spørgsmål supplerer PRO med borgerens egne perspektiver



Metode

- Retrospektiv praksisbaseret casebeskrivelse
- > 6.000 behovsvurderingssamtaler med PRO
- Interviews med borgere og sundhedsprofessionelle
- Brugerundersøgelser
- PRO-analyser og forskningsstudier
- Organisatoriske dokumenter og arbejdsgange

Husk hvem der er med

- Manglende udsendelse og besvarelse af PRO → ulighed i inddragelse og påvirker datagrundlaget

Forfattere

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¹Center for Kræft og Sundhed København, Københavns Kommune, ²Senfølgerforeningen

Publikationer



Assessment of physical function of hospitalized older patients in routine clinical practice predicts 1-year mortality; A cohort study of 5,062 medical and surgical patients.

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Conclusion

In older medical and surgical hospitalized patients, reduced physical function (CAS, HGS or 30s-STs) was independently associated with markedly increased 1-year mortality. This association was consistent among patients aged ≥85 years and for CAS in high-risk subgroups.

These assessments constitute a simple, low-cost bedside test battery that can easily be implemented in hospitals, acute care facilities, and other healthcare settings, and may support early risk stratification, discharge planning, and targeted rehabilitation across healthcare sectors.

Background and Aim

Reduced physical function in hospitalized patients is linked to adverse health out-comes, including mobility limitations, readmission, and mortality. Early identification of at-risk patients is essential to enable timely preventive interventions, yet physical function is not systematically assessed.

We examined the association between in-hospital physical function and 1-year mortality in adult patients across wards and diagnosis.

Methods

Cohort study including adult patients referred for physical function evaluation by physio- or occupational therapists at Bispebjerg Hospital during a 1-year period, evaluated using CAS, HGS & 30s-STs. Risk of 1-year mortality was analyzed with Cox regression adjusted for age, sex and multimorbidity.

Danish reference values for Cumulated Ambulation Score (CAS) - Handgrip strength (HGS) & 30s Sit-To-Stand test (30s-STs)									
CAS, 0-6 points				HGS, Kg			30s-STs, repetitions		
Age, years	Normal	Reduced	Strongly reduced	Normal	Reduced	Strongly reduced	Normal	Reduced	Strongly reduced
Women									
18-29	6	4-5	< 4	26.8 - 38.6	20.9 - 26.7	< 20.9	19 - 30	14 - 18	< 14
30-39	6	4-5	< 4	27.8 - 39.4	22.0 - 27.7	< 22.0	19 - 30	13 - 18	< 13
40-49	6	4-5	< 4	27.4 - 37.6	22.3 - 27.3	< 22.3	17 - 28	11 - 16	< 11
50-59	6	4-5	< 4	24.7 - 35.1	19.5 - 24.6	< 19.5	15 - 26	9 - 14	< 9
60-69	6	4-5	< 4	21.8 - 31.6	16.9 - 21.7	< 16.9	13 - 23	8 - 12	< 8
70-79	6	4-5	< 4	19.2 - 28.2	14.7 - 19.1	< 14.7	11 - 19	7 - 10	< 7
80-89	6	4-5	< 4	16.2 - 24.4	12.1 - 16.1	< 12.1	10 - 17	6 - 9	< 6
≥ 90	6	4-5	< 4	12.4 - 18.6	9.3 - 12.3	< 9.3			
Men									
18-29	6	4-5	< 4	42.3 - 58.1	34.4 - 42.2	< 34.4	19 - 30	14 - 18	< 14
30-39	6	4-5	< 4	44.5 - 60.5	36.5 - 44.4	< 36.5	20 - 31	15 - 19	< 15
40-49	6	4-5	< 4	44.7 - 59.7	37.2 - 44.6	< 37.2	19 - 29	14 - 18	< 14
50-59	6	4-5	< 4	41.6 - 55.4	34.7 - 41.5	< 34.7	16 - 27	11 - 15	< 11
60-69	6	4-5	< 4	37.1 - 51.9	29.7 - 37.0	< 29.7	13 - 24	8 - 12	< 8
70-79	6	4-5	< 4	31.2 - 45.6	24.0 - 31.1	< 24.0	12 - 21	7 - 11	< 7
80-89	6	4-5	< 4	25.5 - 38.9	18.8 - 25.4	< 18.8	9 - 18	5 - 8	< 5
≥ 90	6	4-5	< 4	14.7 - 27.3	8.4 - 14.6	< 8.4			
Green = normal level (based on mean ± 1SD for HGS og 30s-STs decades). Yellow = Reduced level (interval between normal and strongly reduced) Red = Strongly reduced level (< -2SD). Colors for CAS are based on consensus and evidence. Kristensen MT, Dall CH, Aadahl M, Suetta C. Systematic assessment of physical function in adult patients across diagnoses. Ugeskr Laeger. 2022 Oct 24;184(43) https://pubmed.ncbi.nlm.nih.gov/36331169/									

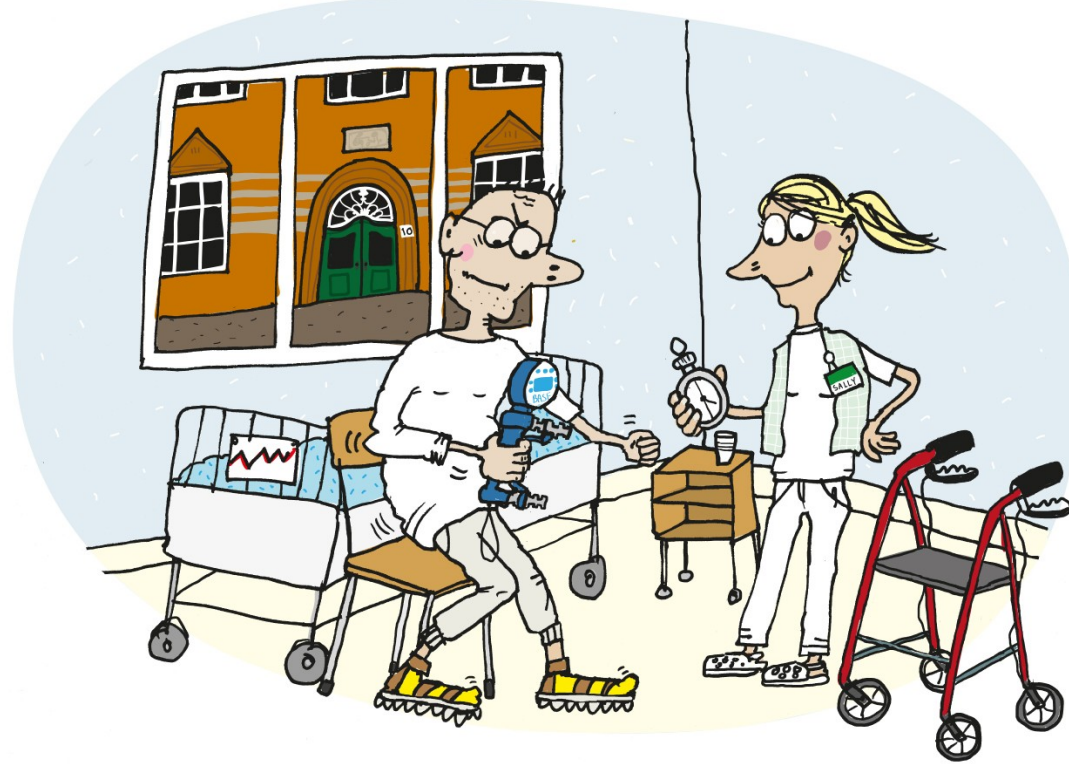
Results

A total of 5062 patients with a mean (SD) age of 74.5 (13.9) years (54% women), were evaluated with CAS in an acute (n = 337), surgical (n = 1671) or medical (n = 3054) ward. Of these, the 30s-STs was assessed in 85% (n = 4309) and HGS in 51% (n = 2580) patients, respectively.

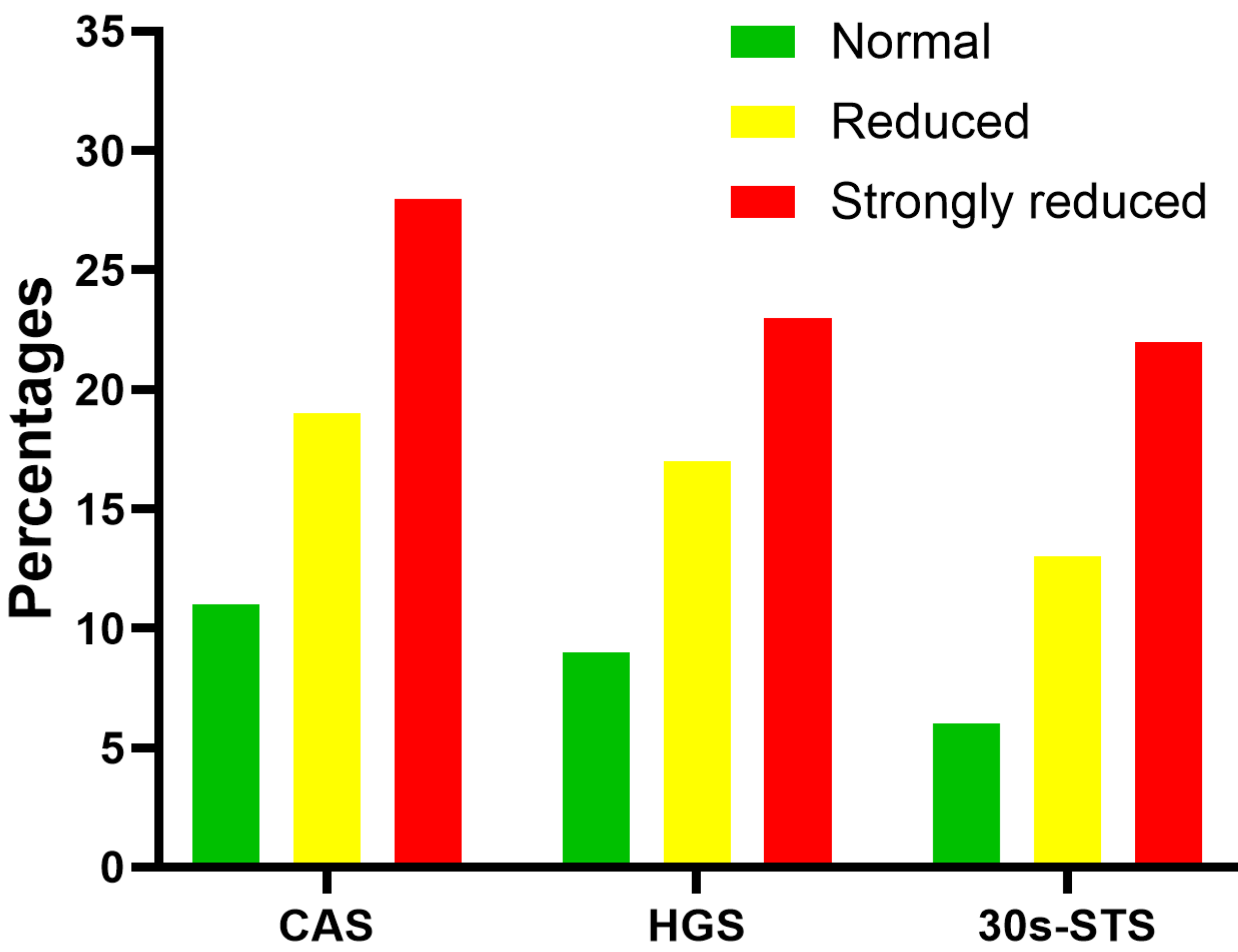
Results

One-year mortality;

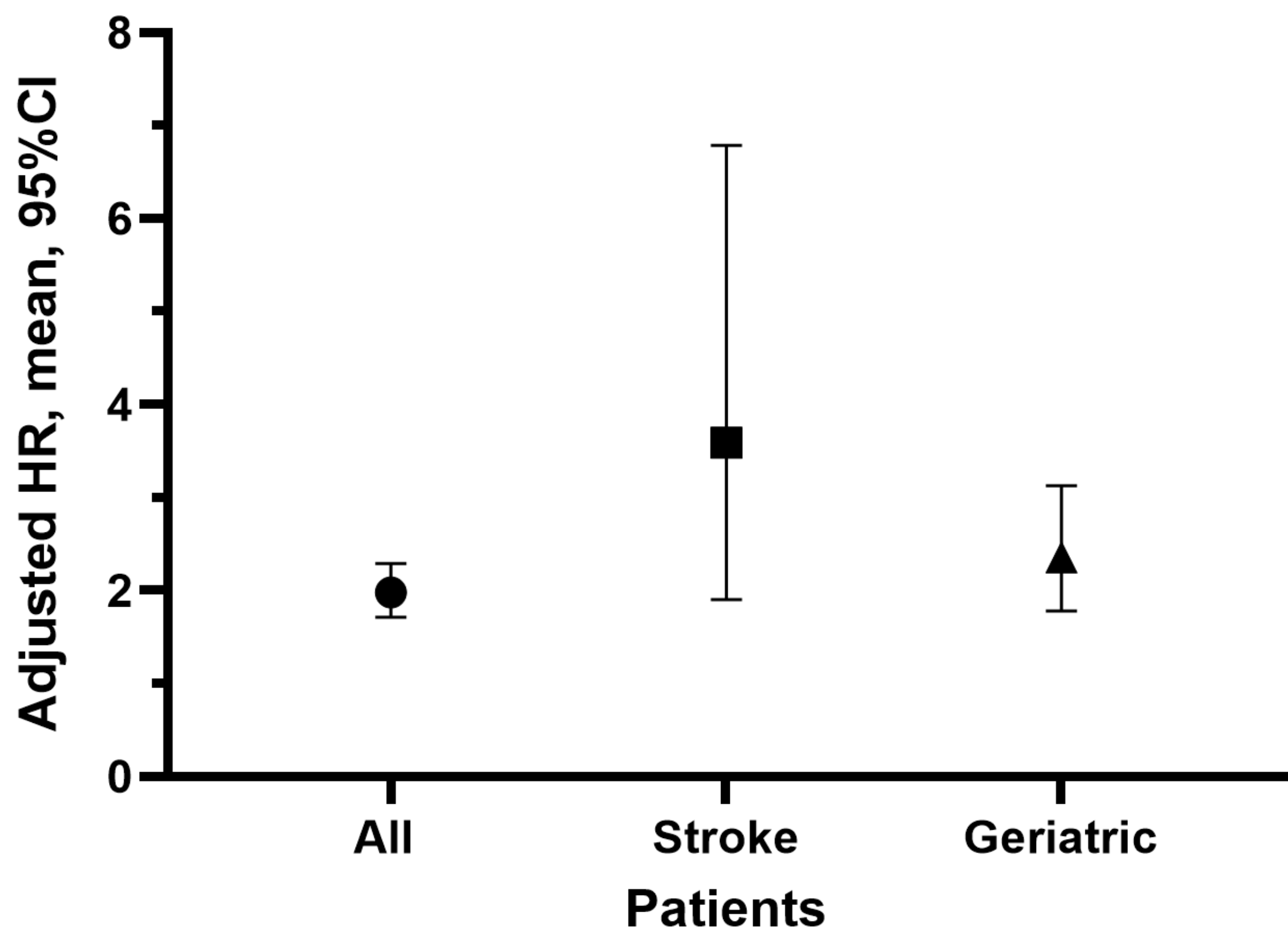
- ✓ Overall 1-year mortality was 19.3%
- ✓ Adjusted Hazard Ratio (aHR) for 1-year mortality for patients with reduced CAS, HGS and 30s-STs was 1.98 (95%CI, 1.71-2.29), 2.06 (1.66-2.56) and 3.57 (2.21-5.78), respectively
- ✓ Correspondingly, aHR for all patients ≥85 years of age (n=1185) were 2.02, 1.98 and 3.34, respectively
- ✓ For patients with stroke (n=631) and admitted to geriatric wards (n=862), 1-year mortality was 16.2% and 31.7%, respectively → aHR for 1-year mortality for patients with reduced CAS-mobility (63% and 61%) were 3.59 (95%CI, 1.90-6.79) and 2.36 (95%CI, 1.78-3.13), respectively



Physical function and 1-year mortality



CAS < 6 points and 1-year mortality



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More info →



Sponsors



Bispebjerg and Frederiksberg
Hospital

Fra audit til forbedring – 38% → 66%

Kvalitetsforbedring af udlevering af samtykkeerklæringer i stråleterapi

Vanja Remberg Gram, Sofie Scheel Clausen
Afdeling for Kræftbehandling

Baggrund:

Patienter i stråleterapi genererer store mængder patienthenførbare data, som kan anvendes til bl.a. undervisning, kvalitetsudvikling og forskning. Korrekt udlevering af samtykkeerklæringen er en forudsætning for denne anvendelse. Anekdotisk oplevelse af manglende udlevering førte til en systematisk audit.

Formål:

At undersøge medarbejdernes efterlevelse af afdelingens praksis for udlevering af samtykkeerklæringer, identificere barrierer og variation mellem patientgrupper, samt iværksætte målrettede forbedringstiltag med henblik på at øge udleveringsprocenten til afdelingens fastsatte mål på 70%.

Baseline audit



Figur 1. Baseline audit viste 38% efterlevelse af afdelingens praksis for udlevering af samtykkeerklæringer.

Metode:

Baseline audit på 139 patienter bekræftede lav udlevering af samtykkeerklæringer. Der blev undersøgt variation i udleveringen på tværs af diagnosegrupper, acceleratorer, og mellem kurative og palliative forløb. Dette førte til en handlingsplan i form af forbedringsprocessen (Figur 2) med opfølgende audits hver 6. måned.

Forbedringsprocessen

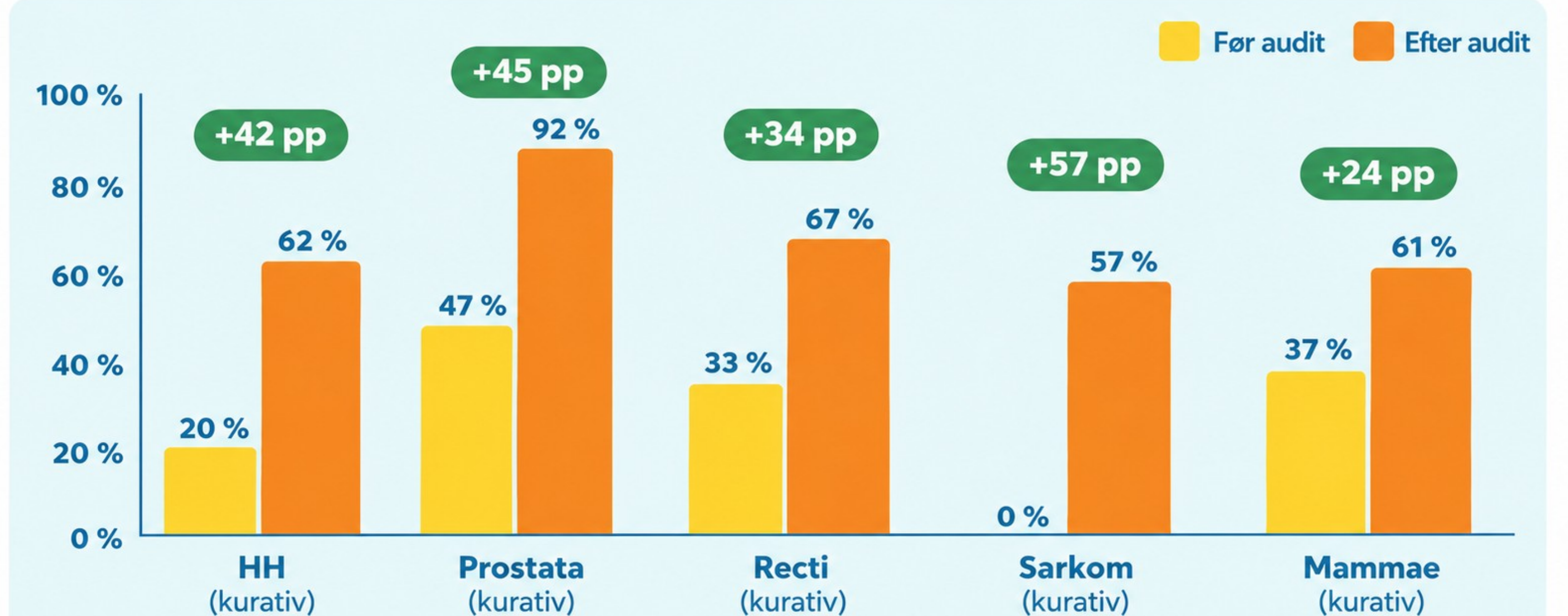


Figur 2. Forbedringsprocessen

Resultat og analyse:

- 38% → 66%: +28 procentpoint samlet.
- Kurativ: 39% → 71% (+32 procentpoint).
- Palliativ: 35% → 48% (+13 procentpoint).
- Forbedringen var ikke ensartet på tværs af behandlingsintentioner og acceleratorer.
- Forskellen mellem kurative og palliative forløb steg fra 4 til 23 procentpoint.

Udlevering af samtykkeerklæringer på udvalgte diagnosegrupper



Figur 3. Variation imellem diagnosegrupper. Forbedring sås på tværs af mange diagnosegrupper, men var ikke ensartet.

Udlevering af samtykkeerklæringer pr. accelerator



Figur 4. Sammenligning imellem acceleratorer viste stor variation i udlevering af samtykkeerklæringer og peger på forbedringspotentiale

Efter intervention



Figur 5. Efter intervention ses forbedring på +28 procentpoint. Forbedringen var dog ikke ensartet, med stor variation i fordeling mellem kurativ og palliativ behandlingsintention

Konklusion:

Audit og målrettede forbedringstiltag øgede udleveringen af samtykkeerklæringer fra 38% til 66% (+28 procentpoint). Målsætningen på 70% er nået for patienter med kurativ, men ikke palliativ behandlingsintention. Variation på tværs af behandlingsintention og acceleratorer peger på behov for yderligere forbedringer for at sikre en mere ensartet udleveringspraksis.

Næste forbedringscyklus fokuseres på:

- Palliative forløb – målrettet indsats for at øge udlevering
- Løbende audit – halvårlig måling af efterlevelse
- Feedback – Data tilbage til personalet med dialog om barrierer og bias
- Fastholdelse – Ved stabil målopfyldelse → årlig audit

Udvikling af et patientrettet materiale til Fælles Beslutningstagning

Af Stina Brogård Andersen, PhD, Sundhedsstaben, OUH og
Helle Sørensen von Essen, PhD, Neurokirurgisk afdeling, OUH



Baggrund

I Region Syddanmark er implementering af fælles beslutningstagning et prioriteret område. Hidtil har fokus været på uddannelse af sundhedsprofessionelle, mens der har været mindre opmærksomhed på at klæde patienter på til aktivt at efterspørge og drøfte deres muligheder.

Formål

Formålet med dette projekt har været at udvikle et patientrettet materiale, der kan motivere patienter og pårørende til at stille spørgsmål og efterspørge information om deres valgmuligheder. Materialet skal kunne anvendes uanset klinisk kontekst, diagnose og årsag til kontakt med hospitalet.

Metode

En arbejdsgruppe bestående af seks patient- og pårørenderepræsentanter samt to eksperter i fælles beslutningstagning udarbejdede i samarbejde med en designer de første udkast til materialet. Indholdet var inspireret af eksisterende materialer og modeller såsom Ask 3 Questions [1], Choosing Wisely [2] og en tilpasset version af Three-Talk modellen [3]. Flere brugertests blev gennemført ift. forside tekst, indholdstekst og design (Figur 1).

Materialet blev revideret efter hver testrunde på baggrund af deltagernes vurderinger. Test 1 og 2 omfattede både afstemninger og kommentarer til tekst og design. I den afsluttende testrunde blev der gennemført kvalitative interviews med think-aloud-metode og kognitiv interviewteknik for at undersøge deltagernes umiddelbare reaktioner, navigation i materialet samt forståelse og fortolkning af indholdet. Oplevet brugervenlighed blev desuden vurderet med en tilpasset version af System Usability Scale. Den endelige udgave er foreløbigt pilottestet blandt nogle få patienter, pårørende og klinikere i Neurokirurgisk Ambulatorium på OUH.

Resultater

I alt har 112 patienter og pårørende, 11 hospitalsansatte, herunder to eksperter i fælles beslutningstagning, været involveret i udviklingen. Den endelige version er tilpasset ud fra afstemningernes resultater og feedback fra test- og interviewpersoner. System Usability Scale samt pilottesten i den kliniske afdeling viste at deltagerne vurderede materialets brugervenlighed overvejende positivt. Tilbage meldingerne pegede især på høj oplevet forståelighed, tydelighed og anvendelighed som støtte til at stille spørgsmål i mødet med sundhedsvæsenet.

Figur 1 – Illustration af udviklingsprocessen

Figuren er AI-genereret med ChatGPT på baggrund af forfatterens specifikationer



	Det udviklede generiske materiale kan støtte patienter og pårørende i at stille spørgsmål og efterspørge information om behandlingsmuligheder.
	Materialet har potentiale til at understøtte fælles beslutningstagning og styrke aktiv deltagelse i kliniske beslutninger.
	Yderligere evaluering af effekten på patientaktivering, oplevet inddragelse og anvendelse i klinisk praksis er planlagt.

Referencer

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2. ABIM Foundation, Consumer Reports. 5 Questions to Ask Your Doctor Before You Get Any Test, Treatment, or Procedure. Choosing Wisely; 2016.
3. Elwyn G, Durand MA, Song J, et al. A three-talk model for shared decision making: multistage consultation process. BMJ. 2017;359:j4891. doi:10.1136/bmj.j4891

Interreg



Kofinanziert von
der Europäischen Union
Medfinansieret af
Den Europæiske Union

Deutschland – Danmark

DAILY SDM
Shared Decision Making

Arbejdet er en del af projektet DAILY SDM, der er medfinansieret af Den Europæiske Union gennem Interreg Deutschland-Danmark-programmet.

Region Syddanmark

patienten først OUH

OUH
Odense Universitetshospital
Svendborg Sygehus