



ELSEVIER

Contents lists available at ScienceDirect

Health Policy

journal homepage: www.elsevier.com/locate/healthpol

Health reform monitor

Developing cross-sectoral quality assurance for cataract surgery in the statutory quality assurance program of the German health care system: Experiences and lessons learned



Anke Bramesfeld^{a,b,*}, Jürgen Pauletzki^a, Lars Behrenz^a, Joachim Szecsenyi^{a,c}, Gerald Willms^a, Björn Broge^a

^a AQUA Institute for Applied Quality Improvement and Research in Health Care GmbH, Maschmühlenweg 8–10, 37073 Göttingen, Germany

^b Institute for Epidemiology, Social Medicine and Health System Research, Hanover Medical School, Carl-Neuberg-Straße 1, 30625 Hanover, Germany

^c Department of General Practice and Health Services Research, Universitätsklinikum Heidelberg, Voßstraße 2, 69115 Heidelberg, Germany

ARTICLE INFO

Article history:

Received 14 October 2014

Received in revised form 23 February 2015

Accepted 15 March 2015

Keywords:

Quality in health care
Quality assessment
Quality improvement
Health insurance data
Health policy
Health system

ABSTRACT

Since 2001, statutory external quality assurance (QA) for hospital care has been in place in the German health system. In 2009, the decision was taken to expand it to cross-sectoral procedures. This novel and unprecedented form of national QA aims at (1) making the quality procedures comparable that are provided both in inpatient and outpatient care, (2) following-up outcomes of hospital care after patients' discharge and (3) measuring the quality of complex treatment chains across interfaces. As a pioneer procedure a QA procedure in cataract surgery QA was developed. Using this as an example, challenges of cross-sectoral QA are highlighted. These challenges relate, in particular, to three technical problems: triggering cases for documentation, following-up patients' after hospital discharge, and the burden of documentation in outpatient care. These problems resulted finally in the haltering of the development of the QA procedure. However, the experiences gained with this first development of cross-sectoral QA inspired the reorientation and further development of the field in Germany. Future cross-sectoral QA will rigorously aim at keeping burden of documentation small. It will draw data for QA mainly at three sources: routine data, patient surveys and peer reviews using indicators. Policy implications of this reorientation are discussed.

© 2015 Elsevier Ireland Ltd. All rights reserved.

1. Background

Since 2001, all hospitals in Germany are legally required to provide data for external quality assurance (QA) [1].

* Corresponding author at: AQUA—Institut für angewandte Qualitätsförderung, und Forschung im Gesundheitswesen GmbH, Maschmühlenweg 8–10, 37073 Göttingen, Germany. Tel.: +49 551/789 52 273; fax: +49 551/789 52 10.

E-mail addresses: Anke.Bramesfeld@Aqua-Institut.de, bramesfeld.anke@mh-hannover.de (A. Bramesfeld).

<http://dx.doi.org/10.1016/j.healthpol.2015.03.008>

0168-8510/© 2015 Elsevier Ireland Ltd. All rights reserved.

External QA aims at comparing similar services that are provided by different hospitals and thus, distinguishing hospitals by their quality of clinical performance. For the time being, this type of statutory QA that compares the performance of services is being implemented for inpatient services only. Therefore, at the moment, QA in hospitals can only provide reliable information on outcomes that are achieved during a hospital stay. The assessment of outcome indicators for long- or midterm outcomes after being discharged from hospital is only possible on a voluntary basis and if data is available.

This inability of the present QA scheme to report mid- and long-term outcomes reliably was one of the reasons why the legislator decided in 2007 that external QA should in future be implemented preferably cross-sectorally (section 137a of Book V of the German Social Code (SGB V)). The need for reliable follow-up information after being discharged was reinforced by a steady drop in the number of days spent in hospital in recent decades [2]. It was also emphasized by an increase in surgical and other procedures that used to require hospital admission but which are nowadays performed in outpatient care [3]. In addition, it was acknowledged that the quality of inpatient care for certain diagnoses depends not only on processes in hospital, but also on processes in outpatient care before admission and after being discharged. Finally, it needs to be recognized that in a complex health system that is dominated by multi-morbidity, the quality of care depends significantly on the interplay and cooperation between the medical specialties and sectors involved. Thus, implementing QA from a cross-sectoral perspective seemed an obvious however novel way to proceed [4].

In 2009, the AQUA Institute was commissioned with the development and implementation of statutory QA in the German health care system. Since internationally there are no precedent models of cross-sectoral QA that cover complete health systems this required a pioneer approach. The first clinical area to be selected for development was cataract surgery. This first QA procedure, like also some that followed was halted on account of reservations mainly by the stakeholders about the effort-benefit ratio of these procedures. Although not developed right through to full implementation, this first QA procedure on cataract surgery is a valuable source for learning and highlighting central issues and pitfalls in cross-sectoral QA. By the example of cataract surgery this paper describes these central issues and pitfalls of cross-sectoral QA and reports on lessons learned.

2. Statutory Quo of statutory quality assurance in the German health system

To better understand the challenges of implementing nationally cross-sectoral QA in the German health system, a few facts about this health system need to be highlighted:

The German health care system is based on more than 90% of the population being health insured in one of Germany's statutory health insurance companies. Which services in medical care are reimbursed by statutory health insurance companies and the framework and contents of QA for these services is specified centrally by the Federal Joint Committee (Gemeinsamer Bundesausschuss, <http://www.english.g-ba.de/>). It is the highest decision-making body of the joint self-government of physicians, dentists, hospitals and health insurance funds in Germany. It was the Federal Joint Committee that mandated the AQUA Institute with the development and implementation of QA in the health care system.

At the moment statutory QA assesses clinical performance for 30 clinical areas in almost 2000 hospitals and approximately 4 million hospital inpatients by using indicators on structure, processes and also outcomes (see

Table 1

Clinical areas of the statutory external quality assurance scheme in the German health care system.

1. Cholecystectomy
2. Carotid artery reconstruction
3. Community-acquired pneumonia
4. Pacemaker: implantation
5. Pacemaker: replacement of generator/battery
6. Pacemaker: revision/system replacement/removal
7. Implantable cardioverter defibrillators: implantation
8. Implantable cardioverter defibrillators: replacement of generator/battery
9. Implantable cardioverter defibrillators: revision/system replacement/removal
10. Coronary angiography and percutaneous coronary intervention (PCI)
11. Coronary surgery, isolated
12. Aortic valve surgery, isolated
13. Combined coronary and aortic valve surgery
14. Heart transplantation
15. Lung and heart–lung transplantation
16. Liver transplantation
17. Living liver donation
18. Kidney transplantation
19. Living kidney donation
20. Pancreas and pancreas–kidney transplantation
21. Breast surgery
22. Obstetrics
23. Neonatology
24. Gynecological surgery
25. Femoral fracture near the hip joint
26. Hip replacement: primary implantation
27. Hip replacement: revision and component exchange
28. Total knee replacement: primary implantation
29. Knee replacement: revision and component exchange
30. Nursing: prevention of pressure ulcers

Table 1). For the indicators that are connected to the 30 clinical areas, hospitals collect data continuously throughout the year. Results of performance indicators are reported back to the hospitals once a year and hospitals need to justify their data once they perform outside the expected range [5]. At the beginning of the national QA scheme, data for indicators was collected solely by hand. Today, data is in some parts also drawn from routine data that is available in hospitals' electronic reporting systems.

3. Developing cross-sectoral quality assurance

When the political decision was taken to implement cross-sectoral QA, hopes were raised that this could be a solution for many problems arising from the strict segregation of inpatient and outpatient care in German health care [4]. Cataract surgery was chosen as one of the first clinical areas for which cross-sectoral QA was to be developed because – in part – it is considered a simple, clear cut intervention. Further it is performed similarly in inpatient and outpatient care and requires a simple one-stage follow-up consultation to check for complications and outcomes that is usually done in outpatient care. It is estimated that annually about 600,000 to 800,000 cases of cataract surgery are performed, of which 88% in outpatient care [6,7]. Thus, the established quality assurance system that focuses only on inpatient care would miss most cataract surgery.

The development of new QA procedures by the AQUA Institute follows defined methodological standards that are

Download English Version:

<https://daneshyari.com/en/article/6239396>

Download Persian Version:

<https://daneshyari.com/article/6239396>

[Daneshyari.com](https://daneshyari.com)