

**Building Quality Development Program in Slovakia
MATRA**

MINUTES

**Consensus Workshop on Quality Indicators & Minimal Technical Standards for GPs
(Saturday: June 18th 2005, 9.00 – 13.30)**

Program

Review of selections made during workshop on Thursday on Quality Indicators for GP's and Minimal Technical Standards for GP's offices

Facilitator: Dr. Johannes Dalhuijsen, Primary Care Development Centre, University of Northumbria, Newcastle-upon-Tyne UK

Discussion on refining selected indicators and recommendations of minimal technical standards – suitable for Slovak conditions

Facilitator: Dr. Johannes Dalhuijsen

Coffee break (10.00 – 10.30)

Summary session with formulation Final proposal of: Quality Indicators for GP's & List of Minimal Technical Standards for GPs offices

Chairman: Dr. Johannes Dalhuijsen

Minutes

Present on behalf of project: Dr. Johannes Dalhuijsen, prof. Niek Klazinga, Dr. Jaap Koot, Dr. Lucia Lenartova, Dr. Martin Rusnak

List of participants – *Annex 1*

Dr. Dalhuijsen opened the workshop, welcomed all participants and asked them to briefly introduce themselves.

Dr. Koot stressed the goal of the workshop: to discuss minimal technical standards for equipment of GP practice, internal and external indicators for GPs and draft the final sets. Dr. Dalhuijsen chaired the discussion with GPs and outcome of the discussion with GPs was drafting following materials:

1. List of GP indicators – *Annex 2*
2. Methods of data collection
3. Tasks of GP practice

Methods of data collection

When defining indicators it is useful to look at the methods via which these could be collected. The following methods of data collection could be used as a source of indicators as part of QI for GPs in the Slovak republic.

Practice computer. (Almost) every practice already uses a computer. Software is readily available. The practice computer is suitable to collect internal and external indicators. Routinely collected data can be a source of external indicators. Compulsory at present is the reporting of: number of patients, procedures done, drugs, dg codes. Codes and their inclusion criteria need to be used in a standardized fashion. This is probably already the case for compulsory data collection, but needs to be verified. For internal indicators, the practice computer can be used to make data-selections or queries. Software supporting queries needs to be identified, if available, and if not available it needs to be developed. Here, also,

codes and their inclusion/ exclusion criteria need to be standardized, so that in due time reliable benchmarks can be established.

Survey / Questionnaire – filled in by physician. This is an acceptable method for collecting internal and even for external indicators, as long as there is a means of validation and control, for example by occasionally inspecting/auditing a random sample of physicians.

Patients' satisfaction questionnaire: in principle a useful instrument for improving aspects of quality such as communication, patient focus and specific organizational elements (access). The process of issuing and using a patient survey in quality improvement at the practice level is in itself a potential external indicator. The actual results of the survey should be used for internal quality improvement purposes only.

Practice visits – regular visits of health care insurers are presently taking place in the Slovak republic. All insurers strive to visit all practices every two years, although the actual frequency is probably much lower, reflecting the available capacity. Visits can be used for monitoring external indicators. For reasons of efficiency, it is recommended that insurers cooperate so that each practice is visited only once or twice per two-year period.

A National Health Care Statistics audit is run regularly (about once every two years). There is a plan to continue or even expand this audit in the future. All GP practices are obliged to provide data via a questionnaire. The information seems presently difficult to validate, as verifying practice visits do not take place. Information may be inaccurate or out-of-date at the time of publishing. There is overlap in data collected with the visits done by insurers and with the compulsory routinely provided data sets. Although the National Health Care Statistics at present seems to be the best of internal and external indicators, this may change as the scheme is developed.

Other data sets – hospital, financial, UZIS are potentially useful for internal indicators.

Providing a practice leaflet is compulsory for all practices. This leaflet at present must include names of staff, telephone lines, opening hours, and care facilities and in the future should include information for patients about complaints procedures.

Tasks of General Practice

Main categories of tasks for GPs are:

- A) First contact care
- B) Medical procedures & operations
- C) Disease management
- D) Prevention and health promotion
- E) Infection prevention in the practice

All these categories apply to the Slovak situation. However, against the background of a relatively large number of specialists, children are generally seen by pediatricians and gynecological problems in women are dealt with by gynecologists. For other health problems women are seen by their GP. There are other restrictions to GP tasks, such as that diabetic is seen by endocrinologists – however the endocrinologist's role is to deal only with blood sugar treatment. Other risk factors – equally of influence to health and often equally difficult to treat – are dealt with by GPs.

In discussing tasks of GPs, it appears that the legal framework leaves substantial room for independent prescribing of GPs for a wide range of clinical conditions, but in actual practice this seems to be limited due to:

- the financing structure (few incentives)
- local and regional 'rules' and routines.

If guidelines were developed for important conditions and health problems that would include or even focus on the GPs perspective, that would enhance their clinical autonomy within a quality framework, promote evidence based medicine and probably reduce seemingly arbitrary ideas about what must' and 'mustn't' be done by GPs.

Guidelines topics

From the discussion, the following guideline topics were identified as priorities for GPs care:

- Diabetes Mellitus (there is a need to revise current system of patients supervision and the role of GPs, focusing more on integrated management of risk factors, allocating more responsibility and autonomy to GPs and alleviating load on DM specialized outpatient services)
- Hypertension (rational prescribing and integrated management of risk factors)
- Dyspepsia (rational, efficient diagnostic pathways and prescribing)
- Hyperlipidemia (including all diagnostic as well as therapeutic processes)
- Depression (a very frequent condition with seemingly minimal interest of GPs. Could effectively decrease inappropriate care and the workload of specialized outpatient services)
- Disinfection and Sterilization (this would be necessary to channel increased efforts in dealing with serious infectious diseases and the development of multi-resistant strains); EU guidelines on sterilization on { [HYPERLINK "http://europa.eu.int/comm/enterprise/newapproach/standardization/harmstds/reflist/meddevic.html"](http://europa.eu.int/comm/enterprise/newapproach/standardization/harmstds/reflist/meddevic.html) } are complicated and should be adopted for sterilization in GP office; CDC provides also comprehensive guidelines on the topic for all health care providers: { [HYPERLINK "http://www.cdc.gov/ncidod/hip/enviro/guide.htm"](http://www.cdc.gov/ncidod/hip/enviro/guide.htm) })

Medical Equipment

Basic medical equipment was discussed, leading to consensus about the following requirements.

Diagnostic and therapeutic equipment seen as essential in every GP practice:

stethoscope
otoscope
[tuning fork]
neurological hammer
Snellen chart
penlight
magnifying glass
measuring tape
thermometer
blood pressure meter
Pseudochromatic chart
blue light –optional
dermatoscope - optional
resuscitation set -optional
scales
height ruler/ centimeter
bench/couch
examination or operation light
materials for drawing blood
diagnostic sticks and swabs
cotton swabs and bandages

surgical equipment (scalpel, scissors, tweezers, suturing materials, ear syringe)
emergency drugs for anaphylaxis (adrenalin, antihistamine, steroids), for hypoglycemia (glucose), for acute asthma (B2 agonist inhaler), for cardiac arrest: practice should receive regular CPR training (see later)

Infection prevention equipment essential in every practice:

hand soap (antiseptic)
waste bin
sharps container
gloves
disposables for injection
surface disinfectant
access to an autoclave (bench top sterilizer) or hot air steriliser

External Indicators

After extensive discussion there was consensus on the following external indicators:

-access to the practice-

1. Written information is available to patients about the practice opening hours, appointment system, telephone lines and urgent and chronic care arrangements and about the system for patient complaints and suggestions
2. The practice is accessible by phone to patients for a minimum of 36hrs/week
3. For urgent cases patients can make an appointment within 2 days or arrange a telephone consultation with a primary care clinician (this could be a nurse)
4. For non-urgent cases, patients can be seen by a primary care clinician within a week
5. The practice does house calls for patients that are housebound or too ill to access the practice –unless specifically arranged otherwise with the insurers

-equipment-

1. Every clinician working in the practice and doing house calls has immediate access to: stethoscope, otoscope, neurological hammer, penlight, magnifying glass, measuring tape, thermometer, blood pressure meter
2. The practice holds at least one calibrated sphygmomanometer for blood pressure measurement and one calibrated set of scales
3. The practice holds the materials needed for drawing blood, for examination of urine samples, for microbiological sampling (media for bacteria cultures), for ear syringing and for dressing simple wounds (cotton swabs, fixing materials and plasters)
4. The practice holds the following sterilized equipment: scalpels, surgical scissors, surgical and anatomical tweezers, and suturing materials
5. The practice holds up-to-date drugs, and the equipment needed, to treat anaphylaxis (adrenalin, antihistamine, steroids) and hypoglycemia (glucose)
6. The practice holds equipment for sterilization of instruments or has demonstrable arrangements for sterilization by outside parties
7. Sterilization of instruments follows national guidance applicable to primary care (this has first to be developed)

-preventative tasks-

1. Smoking cessation support facilities are available within or to the practice
2. There are written patient information materials visible and available to patients about:
 - smoking cessation
 - health diet (food, drink)
 - regular exercise
 - minor ailments

3. Influenza vaccination is achieved in 85% of target group for high risk groups (COPD, diabetes, cardiovascular disease)

4. The practice offers influenza vaccination to persons age 65 and over

-quality assurance activities-

1. There are arrangements for calibration and maintenance of all diagnostic equipment used in the practice including BP meters, scales, blood sugar meters and spirometers; these arrangements include pre-planned schedules, recording of actual procedures performed and reporting of faults

2. There are arrangements to ensure that all drugs used in the practice are up-to-date

3. Sterilization equipment held in the practice is maintained and, if required, calibrated at least annually

4. There is an independent system for patient complaints - HCSA

5. The practice holds a patient survey once in 2 years, following an established method

6. A review of recent complaints and significant events is held at least twice yearly

7. Practice staff receive cardio-pulmonary resuscitation training at least every 5 years, regarding to skills of the GP, if ambulance is available in principle within 15 min. If ambulance is not available in 15 min –specific resuscitation equipment is required.

It was discussed that, for various reasons, the following indicators are potentially useful as external indicators in the future, but at present unfit for this purpose:

- There are defined backup arrangements for computer data including safe storage of back-up tapes (useful as an Internal indicator in practices with electronic signatures)

- % Prescribing of generic drugs (the prescribing system is changing)

- The % of patients with hypertension that smoke, given smoking cessation advice (as recorded in the notes in the last 15 months) is at least 90% (this needs a dated, coded entry for smoking cessation advice in the [computer] records, not generally available)

- The % of patients with hypertension with a blood pressure reading (measured in the last 15 months) is at least 90% (this needs a dated, coded entry for blood pressure in the [computer] records, not generally available)

Internal Indicators

With regards to care processes, a preliminary set of internal indicators will be based on these, to be updated as accepted Slovak evidence based practice guidelines emerge.

Conclusion

At the end of the workshop, Dr. Rusnak informed all participants on next steps with materials drafted during workshop discussions with GPs in Slovakia: List of minimal technical standards for equipment of GP practice, Set of indicators and List of priority guidelines will be presented to MoH for incorporating in preparatory process of new version of legislation for GPs.

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