Building Quality Development Programme in Slovakia

PROGRESS REPORT
Second Quarter
2005

EVD INTERNATIONAL
MAT03/SK/9/1

Consortium

Interaction in Health - Public Health Consultants
AGIS – Health Insurance Company
Department of Social Medicine AMC/University of Amsterdam
Department Health Management Trnava University
Health Management School Bratislava

Amsterdam, July 6th 2005

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2 List of Acronyms

AGIS	Agis Health Insurance Company
AMC/ UvA	Academic Medical Centre - University of Amsterdam
AWBZ	Medical Expenses Act
CBO CME	Dutch Institute of Healthcare Improvement Continuous Medical Education
COTG	Netherlands Tariff Authority
EU	European Union
HKZ	Dutch Certification Institute in Health Care
IAH	Interaction in Health Ltd.
ISTAHC	International Society of Technology Assessment in Health Care
HCSA	Health Care Surveillance Authority
HMS	Health Management School Bratislava
LHV	National Association of family doctors (Netherlands)
LSV	National Association of medical specialists (Netherlands)
MoH	Ministry of Health
MPAP	Matra Pre-accession Projects Programme
NIAZ	Netherlands Institute for Accreditation of Hospitals
OECD	Organisation Economic Co-operation Development
PPA	PSO Pre-accession Programme
ToR	Terms of Reference
UvA	University of Amsterdam
VWS	Dutch Ministry of Public Health, Welfare and Sports
WHO	World Health Organisation

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4 Introduction

4.1 General

This is the sixth progress report for the programme "Building quality development in Slovakia" (Mat 03/SK/91), covering the period January – March 2005.

Overall objective of the project
The project aims to contribute to the accession of the Slovak Republic to the European Union. In particular the project aims to assist the Slovak Republic in creating good conditions to monitor the quality of health care provided.

Project purpose
The purpose of the project is to "… strengthen the capacity of the Section Health Care of the Slovak Ministry of Health to guarantee that care providers can be monitored in a proper way".

Project results
According to the Terms of Reference and the subsequent consortiums' proposal the following four project results are to be achieved in three subsequent project phases:

- Analysis of current system of monitoring and evaluation of quality of health services;
- Set of processes and institutional indicators developed (related to the requirements for health care institutions) for the monitoring and evaluation of the quality of health services provided;
- Set of guidelines and clinical indicators developed (describing step by step professional practices) for the monitoring and evaluation of the quality of health services provided;
- Advice developed for the Ministry of Health on the introduction of a system for internal and external quality monitoring and evaluation in the Slovak health care system.

4.2 Summary of previous phases

In the previous phases of this project an analysis was done of the current system of monitoring and evaluation of quality of health services (expected result 1). The findings have been published in the first draft overview document during the first quarter of 2005. This document will be updated during the last quarter of 2004 as part of the advice to the MOH.
During the fourth quarter of 2004, in conjunction with the WHO, workshops were organised around the PATH project, analysing a set of quality indicators (expected result 2). During that quarter a delegation of the Ministry of Health and other stakeholders visited the Netherlands and acquainted themselves with the quality assurance processes in the Dutch health care system.
In January 2005, in a series of workshops, indicators were refined for hospitals and primary health care physicians. In the first quarter of 2005 the Ministry of Health in Slovakia published a set of indicators, which it is obliged to do according to the new legislation. In that quarter, the consultants paid visits to 13 pilot hospitals in the country and 5 PHC practices to study the availability of information on quality indicators and to get information on quality assurance procedures.
In the fourth quarter of 2004, the National Institute of Quality and Innovation (NIKI) was established, which could take the lead in the development of guidelines (expected result 3). The process of development of guidelines was also discussed during the workshops in January 2005.

4.3 Executive summary of this quarter

On 13th April the Project Advisory Committee met and discussed the progress of the project so far. The consultants presented the most important achievements. The Ministry of Health showed satisfaction with the draft overview document and with the overall progress of the project. Globally, the planning for the remaining period of the project was discussed.

From 9th to 11th May Dr. Rusnak and Dr. Lenartova visited the Netherlands to discuss with the Dutch colleagues the findings of the pilot visits to hospitals and general practitioners and to formulate core indicators. During that visit a series of workshops in June was prepared.

On the 13th of May representatives from the pilot hospitals met and discussed the findings of the survey done during the pilot. There is a great variation in the availability of guidelines and protocols and in the availability of information for quality indicators. Some hospitals are quite advanced, while others are still at the starting point of quality assurance processes. (Annex 1)

From 23 - 27 May a delegation of Slovak experts from health insurance companies and the Health Care Surveillance Agency visited the Netherlands to study the role of Dutch health insurance companies in quality assurance in health care. AGIS insurance company organised most of the programme, which also covered visits to the Ministry of Health. (Annex 2)

On 14th June the consultants met with the taskforce and with consultants from the World Bank project, who were just starting their assignment. It appeared that quite some overlap in Terms of Reference of the Matra project and World Bank project existed. However, mutual exchange was agreed. The World Bank consultants would participate in the upcoming workshops and would use the conclusions of those workshops as basic materials for their work. The taskforce discussed the draft documents on indicators and guidelines and gave advice on further implementation of the programme. The taskforce will receive documents to be produced during the workshops and will give comments.

From 15th to 18th June a series of workshops was conducted, with several consultants facilitating:

- A workshop on quality indicators for hospitals, with selection of appropriate indicators which could be proposed to the MOH; (Annex 3)
- A workshop on quality reporting and analysis of quality indicators by hospitals; (Annex 4)
- A workshop on formulating clinical practice guidelines and organisation of NIKI; (Annex 6)
- Two workshops for general practitioners on minimum standards and quality guidelines. (Annex 5)

The outcomes of the workshops constitute the inputs for the next phase in the project, i.e. the formulation of an advice to the MOH on quality assurance in the Slovak Republic.

On 29th June the Board of NIKI met and discussed the outcomes of the workshops together with the World Bank consultants. NIKI will elaborate a structure of the organization and will get in touch with the MOH for further discussion of the institute in further guideline development. (Annex 7)

5 Progress in the reporting period

5.1 Progress report

Result 1 Analysis of the current system of monitoring and evaluation

Most of the analysis of the system was incorporated in overview document which was ready in February 2005 and presented to the PAC meeting of April 2005. In its statement presented during the PAC meeting, the MOH expressed its satisfaction with the presented analysis.
The overview document gives an historical overview of quality assurance programmes in Slovakia.
The document describes the national and international perspective of:

- Guidelines, including an assessment of existing guidelines in Slovakia, using the AGREE methodology
- Indicators developed in Slovakia, including the PATH project and international developments in the EU and OECD
- Continuing medical education, comparing different models applied in EU countries

The document also provides an elaborated bibliography of literature on quality.
The overview document will be updated during the last quarter of 2005 and will be one of the end-products of this project.

Result 1: Analysis of current system of monitoring and evaluation of quality of health services						
Activity	**Products and deliverables**	**Expected starting date**	**Started on**	**Completed**	**Remarks**	**Expected completion date**
An assessment of the existing quality of care policies in the Slovak Republic with respect to professionals and institutions as compared with the existing policies in The Netherlands and other EU countries.	An overview document (including technical sub-documents) describing the current state of the art in quality of care in the Slovak Republic.	01-05-04	1-5-2004	15-3-2005 Note: further improvements will be made in the advisory phase of the project!	Reference centre established, draft documents distributed	15-1-2005
Inventory state of the art quality systems	Report describing the state of the art of quality systems for hospitals and primary care facilities.	01-06-04	05-6-2004	15-3-2005	Included in overview document	01-01-2005
Assessment on technological Standards in Primary Care	Report on technological Standards in Primary Care.	01-06-04	05-6-2004	30-06-2005	Workshop of 18 June completed	01-02-2005

Assessment on continuing medical education policies, structures and activities.	Report on continuing medical education policies, structures and activities.	01-06-04	05-6-2004	15-03-2005	Part of overview document	15-02-2005
Overview on quality requirements in the contracting between financiers and providers	Report on quality requirements in the contracting between financiers and providers.	01-06-04	04-6-2004	15-03-2005	Presentation done. Document included in overview doc.	15-01-2005

Result 2 Set of process and institutional indicators

During this quarter much attention has been paid to formulating appropriate quality indicators for hospitals and general practitioners. The indicators concentrate on quality of care and not on health systems in general. In previous phases of the project, it has been decided that the OECD indicators are suitable as health systems indicators for Slovakia.

Indicators serve for two purposes:
- Internal quality assurance aiming at self-reflection on quality issues
- External accounting for quality to national or regional government, health care surveillance authority or health insurance companies

The hospital indicators follow the PATH methodology and are grouped in the following areas:
- Outcome of health care
- Performance
- Staff-centeredness
- Patient-centeredness

Most of the selected indicators were pre-tested in the PATH programme. Some additional indicators were selected to cover different departments in the hospital. Availability of data for the indicators was an important criterion for selection, as well as interest for external stakeholders (government, HICs, HCSA).

From the presentation of experiences in the Netherlands with quality control in hospitals[1] it transpired that analysis of indicators by hospitals before submission of reports to the health inspectorate was of crucial importance. This analysis increased motivation of staff to work on quality improvement and gave the opportunity to put data in a context. The important lesson learned for the Slovak situation is that annual quality reports should be stimulated and that hospitals should be given an opportunity to give explanation on their performance, when submitting data to the MOH or HIC.
In a workshop on 16th June, a format for the annual quality report was presented. This format will be pre-tested in a number of hospitals during the coming quarter.

During this quarter the consultants worked on minimum technical standards for General Practitioner offices and on quality indicators for GPs.
The minimum standards were discussed in a workshop with GPs and a list of minimum standards was elaborated.

The indicators for GPs were grouped in categories:
- Structure and organisation of the practice

[1] M. Berg et al: Feasibility first, Developing Public Performance Indicators on Patient Safety and Clinical Effectiveness in Dutch Hospitals, Erasmus University, March 2004

- Care process: protocols and standards applied
- Intermediate outcomes of care (morbidity and mortality)
- Preventive tasks of the GP
- Quality assurance activities undertaken by GPs

The indicators serve both as internal indicators, which the GP can monitor (and discuss in a peer group), and also serve as external indicators to be monitored e.g. by contracting HICs.

The activities during this quarter have brought the expected result 2 nearly to completion. The extensive consultation process with hospitals and GPs has resulted in a well-defined set of indicators, which now will be presented to other stakeholders.

In the context of this result, a study visit was organised for experts from Slovak Health Insurance Companies and Health Care Surveillance Authority. This study visit concentrated on the role of insurance companies in quality assurance in the Netherlands. The changes in the health insurance mechanisms in the Netherlands are giving the insurance companies a much bigger role in providing incentives for quality and sanctions for non-performance. Although the HICs in Slovakia are still far from applying those mechanisms, the experiences in the Netherlands could show a way forward for the role of the HICs in quality control of health care providers. During the study visit it was agreed that experts from HICs will be closely involved in the last stages of the Matra project.

Result 2: Set of process and institutional indicators						
Activity	**Products and deliverables**	**Expected starting date**	**Started on**	**Completed**	**Remarks**	**Expected completion date**
A joint workshop on strategic purchasing with the WHO Observatory PATH initiative.	Familiarization with indicators in hospital setting. Insight in role of health insurance in purchasing care.	01-05-04	1-05-2004	June 2-4 2004		30-06-04
A workshop on the application of external quality assurance mechanisms on institutional level.	Preparation of key stakeholders for pilots on indicators.	01-09-04	October 2004	October 1st 2004		01-10-04
Education and training at Trnava University/HMS in quality process management with the aim to help to develop a local module on quality of care in the public health/management curriculum	- Education/training at Trnava University/HMS in quality process - Local module on quality of care in the public health/management curriculum.	01-10-04	October 2004		Under development, proposal made	01-01-05
Teams of Slovak experts on study visit to the Netherlands as a contribution to the inventory of state of the art and a preparation for the pilots.	Insight in the role of different stakeholders in designing and implementing indicator sets and monitoring its use.	10-10-04	10–10-2004	15-10-2004		01-11-04

Study visits to Austria and Hungary for similar, small-scale projects.	Exchange of experiences.	01-10-04	23-05-2005	27-05-2005	Alternative visit organised to the NL for Health Insurance staff	May 27 2005
Set up of health system indicators, hospitals / institutional indicators and primary care indicators.	- Proposed indicator set on health system performance (10-15 indicators). - Proposed indicator set on the quality of hospital/institutional performance (10-15 indicators). - Proposed indicators set on the quality of primary care (10-15 indicators).	01-02-05	15-01-05		During workshops in June final drafts were formulated, which will be presented to taskforce and MOH for comments	01-08-05
Performance indicators and role of health insurance and regional government	Determination of roles and responsibilities through workshops.	01-02-05			Discussion during visit to the Netherlands	01-08-05
Preparation of pilots and questionnaires.	Start of pilots	01-02-05	15-01-05	30-03-2005	Pilot implemented	01-07-05
Pilots in 4-5 hospitals.	Implementing / calculating indicator set in hospitals / Annual quality report	01-02-05	01-02-05		Indicators analysed, annual quality report in third quarter 2005	01-08-05
Pilots in 2 primary care settings.	Implementing / calculating indicator set in primary care setting	01-02-05	01-02-05	30-06-2005	Discussion with general practitioners completed during workshop 18-06	01-08-05
Summary of results.	Presentation in a forum	01-09-05				01-10-05
Policy document.	Wrap up with a focus on roles of stakeholders	01-09-05				01-10-05

Result 3 Guidelines and clinical indicators

During this quarter major activities have been implemented to develop a model for ongoing design of clinical performance guidelines.
During the previous phase of the project the National Institute of Quality and Innovation (NIKI) was established, an initiative of consultants working in the Matra project and experts in the task force of the project.
The institute is still in an embryonic stage.
During the workshop of 17th June consultants brought together international experiences from several countries (Great Britain, Scotland, New Zealand, and the Netherlands) and discussed lessons learned from those countries.
The different aspects were discussed and agreements were reached:
1. Organisation of guideline development
2. Selection of guideline topics
3. Composition of the guideline development group
4. Systematic literature review
5. Formulation of recommendations
6. Consultation and peer review
7. Presentation and dissemination
8. Local implementation
9. Audit and review

The consultants have elaborated a model which could serve Slovakia. This model was presented to the Board of NIKI. Experiences from other countries learn that development of guidelines is not a one-off activity, but an ongoing process, which needs to be institutionalised. Carbon-copying the clinical performance guidelines from other countries is never a solution (though international experiences may be used). Acceptance of the guidelines by the professionals is of utmost importance; therefore formulation of recommendations and peer review of draft indicators is necessary. From the workshop it transpired that NIKI should be structured in a way which guarantees optimal inputs from the professionals in Slovakia.
The consultants are now working out a structure and procedures for NIKI, which take into account the lessons learned from other countries and conclusions of the workshop.

The activities during this quarter bring expected result 3 closer to completion.

Result 3: Set of guidelines and clinical indicators						
Activity	**Products and deliverables**	**Expected starting date**	**Started on**	**Completed**	**Remarks**	**Expected completion date**
An inventory on existing clinical practice guidelines in the SR.	Report on existence and quality of local guidelines (including assessment of selected guidelines from international sources for implementation in Slovakia).	01-06-04	01-06-04	15-03-05	Done; see report in overview document	01-11-04

Assessment of the quality of existing sets of clinical guidelines in the Slovak Republic with the help of the AGREE instrument.	See above	01-06-04	01-06-04	Assessments done	Through taskforce	01-12-04
Training of local expert with the AGREE instrument and development of user manual	Training module for local experts on the AGREE instrument and development of user manual	01-08-04	01-09-2004	30-03-2005	Training of NIKI board members	01-08-05
Development of a model for ongoing design of guidelines.	Training module of evidence-based guideline development	01-08-04	01-10-2004		With taskforce / NIKI	01-08-05
Support with the development of a limited set of guidelines.	A set of tested guidelines and an endorsed format for guideline development.	01-08-04				01-08-05

Result 4

Result 4 will be tackled during the last two quarters of 2005.

Result 4 Advice developed on the introduction of a system for internal and external quality monitoring and evaluation						
Activity	**Products and deliverables**	**Expected starting date**	**Started on**	**Completed**	**Remarks**	**Expected completion date**
Refine guidelines	Quality book consisting of tailor-made approaches adapting internationally proven best practices.	01-08-05				01-10-05
		01-08-05				01-10-05
Identification quality monitoring		01-08-05				01-10-05
Revisiting experiences						

Four workshops	Integrated advice on the implementation of quality assurance and monitoring in Slovakia, endorsed by stakeholders. List of process and institutional indicators for hospitals and general practitioners, a set of guidelines and clinical indicators and a monitoring mechanism for each of these.	01-10-05			Re-design of advisory process with stakeholders	31-12-05
Overall implementation advice						
National conference		01-12-05				31-12-05
		01-12-05				31-12-05
					The advisory process will be organised jointly with HSA in liaison with World bank project.	
Training course for policy makers	Training course for policy makers	01-10-05			To be included in advisory process	31-12-05

5.2 Resource utilisation

Result 1

expert name	days spent in NL	days spent in Slovakia
Heijdelberg		
Koning		
Klazinga		
Rusnak		
Rusnakova		

Result 2

expert name	days spent in NL	days spent in Slovakia
Heijdelberg		
Koot		
Klazinga		
Koning		
Boon		
Rusnak		
Rusnakova		
Lenartova		

Result 3

expert name	days spent in NL	days spent in Slovakia
Heijdelberg		
Koning		
Dalhuijsen		
Rusnak		
Lenartova		

Result 4

expert name	days spent in NL	days spent in Slovakia

Result 5 / visit to NL

expert name	days spent in NL	days spent in Slovakia

6 Implementation Issues

6.1 General Implementation Issues

The consultants, engaged by the World Bank for the quality element of the health sector support programme, have started their work. The programme will take 10 months and will encompass:

- Formulation of facility level quality indicators
- Investigate feasibility of data collection for these indicators
- Perform consultations on clinical protocols
- Field test 4 protocols in primary care and 8 protocols in hospitals
- Formulate final versions of indicators and protocols

During the inception phase of the World Bank project intensive exchange between the consultants of the Matra project, the World Bank consultants and MOH officials took place. The World Bank consultants also participated in the series of Matra workshops in June.
The World Bank consultants are eager to use the products of the Matra project as input for their work. However, waiting until the end of the year to get final products is not possible. It was agreed that the Matra consultants will provide all drafts immediately after the workshops and will formulate preliminary documents, which World Bank consultants can use in their work. In the coming months frequent exchange will minimise duplication or conflicting advices to the MOH.

6.2 Specific implementation issues per project result

Result 1 Analysis

The Overview document was finalised and with attached sub-documents sent to all stakeholders. It was approved in the PAC meeting of April. It will remain open for improvements and additions throughout the projects running period, culminating in an implementation advice in November 2005.

Result 2 Indicators

In January 2005 the MOH has formulated a set of indicators consisting of health systems indicators and quality indicators. (These indicators can be adjusted in due course. The Matra project will propose quality of care indicators.) The hospitals are obliged to report on these indicators and the MOH is preparing data collection mechanisms. Data collection will take place towards the end of this year. It is not yet clear to what extent hospitals will be invited to analyse data themselves, neither have feed back mechanisms been formulated.
In the advisory phase the project will discuss with the MOH officials how data analysis can be done by hospitals and how feed back can be provided to hospitals.

In discussions with providers time and again the fear is expressed that indicators will serve government and HICs to take punitive measures if the quality is not up to standard. The providers do not expect that the indicators will serve to stimulate quality. In the process of further advising the MOH, the element of trust building between providers and external stakeholders will be very important, in order to establish a culture aiming at quality improvement.

Result 3 Guidelines

The consultations and discussions during this quarter have made clear that the formulation of clinical performance guidelines cannot be a quick and dirty process. It is not a matter of translation of foreign documents, or hiring external consultants to write documents on their

own. The country's organisation of health services, the package of health care offered, the local culture, and other factors are very important in the shaping of clinical performance guidelines. Therefore, guideline production in Slovakia has to be an institutionalised process, with a good legal fundament and with involvement of all stakeholders, especially the providers. The professionals have to accept and internalise the guidelines. The guidelines will be the basis for performance standards, for future quality indicators and performance monitoring mechanisms.
Therefore the project will further emphasise the role of NIKI and will assist in developing an organisation structure for NIKI which will be acceptable to the broad range of professionals and their organisations. The project will not develop clinical performance guidelines, as time is too short for the thorough consultations required. It will come up with a well-elaborated advice on the processes and organisation of formulation of clinical guidelines.

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Result 4 Advice

According to plan this activity has not yet been implemented. However preliminary discussion has started on the desired formats for analysis, finalisation and implementation of project results. In the second quarter discussions will be held with the insurance companies and the HSA to see how a joint finalisation of the project can be organised.

6.3 Change request

At this moment in time the project is well underway and no fundamental changes in the project set-up or implementation is required. Due to acceptance of other jobs or other positions, some consultants are no longer available for the project. However, other consultants – already listed in the inception report – will take over the responsibilities.

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8 Plans for the next reporting period

8.1 Detailed work plan

Result 1

Based on the outcomes of recent activities the overview document will be updated.

Result 2

The hospital indicators which were selected during the workshops in June will be elaborated to a full list of indicators (including case definitions, background information, etc.). This list will be made available to World Bank consultants. Early June the list will be presented to the vice minister Dr. Novotna. A consultation process will start to get feed back from the task force and other stakeholders, in preparation of the final list.
A number of pilot hospitals will be approached to collaborate in the piloting of annual quality reporting, as discussed during the June workshops. In September the consultants will visit the pilot hospitals and work together on the production of those reports. The reports will be presented during final conferences.

Result 3

The consultants will elaborate structures and procedures for NIKI and will consult the MOH and other stakeholders. Possibly in September, the Matra project will organise a meeting for stakeholders (MOH, HCSA, HICs, professional associations, SMC, etc.) to present drafts and to build consensus on a Slovak system for guideline development. This can also serve as input for the World Bank project.

Result 4

As discussed above, preliminary consultations have started to formulate the final list of indicators, minimum standards and to define structures and procedures for formulation of clinical performance guidelines.

4.1Human Resource Allocation

Result 1

Name	days NL	days SK
Rusnak		2
Heijdelberg		
Koning		
Klazinga		
Koot	2	
Boon		

Result 2

Name	days NL	days SK
Rusnak		5
Lenartova		15
Koning	2	4
Dalhuijsen		
Heijdelberg		
Boon		
Koot	2	5
Lombarts		

Result 3

Name	days NL	Days SK
Rusnak		8
Lenartova		15
Heijdelberg		
Rusnakova		
Koot	2	2
Lombarts		

Result 4

Name	Days NL	days SK
Heijdelberg		
Lenartova		

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10 Annexes

11 Annex 1: Workshop Quality Indicators for hospitals

(May 13th 2005, MoH SR, room 105)

Present on behalf of the project:
Dr. Martin Rusnak – local senior consultant
Dr. Lucia Lenartova – project coordinator

Dr. Rusnák opened the workshop and informed participants on preparation of the workshops in Banska Bystrica in June. Aim of these workshops is to collect opinions of participating hospitals to relevant topics in area of quality improvement and the results will be used in recommendation for MoH.

Consensus workshops for hospitals will be related to:
- Quality indicators in hospitals
- Annual Quality Report – structure
- Guidelines / Standards – legislative framework, methodology, defining role of HC providers, MoH, HIC, HCSA

Purpose of today's workshop is to focus on:
- Structure of PATH indicators – Core set, used for internal quality assessment and preparation for 2nd step – External accountability
- Proposals for new quality indicators

Dr. Rusnak explained final use of results of our project for MoH in 3 products:
- Procedure of implementing quality of HC on level of health care facilities as recommendation to MoH, HIC, HCSA
- List of quality indicators for external accountability
- Guidelines – structure, use, methodology

Participants received materials on defining roles of MoH, HIC, HCSA and Quality report.

Dr. Rusnak asked the participants how they used the core set of PATH indicators after WHO project was over.
Answers of participating hospitals:
- Teaching Hospital Bratislava – Dr. Špaček: they did not continue in further using, due to the organizational changes with the hospital, the only activities were - economical arrangements and patient's satisfaction questionnaire.
- Hospital with policlinic Levoča – Dr. Dluhá: they plan to use PATH indicators in international benchmarking.
- Hospital with policlinic Stará Ľubovňa – Mgr. Pčolková: they use patient's satisfaction questionnaire.
- Teaching Hospital Nitra – Mgr. Škablová: it is difficult to compare the results, because only few departments were involved.

Dr. Rusnak introduced draft set of indicators designed by project experts during planning meetings in NL, which were selected from Core set of PATH indicators and completed with

proposals of missing indicators, and asked participants to prepare arguments and other proposals for workshop discussions in June and indicators to be completed in set of indicators feasible in Slovak conditions.

Comments to selected draft set of indicators:

Dr. Olejnik stressed the need to define all indicators without definitions and added comments to occupancy rate – it is good indicator for HIC, depending on budget.

Mortality for surgery - mors in tabula within 2 hours from operation.
4 types:
- Conservative type
- Surgical type
- Intensive type
- Children's diseases

Admission after day surgery – need to define conditions for cataract.
Re admission – without comments
Caesarean section – without comments

Antibiotic prophylaxis use for colorectal cancer
Comments:
Find out what is the rate of One Shot in % from all elective procedures of colorectal cancer
To be completed in definition.

Efficiency: - will be extended
- % from total costs for salary
- % from total costs on drugs and health care aids
  Dr. Žak prepares detailed description of cost indicators.
- Length of stay – by elective cholecystectomy
- Waiting lists for carcinoma
- Waiting lists for carcinoma GIT
- Waiting lists for uterus carcinoma
- Waiting lists for prostate carcinoma
- (Mention in diagnosis number of days after surgery)
- Complications rate Hospitalization after 1 – day surgery for inguinal hernia

Work-related injuries - without comments
Training expenditures - without comments
Patient surveys – recommendation to use standardized questionnaire, this indicator only monitors whether hospital uses the questionnaire or not (if it's the patient's satisfaction the interest of hospital management).

Missing indicators:
- Infection control – nosocomial infections - without comments
- Bedsores rate incurred in relation to admission
- Transportation time – excluded because hospital can not influence it
- System of incident reporting – excluded
- Autopsy rate – excluded, belongs to responsibility of HCSA, no relation with hospitals

- Occupancy rate and average treatment time depends on contracting with HIC
- Laboratory services - Dr. Rusnák will search for relevant literature sources what exists in this area
- Complications after transfusion – will be discussed during workshop in June
- Sudden abdominal accidents – 3 groups: ileus, peritonitis, bleeding in GIT

For each group of operated patients there should be 2 indicators:

1. Morbidity – percentage of patients from all patients with extended hospitalization, caused by complications requiring re - surgery
2. Mortality – percentage of lost patients from all operated for this diagnosis

Reported by: Dr. Lucia Lenartova

12 Annex 2 Study visit to the Netherlands

May 23rd – 27th 2005

Reported by: Lucia Lenartova

Program

Monday, May 23		AMB 0.03 van 13.00 – 17.00
Morning:	Arrival at Schiphol Airport	09.20 Flight OS371
		Stefan Kleintjes meets the delegation at the airport
	Arrival at Berghotel	Chandra Verstappen and Jaap Koot meet the delegation at the Berghotel at 12.15.
Lunch:	13.00	lunch in room AMB 0.03
Afternoon:	*Tour through our new building*	*Who?(Exact time and date to be planned)*
	15.00 - 17.00 strategy, policy and management	Maarten Boon and Joop Hendriks
Tuesday, May 24		AMB 0.05 09.00 – 17.00
Morning:	09.30 – 11.00 Organisational aspects of Agis Care purchasing department	Brian Esselaar
	11.15 - 12.45 Purchasing Mental Health Care	Thijs Stoop
Lunch:	13.00	Lunch in restaurant AMB
Afternoon:	15.00 – 16.30 Purchasing hospital care	Paul Offringa
	16.30 – 17.30 Purchasing primary Care (GP, etc.)	Hans Pareau Dumont
Wednesday, May 25		AMB 0.03 09.00 – 17.00
Morning:	10.00 – 11.30 Capitation, High Risks Compensation, etc.	Arnold van der Lee
	11.30 – 13.00 Demonstration Data Ware House/Business Objects	Nico Essenstam
Lunch:	13.00	lunch in restaurant AMB
Afternoon:	14.00 – 15.30 integrated care for diabetes patients, indicators	Aldien Poll
	15.30 – 17.00 CAHPS	Barbara Vriens

	Practical use of the outcome and results for Agis	
Evening:	18.30 Diner	Bistro 'Het Kannetje' Address: Lieve Vrouwenstraat 11, Amersfoort (033-4659474)
Thursday, May 26		AMA 8.42 09.00 – 17.00
Ochtend:	10.00 – 11.30 Presentatie NIVEL (general CAHPS for HIC's)	Herman Sixsma (030 2729710)
	Tour through our new building	*Who?(Exact time and date to be planned)*
Lunch:	12.00	lunch in restaurant AMA
	Travelling to The Hague by train	Departure 12.57 Amersfoort CS, platform 6 (arrival The Hague CS 13.53)
Afternoon:	14.00 – 16.30 Visit to MoH	Address: Parnassusplein 5, The Hague
	16.30 - … Sightseeing in The Hague	
Friday, May 27		AMA 8.42 09.00 – 17.00
	09.30 Berghotel – Van Asch van Wijckstraat	Taxi (with luggage)
Morning:	10.00 – 11.30 Rol ZN in NL	Walter Annard (ZN)
	12.00 – 13.00 Evaluatie werkbezoek	Jaap Koot (IAH)
Lunch:	13.00 – 13.40	lunch in restaurant AMA
Afternoon:	Travelling to Schiphol by train	Departure 13.59 Amersfoort CS, platform 7 (arrival Schiphol 14.41)
	Departure to Vienna	16.35 Flight OS374

Monday, May 23rd 2005, AGIS

Present on behalf of project: Jaap Koot, Maarten Boon, Chandra Verstappen, Lucia Lenartova
Participants of Slovak delegation.
Dr. Koot welcomed the Slovak delegation and asked for short introduction of all participants.
He informed shortly on major project objectives and expectations of this study visit:

- Quality indicators, guidelines, standards for GPs, CME, final advice to MoH
- Results of the discussions from this visit to be used for MoH advice, whether HICs' should work together or separately, process of quality control, how to proceed with indicator sets (one or more needed)

Maarten Boon introduced the strategy, policy and management of AGIS to Slovak delegation:
AGIS has 1,6 mil insurees. In NL exit 59 health insurance companies (HIC) - 22 public and 37 private. They do not provide preventive check ups. AGIS develops own standards to get more people insured. 60% population is insured with AGIS, in regions with 20 – 60% of region growth, AGIS wants to purchase care and invest energy in regions with less then 20% they are not in interest.
1st step – competition between HIC, advantages for insurees
2nd step – competition between HC providers, HIC cannot contract HC provider
Investigation – do you know what's happening, do you want to choose – asking clients
From 1.1.2006 change of the insurance system is planned. All citizens can choose the HIC.
Customer is part of: Market management, Product management, Channel management and Communication management.
From 1.1.2007 shift to market management leading in company is prepared.
5,4% is the unemployment rate in NL, it has increasing trend.
AGIS has very well working Call centre, with 100 permanent employees and another 100 for part time employment in case of inrush campaigns. Each employee owns mobile container with documentation - manuals with standards and providers addresses. Each assistant can manage 10 – 12 phone calls in 1 hour; average waiting time is 30 seconds.
Satisfaction with HICs' in NL is very low only 6,2%.
In AGIS they focus on risk groups with aim to profit, system updating every 2 years.
He spoke also about 3 elements of HC purchasing:
1.Medicines /drugs
2. Medical aids
3. Chain – managed care, disease management (long term care)
Market watch is also very important, the figures are published to public (from annual report), with different information on: performances - costs, what regions are active in marketing.
Website on getting more information on Dutch HC system was recommended: www.zn.nl.

Tuesday, May 24th 2005, AGIS

Brian Esselaar – The new hospital care financing system based on HC products – the health insurer perspective
Contracting system between HIC and HC providers based on service packages where they defined purchasing mission – discussions with HC providers how to improve quality with ensuring: Affordability, Quality and Accessibility of HC.
Purchasing strategy consists of: Care provider – negotiating and contracting, Control compliance and penalize, Material and formal control, Benchmarking / model projects, Communicate with HC providers and customers, Confront with outcomes.
Introduced also membership committee – where clients are members.

Thijs Stoop - Changes in financing of mental care and implications for care purchasing

Mental HC financed by government – pass money to mental HC providers.

In new system mental HC will be organized via DBCs'. HIC started working on standards and criteria development, for extra expensive care.

Purchasing instrument to manage throughput – benchmarking:

a) Compare costs of each care option
b) Compare waiting times within each option
c) Compare relapse %

Social nurses will be the first level of mental HC, which are working in GP offices.

Paul Offringa - Purchasing hospital care: New hospital care financing system based on HC products, health insurer perspective

Source of financing is government, pays for chronic, long term, mental and extra demanding HC.

There is a lack of information on activities of hospitals performance.

He stressed Necessary shift of responsibilities: Less price and capacity regulation

More incentives for insured and insurers to control costs

DBC – Diagnosis Treatment Combination can have 3-4 different DBC on the same time.

Main goals of hospital finance reforms are: transparency, performance based payment and competition.

Purchasing primary care – Hans Pareau Dumont

There is a lack of GPs in NL; average capitation is 2300 per 1 GP. GPs are grouped in federation NHG.

Basic contract between AGIS and GPs contains definition of quality requirements.

Relationship managers visit GPs and provide with mirror information on half-year basis, and focus on efficient use of medicines.

Monitoring of quality is not very well developed; feedback on quality of GP practices is limited.

Accreditation of GPs is organized via visitation within GPs professional body.

OLD SYSTEM:	NEW SYSTEM
20% - own activities	15% - plan based
80% - capitation	15% - Number of consultations – fee per consultation = 7 euro
	70% - capitation

Plan based – more money for GP, if they want to work extra, competition in care market – market orientation.

Wednesday, May 25th 2005, AGIS

Arnold van der Lee - Risk bearing in the Dutch health insurance

Market share of AGIS: 1,4mil – sickness fund and – 0,2 mil - private insurance.

2 senior researchers are responsible for budgeting system.
Purpose of financing system is to contract efficient providers and listen to needs and wishes of insurees.
Options of sickness funds with positive effects are: Stimulation of efficient health care, Mitigation of inefficient health care and
Cream skimming / quality skimping.

Special care for DM patients (within contracting efficient providers) was developed by AGIS.

Nico Essenstam - Business Intelligence and Data warehousing
Oracle database is used with 4,7 mil records and 400 named users.

Aldien Poll - Purchasing integrated Diabetes Care - Indicators for good HC
60 000 insurees with DM are registered in AGIS and they spend 11% of total costs from sickness fund. HC to DM patients is provided by GPs. AGIS runs frequently questionnaire surveys, where they concentrate on medical outcome, health improvement and patients experiences.
Business process redesign – they offer bonus, pay for performance, offer packages with different lower premium – patient is obliged to use only providers recommended by AGIS.

Barbra Vriens - Consumer Assessment Health Plan Survey – CAHPS
CAHPS as tool for quality control, where the questionnaire gets information from patients experiences with provided HC and clients experiences so called health plans. AGIS decided to run this method on DM.

Thursday May 26th 2005, AGIS
Herman Sixma - Quality of care from patients' perspective
SERQUAL – CAHPS
CAHPS - commissioned by AHQR with the Questionnaire, which contains experiences with: health care providers, insurance company, general rating of health care and health plan.

VWS, Den Hague
(Marieke Prins, Marc Soeters) - Diagnosis Treatment Combination: Introduction of new HC system for hospitals – DBC
Ministerial representatives informed Slovak delegation on ongoing reform in social – health insurance in NL, which will come in use in January 1st 2006.
Informed also on 3 roles of new HC system for hospitals and DBC's scope – outpatient visits, clinical episodes, Day care, Rehabilitation – Aftercare were presented.

Haag Jan - Supervision of HC in hospitals in NL, Inspectorate of HC
Core task of HC inspectorate is to monitor public health in NL.

14 inspectors supervise 8 academic hospitals and 88 general hospitals. Yearly HC inspectorate receives 220 reports from hospitals.
Their aim is to improve supervision, stimulate quality, and improve transparency in hospital care.
Phased supervision: Collecting information, Testing and Intervention if necessary.
Process with Indicators is: every year they change 25% of the set but first discuss with professional organization, providers, follow trends to increase the efficiency in performing high risk procedures
Dr. Haag recommended following books as WHO publications: Crossing the quality chasm, Patient safety and To err is human.

Friday, May 25th 2005, AGIS

Walter Annard - Providing a unified voice for the Dutch health insurers

Dutch HC sector is private sector with managed competition and contains 3 compartments:
1. Long term care insurance – Public social health insurance – compulsory protection
2. Health insurance for treatment
3. Supplementary insurance

Private health insurance – 1/3 of population, pays nominal premium 150 euro per month, regulated by EU directive.

Market:
2/3 – mandatory + supplementary insurance
1/3 – private + mandatory insurance

Wrap – up meeting – Friday 27th 2005

Present: Jaap Koot, Chandra Verstappen, Lucia Lenartova
Participants of Slovak delegation
Dr. Koot stressed the role and contribution of this visit, also explained process of assuring quality mechanisms, external system of quality control in relation with different stakeholders– MoH, HCSA, HIC, Quality guidelines development advice on monitoring mechanisms and quality indicators to be used.
Dr. Koot asked the participants to summarize the visit, by distributing evaluation form of the visit and asked on:

1. What issues of contracting quality control of HC providers are relevant to Slovak conditions
2. What are the next steps after visit as input information in project advice for MoH

Dr. Kondelova (GHIC) spoke about investigations of HIC by inspection physician, where they check: certificates of technology, education of personnel, methods, patient safety, standardized methodology – contract with provider can be closed. Feedback information is sent to providers.
Dr. Rolna (GHIC) as member of Task force stressed the importance of developing unified methodology for already published MoH set of indicators and to use them as tool for quality

assessment. She also mentioned the lack of standards, so in process of their development to concentrate also on defining GP's responsibilities and competencies.
Dr. Simo (GHIC) underlined our EU membership, which requires unified system for quality control. For MoH Regulation with Set of quality indicators is the methodology missing so the round table discussion is needed in near future with HCSA, MoH, HIC to make agreement on quality indicators how to manage the whole process of data collection and evaluation.
In NL he noticed, they follow quality guidelines in process of quality control.
He agrees with using the expertise of MATRA project by using the experiences from the visit for next year set of quality indicators development, where stakeholders have different priorities of MoH, HIC, HCSA. He also stressed that HIC's should have own indicators for providers to stimulate their improvement.
Dr. Kucerova (HCSA) as representative of supervision body, underlined the need to help to HC providers and very important role of HIC, who has to fulfil the criteria; cooperation between HIC and HCSA is needed.
Ing. Rybarik (Spolocna HIC) explained the situation with HC providers; their information technology is at low level, need to improve for quality improvement.
Mr. Orosi (HIC Sideria) spoke about the need of working with reliable data – updated regularly, developing questions list manually for data collection. Process of negotiations insurees with HIC is very important but we miss branch organization in SR.
Dr. Koot informed on the next steps planned for further cooperation with stakeholders:

- Discussions with HC providers during consensus workshops in field of quality Indicators, guidelines, Quality report and Technical standards for minimal equipment of GP practices
- Consultations with HCSA, MoH, HIC,
- Round table discussions for advice finalization process

13 Annex 3: Consensus Workshop quality indicators for hospitals

(Wednesday: June 15th 2005, 9.00 – 16.00)

Program

General Introduction into quality indicators – process of description

Johan de Koning, PhD, Academic Medical Centre, Department of Social Medicine, Amsterdam, The Netherlands

Group discussions on the content – use of the indicators, consequences of reporting to MoH, HIC, HCSA

Present on behalf of project: Dr. Erik Heijdelberg, Dr. Johan de Koning, Dr. Jaap Koot, Dr. Lucia Lenartova, Dr. Martin Rusnak

Dr. Heijdelberg opened the workshop, welcomed all participants and informed on the aim of the workshop:

- Formulate indicators set, which will be presented to MoH
- Annual quality report
- World Bank's project was represented by two experts from the Quality Module. Their participation at workshops will contribute to sustain the activity in the area of indicators and guidelines.

Johan de Koning: Quality indicators – presentation

Use of performance indicators – improve the quality and be more transparent.

Group assignments:

Dr. Rusnak divided all hospital participants in 3 groups to revise 10 indicators per group with Checklist for each indicator. Each group commented and the discussion on the indicators lead to consensus statements as listed below:

Indicator	PATH[2]	User	Type of indicator	Comments/Suggestions	Source of data
1. Mortality for Stroke	YES	MoH, HIC, HCSA	Outcome	Depends on type of hospital; Recommended suggestions: standardize (age, gender), compare with similar types of hospitals, data available	Discharge diagnosis

[2] PATH Joint project with WHO, where a set of indicators was collected in 10 Slovak hospitals.

2. Mortality for AMI (PATH)	YES	MoH, HIC, HCSA	Outcome	Not specific, needs to be more specific by regions; definitive evaluation of the indicators is not decided yet	
3. Mortality for Pneumonia (PATH)	YES	MoH, HCSA, HIC	Outcome	Indicator is too general, not needed for MoH, information collected by UZIS (Institute of health informatics and statistics)	
4. **Mortality for Trauma (E/O), TRISS**	NO	MoH, HIC, HCSA	Outcome	In intensive HC for injuries, probability of patient's death, standardization: age, gender and scope of injury. TRISS is re - counted every 10 years. Need to be divided in 3 groups, hospital with number of expected mortality is higher then observed - the outcome is very good	
5. **Mortality for Asthma**	YES	MoH, HIC, HCSA	Outcome	Considered as inappropriate indicator, specific, feasible for paediatrics, suggestion: to consult this indicator with prof. Kristufek. Recommendation – to exclude it	
6. **Mortality for Mors in Tabula**	NO	MoH, HIC, HCSA	Outcome	Opened question in 30 days, easily identifiable, each case of Mors in tabula is reported to HCSA.	
7. **Admission after day surgery for inguinal hernia**	YES	HIC	Performance	Feasible for limited number of providers, depends on legislation.	
8. **Admission after day surgery for cataract**	YES	HIC	Performance	Limited number of providers - depends on legislation.	
9. **Readmission for AMI**	YES	HIC	Performance	No comments	
10.**Readmission for Pneumonia**	YES	HIC	Performance	Higher probability of this diagnosis in socially lower environment, for children patients.	

11.**Readmission for Asthma**	YES	HIC	Performance	No comments	
12.**Readmission for DM**	YES	HIC	Performance	Main diagnosis	
13.**Readmission for inguinal hernia**	YES	HIC	Performance	No comments	
14. **Caesarean section**	YES	MoH, HIC, HCSA	Performance	No comments	
15.**Rate of one shot Antibiotic prophylaxis use for colorectal cancer by elective procedures**	YES	HIC, HCSA	Performance	No comments	
16.**Bedsores rate incurred in relation to admission**	NO	HIC, HCSA	Performance	No Comments	Source: nursing report.
17.**Infection control – nosocomial infections**	NO	MoH, HIC, HCSA,	Performance	Factors allowance, adequacy of HC facility need to be considered.	
18.**Complications after transfusion**	NO	MoH, HCSA, HIC?	Performance	No comments	
⇨ **Efficiency**					
19.**Length of stay for stroke**	YES	MoH	Performance	No comments	
20.**Length of stay for AMI**	YES	MoH	Performance	No comments	
21.**Length of stay for elective cholecystectomy**	YES	MoH	Performance	No comments	
22.**_Medium value of waiting**	NO		Performance	Need to be defined for Slovak conditions.	Source: oncological

time from indication to performance of the surgery for carcinoma of GIT					report
23. Medium value of waiting time from indication to performance of the surgery for carcinoma of uterus	NO		Performance	Need to be defined for Slovak conditions.	Source: oncological report
24. Medium value of waiting time from indication to performance of the surgery for carcinoma of prostate	NO		Performance	Need to be defined for Slovak conditions.	Source: oncological report
25.Occupancy rate and average length of stay	NO	MoH, HIC	Performance	No comments	
26.Laboratory services (x-rays, ct scans)	NO			Excluded. For use in future need to be defined.	
⇨ Staff orientation and staff safety					
27.Work related injuries	YES		Staff centeredness	Excluded. Will be used only as internal indicator of hospital.	
28.Training expenditures	YES	MoH	Staff centeredness	No comments	

29.**Sudden abdominal accidents**	NO	HIC, HCSA	Outcome	Methodology of collection needs to be specified. 3 groups: ileus, peritonitis, bleeding in GIT. Suggested indicators for each group: 1.Morbidity (percentage of patients from all number patients with extended hospitalization for complications and needed operation) 2. Mortality (percentage of lost patients from all operated for sudden abdominal accidents)	
⇨ **Patient centeredness**					
30.**Patient surveys**	YES	MoH, HIC, HCSA		Monitor whether the survey is done in hospital. Yes/ No.	
31.**Last minute cancelled surgery**	YES	HIC, HCSA		No comments	
32.Continuity of nursing care	NO			Proportion number of patients with consistent nursing care provided after discharge from hospital towards all discharged patients	

14 Annex 4: Consensus Workshop on quality report for hospitals

(Thursday: June 16th 2005, 9.00 – 16.00)

Program

Introduction of the quality report for hospitals – role, structure and people involved

Dr. Erik Heijdelberg, Interaction in Health, Amsterdam, The Netherlands

Present on behalf of project: Dr. Erik Heijdelberg, Dr. Jaap Koot, Dr. Lucia Lenartova, Dr. Martin Rusnak

List of participants

Dr. Koot opened the workshop and explained the main goal of the workshop: how hospitals can use information, which they collect and do the indicators analyses.

Erik Heijdelberg – The Annual Quality report – dynamic tool for quality management and accountability

Dr. Heijdelberg presented structure, role and use of quality report in hospital = AQR

Main topics mentioned: Expert panels, patients' experiences, complaints box, development of quality policies, and accountability towards stakeholders.

He informed all participants on result of the workshop - each hospital will produce quality report at final conference in November.

Group assignments:

Participants were divided in 3 groups.

With materials they received – *Annex 2*, they were asked to:

1. Analyze the format and make suggestions for improvement
2. Give your approach in terms of building commitment and compliance
3. Present the major points per heading of each hospital
4. Briefly present

The 3rd groups was special group consisting of representatives of HIC, HCSA and World Bank

They were asked:

What do they expect from the AQR of hospitals?

How will you use it in your scope of work – what is the purpose of developing AQR?

Replies:

I. Group: presented by Dr. Hornak from Hospital Zlate Moravce

The group designed virtual hospital, with own aims and activities. Their comment was to make the structure of AQR more detailed with subchapters.

Comments of Dr. Rusnak: he suggested making shorter formulations, clearly defining the vision, interpreting the indicators, where did they improve.

II. GROUP: presented by Ing. Kompis from Teaching hospital Martin
The group designed vision, quality policy and had several comments on what to complete the structure: health marketing, Human and financial sources, include indicators of ambulatory care, evaluation of patient and his satisfaction and evaluation of the staff (motivation).

III. Group: presented by Dr. Sladka – HCSA
She stressed the importance of AQR, to publish true information.
3 interests: Activities of HC improvement, Indicators, Quality standards
AQR should also contain: In core Indicators set: patients safety, complaints – divided according to purpose. Dr. Sladka also stressed the existence of HC providers act, where provider is obliged to have system of quality implemented.
Dr. Simo presented the priorities of GHIC: quality and level of HC of insurees, the aim is to improve HC of population.
Presentations on experiences with quality assurance activities in hospitals:
Teaching hospital Banska Bystrica – Dr. Volekova
Hospital Zlate Moravce – Dr. Hornak
Hospital Stara Lubovna – Ing. Sroka
Hospital Poprad – Ing. Zalom
Teaching hospital Martin- Ing. Kompis
Martin Rusnak – Questionnaire analyses of hospitals survey – presentation – *Annex 2*
CONCLUSIONS
Dr. Koot stressed again the purpose of AQR: data analyses for internal use for quality improvement in hospitals explain context of the indicator, provide reasons of indicators improving, and tool for external public how they perform.
Dr. Heijdelberg informed the participants on draft version of Indicators set, which will be presented to MoH. Underlined also continuum of working together, discuss how to incorporate results of the workshop in MoH advice, continue in HC improvement with World Bank project.

Pilot hospitals were asked to develop AQR, use the structure presented during workshop and project consultants will assist them in development process. The quality reports will be presented during final conference of the project in November 2005.

Next steps: hospitals will start developing the reports; experts from the project will visit each hospital to discuss the purpose of the report and its role in overall quality improvement process. The reports should be finalized before the conference, the first draft available by the end of October.

Reported by: Lucia Lenartova

15 Annex 5 Consensus Workshop on Quality Indicators for GPs

(Thursday: June 16th and Saturday 19th June 2005)

Present on behalf of project: Dr. Jaap Koot, Dr. Lucia Lenartova, Dr. Martin Rusnak

Dr. Koot opened the workshop, welcomed all participants and asked them for short introduction.

Jaap Koot – presented main objectives of the GP workshop:

- What is this project about?
- Quality indicators and their context
- Internal and external use of indicators
- Process of developing indicators
- Technical Standards
- Minimum standards recommended
- Preparation for the discussion on Saturday

Dr. Koot asked the participants following questions:

Where can you discuss quality issues as a GP?

Can you use the indicator in negotiations with HIC?

Comments of GPs:

Dr. Ojej - They realize that indicators should indicate the problem, but they are afraid HIC will use indicators as repressive tool.

Dr. Kuniakova – GPs miss relevant environment (licences, contracts), to consider quality as priority.

Dr. Svedova – problem of personal assurance, no methodology.

Dr. Findo stressed the existence of the Act 581/ 2004, GP cannot get sanctions for not having quality system implemented, because no methodology, format and way of interpretation was introduced.

Dr. Simo from GHIC informed all participants on purpose of use the indicators set: it is not meant to be repressive tool but first of all used for benchmarking of HC providers and HIC can make competition orders for contracting. MoH prepares the methodology how to analyse the indicators.

Dr. Rusnak divided the materials from Dr. Dalhuijsen into 8 groups to be discussed on Saturday workshop:

1. Basic equipment
2. Expensive equipment
3. Materials and equipment I use most often
4. Public premises
5. Non clinical premises

6. Methods of communication
7. External telephone lines
8. Infection prevention in GP practices

Dr. Rusnak asked the participants to prepare for Saturday for discussion in 2 levels:

1. What is relevant for today's situation in SR
2. What could be expected to become relevant in future, from the quality improvement point of view

Main goal of Saturday's workshop is to discuss minimal technical standards for equipment of GP practice, internal and external indicators for GPs and draft the final sets.

Saturday meeting

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

Dr. Dalhuijsen opened the workshop, welcomed all participants and asked them for short introduction.
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

2. Methods of data collection

Practice computer - Routine data

- Compulsory = number of patients, procedures, drugs, dg codes
- Every practice
- Codes
- Software

Survey / Questionnaire – by physician
Patients' satisfaction questionnaire

Practice visit – regular visits of insurers

Other data sets – hospital, financial, UZIS

Practice leaflet, (compulsory)

- Name, telephone line, opening hours, complaints

3. Tasks of General Practice

A) First contact and Categories

B) Medical procedures & operations

C) Disease management

D) Prevention and health promotion

E) Infection prevention in the practice

A) First contact

Categories

- Acute problems
- Women's problems
- Children's problems
- Psychosocial problems

B) Medical procedures and operations

Examples:

Suturing

Incision of abscesses

Excision biopsies

Cryotherapy (warts, BCC)

Cauterisation/electrosurgery

Joint injections

Ankle strapping

Inserting IUD

Setting up an intravenous infusion

Setting up oxygen therapy

Plaster application

Vasectomy

C) Disease management

Hypertension

Coronary heart disease

Left ventricular failure

Stroke

Diabetes Mellitus Type 2

Diabetes Mellitus Type 1

Asthma / COPD

Cancer/ palliative care
Lumbago with sciatica (herniated disc)
Osteoarthritis
Rheumatoid arthritis
Dyspepsia, gastric ulcer, hernia diaphragmatica
Ulcerative colitis
Pelvic inflammatory disease
Depression
Epilepsy
Hypothyroidism
Chronic leg ulcers
Bedsores

D) Prevention and health promotion

Child immunization
Family planning
Screening for risk factors for cardiovascular disease
Cervical screening
Breast cancer screening
Smoking cessation
Healthy eating / dietary advise
Exercise and lifestyle advice

E) Infection prevention in the practice

Basics:
hand soap (antiseptic)
waste bin
sharps container
gloves
disposables
surface disinfectant
autoclave (bench top sterilizer) or hot air sterilizer
ultrasonic cleansing machine

Basic Diagnostic Equipment
Examples:
stethoscope
otoscope
penlight

blue light – can be recommended
magnifying glass
scales
Measuring tape – height meter, centimetre
thermometer
blood pressure meter
Added: Snellen chart, Resuscitation set, Pseudo chromatic chart

Equipment the practice hold:
Acute care:

Anaphylaxis – adrenalin, antihistaminic, steroids
Hypoglycaemia - glucose
Cardiac arrest
Acute asthma

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.

Reported by: Lucia Lenartova

Internal / external indicators for gp practices
1. STRUCTURE AND ORGANISATION: building, equipment, records
Premises
The premises allow respect for the comfort, dignity, privacy and safety of patients Conversations in the consulting room cannot be overheard by patients elsewhere in the practice premises The temperature of the premises is regulated (between 18 and xx degrees) There is at least xx m2 of clinical space in the practice available/ 1000 patients *(criterion/benchmark to be established*) The practice premises are accessible for patients with a disability, unless specifically agreed otherwise with the health insurers Cleaning and disinfections of the practice follows national guidance applicable to primary care
Access to the practice
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

The practice telephone line is open daily minimally from 9-17 hrs, on days the practice is open
The practice premises are accessible to patients for a minimum of 36hrs/week
A telephone line is available for patients with urgent calls from 8.30-17.30 for all normal weekdays (bank holidays excepted)
For urgent cases patients can make a same day appointment or arrange a telephone consultation with a primary care clinician (this could be a nurse)
For non-urgent cases, patients can be seen by a primary care clinician within a week
The practice does house calls for patients that are housebound or too ill to access the practice

Medical records

Medical files contain up-to-date summaries of the medical history in at least 60% of patients
-summaries include current medication, key diagnoses including allergies and chronic illnesses.
95% of all newly registered patients have their notes summarized within 3 months of entering the practice
Practices have -or are able to produce- overviews of all their patients that suffer from the following chronic illnesses: diabetes, hypertension, cardiovascular disease, asthma, COPD, cancer, epilepsy and severe mental health illnesses
All patient contacts with a clinician are recorded in the patient's record
All medication and prescriptions issued are recorded in the patient's record, except dressings
There are defined backup arrangements for computer data including safe storage of back-up tapes (**Internal indicator)**

Equipment

Every clinician working in the practice and doing house calls has immediate access to: stethoscope, otoscope, penlight, magnifying glass, measuring tape, thermometer, blood pressure meter
The practice holds at least one calibrated sphygmomanometer for blood pressure measurement and one calibrated set of scales
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)
The practice holds the following sterilized equipment: scalpels, surgical scissors, surgical and anatomical tweezers, and suturing materials
The practice holds up-to-date drugs, and the equipment needed, to treat anaphylaxis and hypoglycaemia
The practice holds equipment for sterilization of instruments or has demonstrable arrangements for sterilization by outside parties
Sterilization of instruments follows national guidance applicable to primary care

2. CARE PROCESS, protocols and procedures applied

General

All patients referred to secondary care are accompanied by a letter that mentions the reason for

referral, the present medication, a summary of the medical history and any allergies known of – unless this information is transmitted by phone
Hypertension
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)* The % of patients with hypertension whose notes record smoking status (measured in the last 15 months) is at least 90% *(this needs a dated, coded entry for smoking habit in the [computer] records)* 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)* The % of patients with hypertension using an A2-antagonist (losartan, etc) with a record of undesired side effects to an ACE-inhibitor (captopril, etc) is at least 90% *(exact benchmark to be established)* The % of patients <65yrs treated for uncomplicated hypertension with a thiazide diuretic and/or a beta-blocker is at least 90% *(exact benchmark to be established)* The % of patients >65yrs treated for uncomplicated hypertension with a thiazide diuretic and/or an ACE-inhibitor is at least 70% *(exact benchmark to be established)*
Diabetes type 2
The % of patients with diabetes whose notes record BMI (measured in the last 15 months) is at least 90% The % of patients with diabetes whose notes record blood pressure (measured in the last 15 months) is at least 90% The % of patients with diabetes whose notes record HbA1c (measured in the last 15 months) is at least 90% *The % of patients with diabetes whose notes record smoking status (measured in the last 15 months) is at least 90% The % of patients with diabetes whose notes record foot neuropathy testing (measured in the last 15 months) is at least 90% The % of patients with diabetes whose notes record retinal screening (measured in the last 27 months) is at least 90% The % of patients with diabetes and microalbuminuria treated with an ACE-inhibitor or A2-antagonist is at least 70%
Sore throat
The % of patients treated for an uncomplicated sore throat with antibiotics is at most 30%
Otitis media acuta
The percentage of patients treated for uncomplicated acute otitis media with antibiotics is at most 50%
Uncomplicated urinary tract infection (UTI)
The % of patients with uncomplicated UTI treated with trimethoprim or nitrofurantoin is at least 60%

(to be discussed with local microbiologist)
Safe use of antibiotics
The % of antibiotic prescriptions -or adjusted daily quantities of antibiotics- for amoxicillin, penicillin, doxycycline, trimethoprim, nitrofurantion as a percentage of total Rx for antibiotics *(a minimum benchmark to be established)* Total adjusted daily quantities of antibiotics prescribed per 1000 patients *(a maximum benchmark to be established)* No prescriptions/1000 patients for ciprofloxacin*(a maximum benchmark to be established)*
Appropriate use of statins and other lipid regulating drugs
The % of patients prescribed lipid regulating drugs that have an updated full risk profile in their medical records and a calculation of cardiovascular risk, based on nationally or internationally accepted algorithms (both measured in last 27 months) is at least 90% The % of prescriptions for statins -or adjusted daily quantities of statins- prescribed for simvastatin, atorvastatin, pravastatin and fluvastatin as a % of all prescriptions for statins -or adjusted daily quantities of statins- is at least 98%
3. (INTERMEDIATE) OUTCOMES OF CARE, MORBIDITY, MORTALITY
The percentage of patients with hypertension in whom the last blood pressure (measured in the last 15 months) is 150/90 or less is at least 70% The percentage of patients with hypertension that smoke (as recorded in the last 15 months) is less than 30% *(exact benchmark to be established)* The percentage of patients with diabetes in whom the last HbA1c level is 7.4 or less (measured in the last 15 months) is at least 50% *(exact benchmark to be established)* The percentage of patients with diabetes in whom the last blood pressure reading is 145/85 or less (measured in the last 15 months) is at least 50% The percentage of patients with diabetes in whom the last cholesterol level is 5 or less (measured in the last 15 months) is at least 50% *(benchmark to be established)* The percentage of patients with diabetes that smoke (as recorded in the last 15 months) is less than 25% *(exact benchmark to be established)* Standardized mortality ratio *(no benchmark, for monitoring only)* Age standardized admission rates for MI, stroke *(no benchmark, for monitoring only)*
4. PREVENTIVE TASKS: health education, primary prevention
The smoking status (habit) is recorded for more than 50% of all patients on the list Blood pressure is recorded in more than 50% of all adults >45 years in the preceding four years Smoking cessation support facilities are available within or to the practice There are written patient information materials visible and available to patients about: -smoking cessation -health diet (food, drink) -regular exercise -minor ailments

The following childhood immunisation targets are achieved:

-for polio xx% at age 2 *(exact age & benchmark to be established)*

-for MMR xx% at age 6 *(exact age & benchmark to be established)*

The following influenza vaccination targets are achieved:

-for high risk groups (COPD, diabetes, cardiovascular disease): 85%

-for persons age 65 and over: xx% *(benchmark to be established)*

5. QUALITY ASSURANCE ACTIVITIES: quality monitoring and improvement processes, professional development

Calibration & maintenance

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

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

The sterilization equipment is maintained and, if required, calibrated at least yearly

Communication about patients

There is a transparent, effective and reliable means for communication between staff about patients and patient requests

There is a transparent, effective and reliable means for communication between staff about admission, discharge and death of patients

QI

Practice staff have frequent -at least weekly- occasions to meet informally

Practice holds regular -at least quarterly- meetings to discuss clinical issues and policies where all staff members can attend

Records are kept of decisions made in staff meetings and of actions to be taken

The practice is involved in regular audits of care quality and can demonstrate conclusions of these audits and actions taken

There is a system for reporting significant events (accidents & near misses)

There is an independent system for patient complaints - HCSA

There is a clearly visible system in the practice for patient suggestions

The practice holds patient survey once in 2 years

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

Professional development - (External / Internal indicator)

Practice staff receive cardio-pulmonary resuscitation training at least every 5 years

- skills of GP
- ambulance in 15 min
- if not in 15 min – more equipment required

There are annually reviewed personal learning/development plans for each member of practice staff

There is protected time for learning for all practice staff

16 Annex 6: Consensus Workshop on quality guidelines for hospitals and GP's

(Friday: June 17th 2005, 9.00 – 16.00)

Present on behalf of project: Dr. Dalhuijsen, prof. Niek Klazinga, Dr. Jaap Koot, Dr. Lucia Lenartova, Dr. Martin Rusnak
Dr. Rusnak opened the workshop and welcomed all participants.

Prof. Klazinga – General Introduction into Best Practice Guidelines – Annex 2
Development of BPG needs systematic methodology, involvement of all stakeholders (science, clinical epidemiological data).
Topics to be addressed in national guidelines development program: ownership, evidence-base, participation of different parties, legal context, link with local standards, audit, indicators and CME, quality of guidelines (AGREE), international cooperation.
The role of the National Institute for Quality and Innovations (NIKI) was stressed, since the project sees this particular development as a tool to sustain and foster the guideline development process in the years to come. NIKI was established and will start implementing the methodology of guidelines development based on SIGN approach. The methodology handbook will be adopted for Slovak environment and translated to Slovak. It will be handed over to the World Bank project to be used in developing the first sets of guidelines in close cooperation with NIKI.

Martin Rusnak – Assessment of existing guidelines in Slovakia and CR with Agree Instrument

Dr. Rusnak presented what is the aim of AI, who are the users and what guidelines are the best to be appraised.
The results of Slovak assessment proved, that in existing guidelines it is needed to focus on: Rigour of development, Applicability, Editorial independence, Stakeholders involvement.

Discussion:
Prof. Klazinga asked the participants to work in small groups and answer following questions:
What are the reasons for guidelines development in Slovakia?
What parties should be involved?
Comments:
Dr. Zak from Teaching Hospital Nitra – explained that BPG are needed to protect physicians, at court cases of trials and also to convince the politicians to increase the financial flows for HC budget.
Other comment: in Slovakia we need professional, socio – economical and political guidelines

Prof. Klazinga explained what is needed in process of guidelines development: the scope of HC need to be defined, discussions with insurers what need to be reimbursed, patients' involvement, competencies for private insurers.
He also stressed: the professionals start with process of guidelines development, lead discussions with HIC, MoH, HCSA, introduce rational way of decision making and legal context.
Reasons for guidelines development:

- Organization
- Scientific council
- Evidence
- Variance between praxis and development
- Costs in HC system

<u>Important steps to do to start with the process of guidelines development:</u>

- Describe the topic of guidelines to be developed
- Summarize questions (specific areas) to be included
- Setting up working group – chairman
- Researchers work
- Training courses on systematic literature review
- Draft recommendations
- Clear statements – level of evidence 1- 4
- Consultations with professional organizations (on acceptance of the guidelines)
- Final version
- Scientific council – assess the methodology
- Subgroups with implementation plan of guidelines
- Guidelines publishing
- Dissemination
- Patients involvement
- Information on audit, Indicators

Prof. Klazinga stressed the importance of influence context for national guidelines development and recommended SIGN methodology to be discussed as possibly used in Slovak situation. For assuring the complete quality, clinical guidelines are needed.

Reported by: Lucia Lenartova

17 Annex 7: Clinical Practice Guidelines

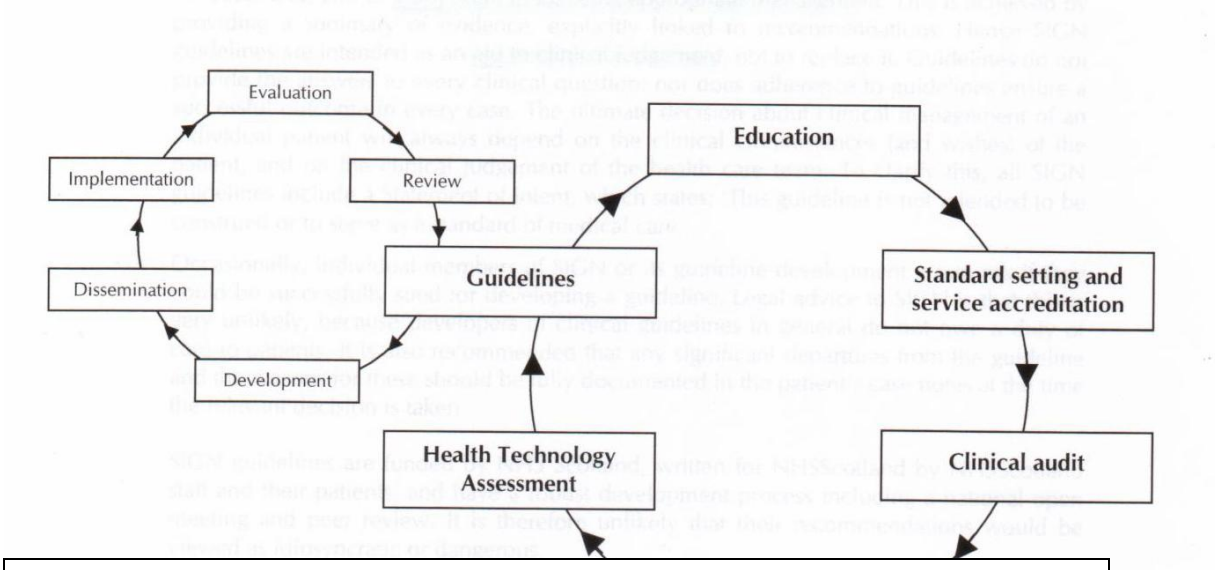
The way forward after the June 2005 workshops

Introduction

Clinical practice guidelines are recommendations on the appropriate treatment and care of people with specific diseases and conditions. They are based on the best available evidence. Guidelines help health professionals in their work, but they do not replace their knowledge and skills.
Good clinical guidelines aim to improve the quality of healthcare. They can change the process of healthcare and improve people's chances of getting as well as possible. For example, well-constructed and up-to-date clinical guidelines:

- provide recommendations for the treatment and care of people by health professionals
- can be used to develop standards to assess the clinical practice of individual health professionals
- can be used in the education and training of health professionals
- can be used by government for priority setting and for improvement of efficiency
- can help patients to make informed decisions, and improve communication between the patient and health professional.

Figure 1 the role of guidelines in the quality assurance process



Definitions

Evidence-based medicine is the *conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients*.

Clinical Practice Guidelines are *systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances.*

Health technology assessments are *recommendations on the use of new and existing medicines, medical devices, diagnostic techniques and surgical procedures.*

There is a rapid increase in knowledge of medical efficacy and effectiveness and of basic science. Clinical practice guidelines have made a contribution both to the methodological progress of evidence-based medicine and to the management of the health problems they address. Although the percentage of care based on evidence continues to increase dramatically, 80 percent of health care still cannot be related to a strong scientific foundation. Development of clinical guidelines therefore is not a one-dimensional activity of taking evidence from international literature; it requires consensus building amongst stakeholders and inclusion of local cultural and economical factors. It is a misunderstanding that clinical practice guidelines can just be copied from other countries, without further analysis or adaptation.

In the history of development of guidelines three generations can be distinguished:
- consensus conferences: experts producing guidelines based on their clinical experience
- evidence based medicine guidelines: using evidence from international literature, collected from various sources
- evidence based medicine and cost-effectiveness analysis, which not only looks at the quality aspect, but also at the value for money aspect

The latter type of guidelines is appropriate to reduce costs, although not enough cost-effectiveness studies have been carried out so far to cover all areas of medicine.

Experiences from other countries can be used to develop an organisational set-up and structure for development of guidelines. In the preparation of this document the experiences from the United Kingdom (NICE), Scotland (SIGN), New Zealand (NZGG) and the Netherlands (CBO) have been used. The respective websites provide further information on specific elements.
Internationally guideline developing organisations work together in the Guideline International Network (G-I-N), with more than 50 organisations and experts represented. The network publishes all guidelines, and maintains a website with links to relevant websites of national organisations.

The guideline development process

Typically a guidelines development process looks like presented in the following table:

1. Organisation of guideline development
2. Selection of guideline topics
3. Composition of the guideline development group
4. Systematic literature review
5. Formulation of recommendations
6. Consultation and peer review
7. Presentation and dissemination
8. Local implementation
9. Audit and review

The steps are discussed below in more detail

1. Organisation of guideline development

A formal independent organisation must be formed to take charge of the guideline development process. The proposed structure for the Slovak situation is discussed in the next paragraph.

2. Selection of guideline topics

The selection of priority areas to be tackled is important, as production of guidelines takes time, and resources are limited. It should be avoided that lack of clarity over the selection criteria leads to a political process of guideline selection.
Reasons may be:

- Areas of clinical uncertainty, with a wide variation of clinical practices and health outcomes, i.e. those areas where apparently very different approaches are possible.
- Areas where effective treatment has been proven, and reduction of morbidity and mortality can be achieved
- Iatrogenic diseases or interventions carrying significant risks for the patients
- Priority areas as selected by stakeholders, e.g. affecting large groups in the population like cardio-vascular diseases, diabetes, mental illnesses
- Areas selected by professional groups

One of the activities in the selection process is scoping, whereby the exact questions which are to be answered by the guideline are formulated.

In some countries, like in the Netherlands there is a special organisation for developing guidelines for general practitioners. In the selection of the topics and areas it is important to define the target group for the guideline.

3. Composition of the guideline development group

The composition of the guideline development group is essential, as the group must have the necessary authority to be acceptable to all professionals in the country. The most important is the selection of the chair, who should not be a party in disputes around the topic selected. The chair should be a professional who can facilitate the professional debate. Furthermore, there should be a multidisciplinary representation in the group, including representatives of patient or consumer organisations. In general, organisations or individuals who have a commercial interest in the area are banned from participation in guideline development groups, especially pharmaceutical companies.

4. Systematic literature review

Based on the scoping of the guideline, detailed research questions are formulated. For example questions regarding sex, age, or ethnic background of patients may lead to specific search for evidence. The search starts with clinical practice guidelines developed in other countries, recent overview documents, meta analysis documents, like the Cochrane library, and other information, e.g. economic analysis. Standardised review of the available evidence allows the guideline development group to get a clear overview. In general, the guideline development organisation employs professionals for this review process.

5. Formulation of recommendations

The obtained evidence is graded carefully, based on the amount of evidence found, and homogeneity of conclusions of research. Guideline development organisations developed a system of considered judgement, where the members of the group use transparent criteria to formulate recommendations.
Nowadays, in many cases the resource implications are considered as well. When recommended practices would be too expensive, adjusted recommendations are formulated, which have feasible resource implications.

6. Consultation and peer review

Guideline development organisations use different methods for consultation and peer review. Some pilot or pre-test guidelines amongst practitioners, to assess whether they are implementable. Some organisations use juries. It is also possible to distribute draft guidelines to professional organisations, organise feed back through internet, organise conferences, etc. After feed back the guidelines are edited and prepared for presentation. A formal approval procedure is applied in the guideline development organisation, by a higher body than the development group.

7. Presentation and dissemination

The presentation is very important. Organisations give clear instructions on the language used, formats of tables, algorithms, references, etc.
Most organisations have clear standardised formats for presentation. For example the NICE standard looks like this:

- summary of recommendations and algorithm
- introduction
  - responsibility and support for guideline development
  - funding
  - GDG membership
  - patient and carer involvement
  - epidemiological data
  - experience of those receiving care, or service use
  - outcomes
  - clinical issues
  - aim and scope of the guideline
- methods
  - literature-search strategy
  - sifting and reviewing the literature
  - synthesising the evidence
  - economic analysis
  - assigning levels to the evidence
  - areas without evidence and consensus methodology
  - forming recommendations
  - consultation
  - related guidance: details of related NICE technology appraisals or clinical guidelines that are published or in preparation
- guideline recommendations
  - evidence statements
  - recommendations
  - audit criteria

  - scheduled review of the guideline
  - recommendations for research
- references
- clinical questions
- appendices, which may include:
  - evidence tables (preferably on a CD-ROM)
  - details of search strategies.

Besides the formal guideline, there can be a summary, which concentrates on the recommendations, a quick reference guide which is used in "bed-side" situations and patient information leaflets containing information for the general public.
Many organisations aim at publication of these materials simultaneously.

8. Local implementation

Implementation of guidelines is only possible in the context of quality assurance programmes. There are many barriers to implementation, like financial barriers, peer group pressure amongst professionals, individual factors of professionals (lack of continuing professional development), patient demands, etc.
There has been research into effective ways of implementation of guidelines. Education and audits are important, but also regulations, financial incentives and other methods, like patient empowerment. The most successful is the combination of strategies, whereby carrot- and stick methods are combined. Isolated development of guidelines, without introduction of quality systems has very limited, of no effect at all. Therefore, the guideline development should be accompanied by an implementation plan, outlining proposed combination of measures to facilitate the implementation.

9. Audit and review

After publication, continuing monitoring of the guidelines takes place. On the one hand the implementation in practice is monitored, which may lead to adjustments in guidelines. On the other hand international scientific developments are monitored. In case of quick developments early review of the guidelines may be considered. In several countries as a standard after four or five years guidelines are reviewed.

Time scale for development of guidelines

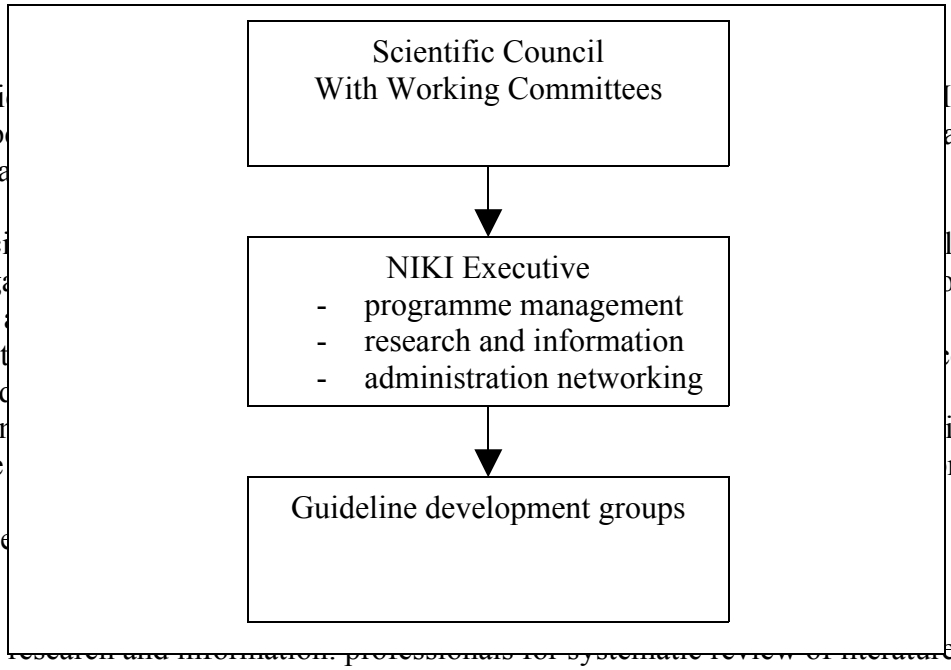
The average time scale for development of guidelines in the UK and Scotland is about 30 months:

- 6 months: scoping and group composition
- 12 months: systematic review and formulation of recommendations
- 9 months consultation and peer review
- 3 months publication

National Institute for Quality and Innovation

The National Institute for Quality and Innovation is still under development. The structure could be adapted from other Guideline Development Organisations in other countries.

The structure could be as follows:



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The exe
-
- research and information: professionals for systematic review of literature
- programme management: support unit for the groups which are producing guidelines, assisting the development groups to rigorously follow the scientific methodology.

Guideline development groups
As mentioned above, the guideline development groups are multidisciplinary. The chair has an important role in facilitating the process. The members of the working groups are volunteers, who get only costs reimbursed.

Funding mechanisms

In many countries the funding mechanisms differ. The contribution can come from:
- government, providing subsidies to the organisation
- insurance companies
- professionals (through their organisations)
- other funding (whereby any interference in the contents of guidelines is strictly avoided)