

euroTC Palma Seminar, 30 Years, 2012
Quality Management in Treatment of Addictions in Germany

A)

About us

TANNENHOF Berlin-Brandenburg e.V. is a voluntary association and was founded in 1979. Its motto, 'ways out of addiction for children and young people', emphasizes the fields in which it has worked since the 1980s in Berlin, and through its network in Brandenburg since 1991.

Our specialized drug therapy sites have been overseen by doctors since their foundation and are accredited as medical rehabilitation clinics by the German statutory pension insurance provider - Deutsche Rentenversicherung. TANNENHOF'S services have now been widened to include the care of children whose parents suffer from addiction, the TANNENHOF school where children are able to repeat their school diplomas, outpatient groups for children with special needs, vocational training, counselling, and projects which promote addiction prevention.

TANNENHOF Berlin-Brandenburg e.V. is a modern provider of social services and employs more than 200 individuals. Our network currently consists of more than 470 places for therapy, counselling, vocational training and schooling. These are complemented by approximately 4,100 therapy sessions in Berlin, and around 4,900 in Brandenburg, every year.

A high level of internal and external cooperation provides a basis for our institutional operations.

Importantly it also creates an optimal environment for the provision of the networked care of individuals suffering from addiction, and children and young people in need.

Positivity is also an essential aspect of our therapy and advice clinics: combined with the understanding on the part of the individual searching for help, positivity provides a common basis for health promotion, as well as permanence and stability in social relations – all of which are essential if we are to ensure an individual's successful social reintegration.

Quality control is managed in a separate department responsible for overseeing our service provision and its costs. Quality management ensures accountability and transparency in all areas and clearly defines each service provider's area of responsibility.

After gaining certification according to DQS 2006, from 2009 to 2012 we were also certified according to DIN EN ISO 9001:2008, each year! Additionally we were obliged to get certification by BAR Association 2011.

B)

Quality Assurance in Rehabilitation under the German Pension Insurance Scheme

To describe the German Pension Fund, respect. the German Insurance Fund, I used some abstracts provided by PubMed (key words: German pension fund and quality management); this means the treatment system is illuminated by inside authors of the pension fund.

12 years after its introduction, the German Pension Insurance's quality assurance program is firmly established within the rehabilitation system.(1)

Regular, substantive reporting to rehabilitation centers and pension insurance organizations has contributed to improving the quality of rehabilitation. Legal codification of quality assurance stipulations has existed since 2001.

The program is in constant development, e. g. by optimization of patient interviewing and inclusion of evidence-based clinical practice guidelines.

New programs, e. g. in inpatient rehabilitation of children and youths or in outpatient rehabilitation, are being developed together with the German health care organizations. In the field of vocational rehabilitation quality assurance had started out with a conceptual study followed by projects concerning client interviewing, evaluation of documentation instruments, and analyses relative to the most important outcome factor, namely the vocational reintegration results achieved. External quality assurance is a mayor input factor for the rehabilitation centres' internal quality management. In future, rehabilitation centres will be asked to demonstrate the appropriate use of this information.

The „dead line” of approval has ended in 2011: every single rehabilitation center had to be approved according to the criteria of the so-called BAR (Bundesarbeitsgemeinschaft für Rehabilitation; Federal Association of Rehabilitation).

C)

Structure of treatment in Germany, according tot he German pension fund (Deutsche Rentenversicherung); here: treatment of addiction:

Responsible institutions in Germany regarding treatment of addiction*:

Pension funds	1 federal institutions and 12 regional fund	SGB VI
Health insure companies	> 300	SGB V
Social welfare (state)	regional communities	SGB XII
Child and youth administration	regional level	SGB VIII

*= somatic, psycho social and / or psychotherapy / rehabilitation

Rehabilitation

Treatment Structure	Number of treatment slots (approx.) / TC
Inpatient treatment	20 to 150
Outpatient treatment	10 to 80*
Full time (6 – 7 hours daily)	20 to 40

*= group therapy and ividual therapy (80 hours per year)

German Quality Programm: Main criterias
(Qualitätssicherung DRV)

1. Scientific concept of the rehabilitation program
2. Appropriate qualification of the personal / team
3. Structure quality (house, installment, housing, accommodation)
4. Quality of the documentation (process documentation)
5. Results oft he peer review evaluation

Number of individual affirmations for rehabilitation in 2010

Structure	2010 (approx., alcohol and drug treatment)
Inpatient treatment	15.000
Full time (6 – 7 hours daily)	<u>10.000</u>
	25.000
Outpatient (estim.)	8.000
Aftercare	5.000

C)

The significance of clinical guidelines for rehabilitation 2)

For rehabilitation under the German pension insurance scheme, there are two main aspects: **the integration of rehabilitation into the curative guidelines** in terms of "local tailoring" on the one hand and the **development of guidelines for rehabilitative processes, demand-oriented control of rehabilitation access, and rehabilitative aftercare** on the other hand.

The elaboration of effective standards is aimed at avoiding over-provision, under-provision or misdirected provision of care and, simultaneously, at ensuring that quality assured treatment is offered to the rehabilitees. Guidelines can facilitate integration of the different sectors in health care provision by operationalising the interfaces both with curative medicine and primary prevention. Throughout the process of guideline development for rehabilitation the specific characteristics of this sector must be kept in mind.

Since therapeutic interventions are multidisciplinary and multimodal in nature guidelines have to be comprehensible and applicable for all members of the multiprofessional team. Corresponding to the relative paucity in rehabilitation research there is no sufficient evidence base for numerous therapeutic interventions. Accordingly, guidelines in rehabilitation will--initially--consist of a mixture of evidence- and consensus-based recommendations. Also, the specific goal of rehabilitation under the German pension insurance scheme, namely maintenance or recovery of the capacity at work, has to be borne in mind.

[Rehabilitation \(Stuttg\)](#). 2007 Jun;46(3):155-63.

Data sources for continual quality improvement in medical rehabilitation- the QS-Reha procedure of the statutory health insurance funds and the Eva-Reha documentation system of MDK Rheinland-palatinate

Bassler M, Nosper M, Follert P, Böwering L, Polak U.

Source

Medizinischer Dienst der Krankenversicherung (MDK) Rheinland-Pfalz, Alzey.
markus.bassler@mdk-rlp.de

Abstract

Rehabilitation centers in Germany with a care supply contract according to section 111 Social Code Book Five - statutory health insurance (SGB V) are legally obligated to implement an

internal quality management and to participate in comprehensive measures of external quality assurance which particularly aim at improving outcome quality (section 135a SGB V). The legislator has left it to the central associations of health insurance funds and to the relevant umbrella organizations of care providers to develop these measures as well as the basic requirements on internal quality management in order to reach a joint agreement about it (cf. section 137d [1] and [1a] SGB V). The corresponding agreement was concluded on April 1, 2004. Whereas configuration of the internal quality management to a large extent lies in the discretion of the individual rehabilitation center, although it has to be geared to the objectives and principles set out in the agreement under section 137d SGB V, participation in the external quality assurance procedures of the central associations of health insurance funds (QS-Reha procedure) is obligatory for all rehabilitation centers with a care supply contract according to section 111 or 111a. The QS-Reha procedure comprises a survey of the central quality dimensions (structural, process and outcome quality as well as patient satisfaction) and permits related quality comparisons, which are utilized by the health insurance funds for quality oriented patient allocation and remuneration. The QS-Reha procedure had been developed to implement the legal requirements for external quality assurance in the field of medical rehabilitation (section 135a in conjunction with section 137d SGB V) as well as to create a basis for quality focussed remuneration and patients allocation, whereas the Eva-Reha database had been developed by the Medical Service of Health Insurances in Rhineland-Palatinate for single case documentation with the objective of utilizing these data for internal quality management and, beyond this, also for various aspects of quality development across centers. The results generated in the framework of external quality assurance and internal management have to be integrated in the concept of internal quality management as they account for important sources of information with respect to the analysis of strengths or weaknesses of the facility. Irrespective of their origin quality relevant results should be integrated into a benchmarking system providing information to the operational and medical management of a rehabilitation center on the effectiveness and efficiency of the medical rehabilitation services provided. Up-to-date data, such as those generated by the Eva-Reha database, or sample survey data as those from the QS-Reha procedure can equally be used for such a benchmarking system and complement each another in a meaningful way. In this paper the main features of the QS-Reha procedure and the Eva-Reha database are described, with the objective of pointing out the particular perspectives of their data structure and results for continuous improvement in the framework of internal quality management. In: [Gesundheitswesen](#). 2009 Mar;71(3):163-74. Epub 2009 Mar 13. [**The quality assurance programme of the statutory health insurance funds in medical rehabilitation: results and further developments**].

[Article in German]

[Farin E, Jäckel WH, Schalaster V; Projektgruppe QS-Reha-Verfahren in der AQMS.](#)

Source

Universitätsklinikum Freiburg, Abt. Qualitätsmanagement and Sozialmedizin.
erik.farin@uniklinik-freiburg.de

Abstract

OBJECTIVE OF THE STUDY:

This study reports on the results of the quality assurance programme of the statutory health insurance funds in medical rehabilitation (QS Reha programme) and on the further

development of the programme in 2007 to 2008. By October 2008, a total of 240 rehabilitation centres with 283 specialised departments were participating in the QS-Reha programme.

METHODOLOGY:

To measure structural quality, the level of compliance with "basic criteria" (compiled beforehand with the help of experts) was determined. This was done by means of a questionnaire and subsequent telephone interviews with each institution. To determine patient satisfaction and measure outcome quality, a multicentric study with three measurement periods was carried out. Risk adjustment was conducted to compare clinics. The latest results presented here include the data from about 8,000 patients.

RESULTS:

On average, the structural quality of the institutions can be described as good to very good (the rate of fulfillment is generally over 90%), but there are clear differences among the clinics. The patients are generally very satisfied with the personnel. The fraction of those not satisfied is about 10-15%. At the end of rehabilitation, medium high to high effects on the central dimensions of outcome can be determined for all the indications observed here. There are also significant deviations from the overall mean for 10-40% of the clinics after risk adjustment.

DISCUSSION:

The preliminary results of the programme provide a comprehensive view of the quality of medical rehabilitation. Limitations exist concerning evidence-based structural quality criteria, methodological problems of patient-reported outcomes and the occurrence of non-responders and dropouts. The reworking of the QS Reha programme pursued the goal of improving the cost-benefit ratio of compiling data without impairing the methodological soundness of the programme. The new concept is scheduled to be implemented routinely beginning in 2009.

Quality assessment in rehabilitation centres: the indicator system 'Quality Profile'.

[Farin E](#), [Follert P](#), [Gerdes N](#), [Jäckel WH](#), [Thalau J](#).

Source

Department of Quality Management and Social Medicine, University Hospital Freiburg, D79106 Freiburg, Germany. farin@aq.s.ukl.uni-freiburg.de

Abstract

PURPOSE:

An indicator system for measuring the quality of rehabilitation centres ('Quality Profile' of rehabilitation centres) is presented. The implementation of the concept is explained with the aid of results regarding structural, process and outcome quality in 26 cardiac and orthopaedic rehabilitation centres.

METHOD:

In each centre, structural, process and outcome quality, including patient and employee satisfaction, are measured. Process quality is determined by means of a peer review procedure that includes examination of 20 randomly selected cases on the basis of discharge reports and therapy plans. The medical outcome is measured by a prospective study with three measurement time points and a sample of approx. N=200 patients per centre.

RESULTS:

Overall, the level of quality of the medical rehabilitation in the institutions participating in the study must be considered high. However, on almost all quality dimensions, even after a risk adjustment there are clear differences between centres, which point to the usefulness of benchmarking analyses and the need for improvements in quality in some centres.

CONCLUSIONS:

The indicator system presented is a starting-point for comprehensive, comparative measurement of the quality of in-patient rehabilitation centres that, with regard to its principles, also appears applicable to other areas of health care.

PMID: 15371035 [PubMed - indexed for MEDLINE]

Citation

1)

Quality Assurance in Rehabilitation under the German Pension Insurance Scheme
Egner U, Gerwin H, Buschmann-Steinhage R.
Deutsche Rentenversicherung Bund, Berlin.

2)

Data sources for continual quality improvement in medical rehabilitation- the QS-Reha procedure of the statutory health insurance funds and the Eva-Reha documentation system of MDK Rheinland-palatinate].
Bassler M, Nosper M, Follert P, Böwering L, Polak U. Medizinischer Dienst der Krankenversicherung (MDK) Rheinland-Pfalz, Alzey. markus.bassler@mdk-rlp.de

3)

The quality assurance programme of the statutory health insurance funds in medical rehabilitation: results and further developments
[Article in German]
Farin E, Jäckel WH, Schalaster V; Projektgruppe QS-Reha-Verfahren in der AQMS.
Universitätsklinikum Freiburg, Abt. Qualitätsmanagement and Sozialmedizin.
erik.farin@uniklinik-freiburg.de

4)

Quality assessment in rehabilitation centres: the indicator system 'Quality Profile'.
Farin E, Follert P, Gerdes N, Jäckel WH, Thalau J.
Department of Quality Management and Social Medicine, University Hospital Freiburg, D79106 Freiburg, Germany. farin@aq.s.ukl.uni-freiburg.de