

Welcome!

Masterclass 1

Quality circles as a model for cross-sectoral quality development

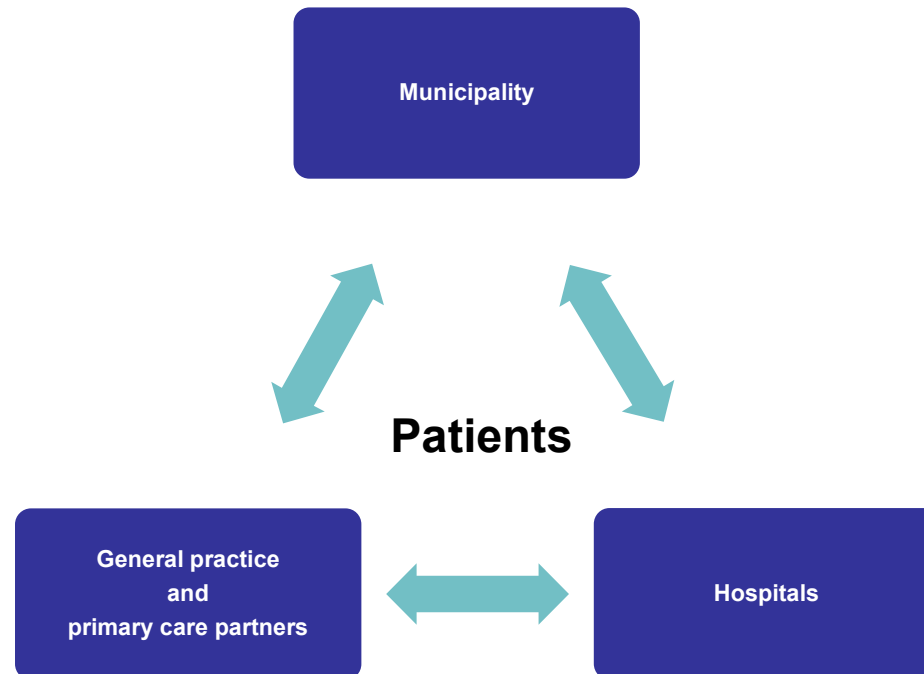
This masterclass is open to all and independent of the keynote lecture by Adrian Rohrbasser yesterday, although participants at the keynote will experience a much deeper and interactive exploration of key issues of the quality circles framework.

- Thomas Bo Drivsholm, senior medical advisor, KiAP. General practitioner, Ph.D., associate professor at University of Copenhagen
- Adrian Rohrbasser, Dr. med. Dr. phil. et MSc in Evidence Based Healthcare

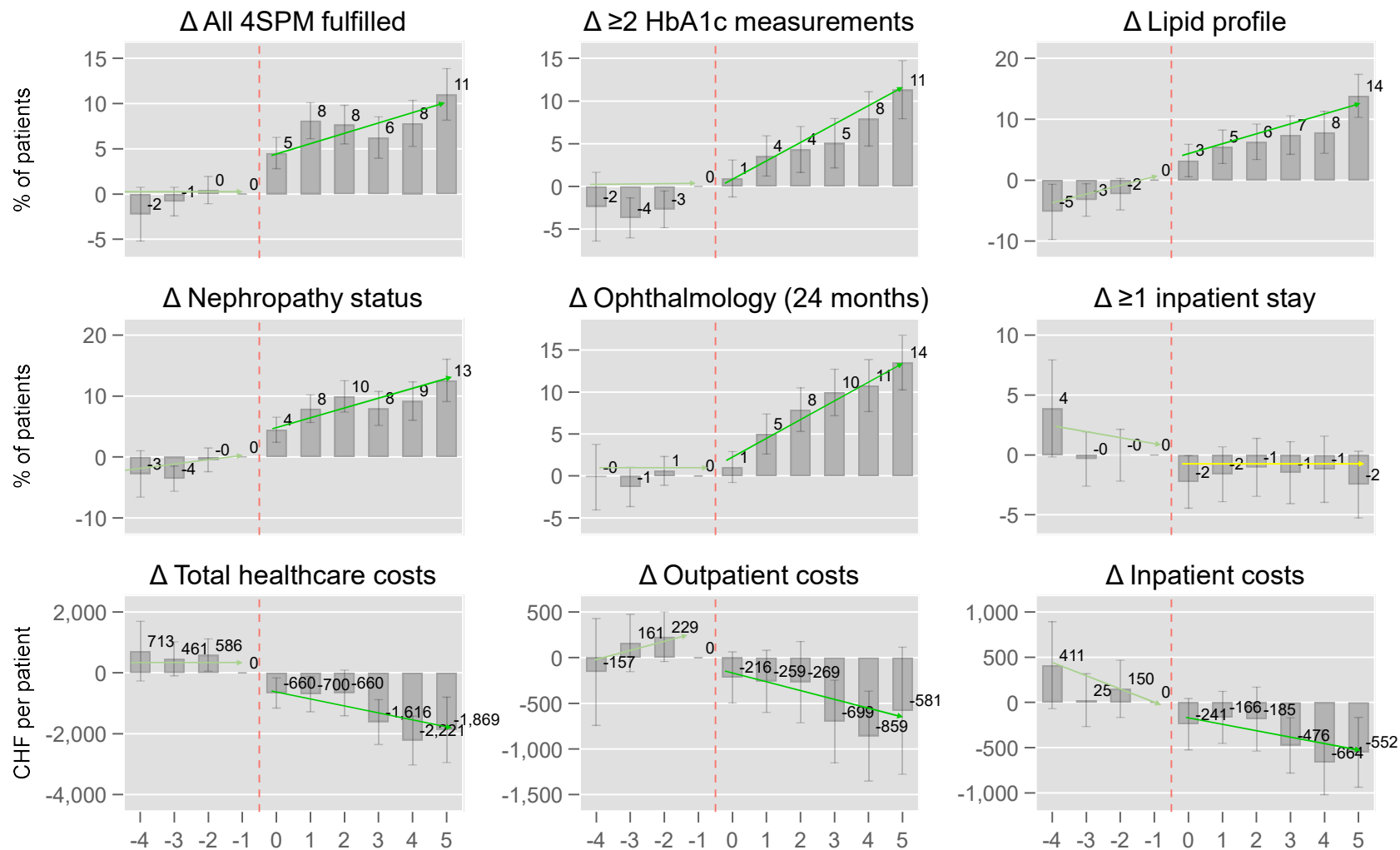


Partners in the public health system in Denmark

How do we improve our cross-sectional work?



Relative improvement with DMP → sustainable & increasing



sample 1

The quality circles model as a new approach (?)

Open access Original research

BMJ Open Understanding how and why quality circles improve standards of practice, enhance professional development and increase psychological well-being of general practitioners: a realist synthesis

Adrian Rohrbasser^{1,2}, Geoff Wong,³ Sharon Mickan⁴, Janet Harris⁵

ABSTRACT
Objectives To understand how and why participation in quality circles (QCs) improves general practitioners' (GPs) psychological well-being and the quality of their clinical practice. To provide evidence-informed and practical guidance to maintain QCs at local and policy levels.
Design A theory-driven mixed method.
Setting Primary healthcare.
Method We collected data in four stages to develop and refine the programme theory of QCs: (1) co inquiry with Swiss and European expert stakeholders to develop a preliminary programme theory; (2) realist review with systematic searches in MEDLINE, Embase, PsycINFO and CINHAL (1980–2020) to inform the preliminary programme theory; (3) programme refinement through interviews with participants, facilitators, tutors and managers of QCs and (4) consolidation of theory through interviews with QC experts across Europe and examining existing theories.
Sources of data The co inquiry comprised 4 interviews and 3 focus groups with 50 European experts. From the literature search, we included 106 papers to develop the literature-based programme theory. In stage 3, we used data from 40 participants gathered in 6 interviews and 2 focus groups to refine the programme theory. In stage 4, five interviewees from different healthcare systems consolidated our programme theory.
Result Requirements for successful QCs are governmental trust in GPs' abilities to deliver quality improvement, training, access to educational material and performance data, protected time and financial resources. Group dynamics strongly influence success; facilitators should ensure participants exchange knowledge and generate new concepts in a safe environment. Peer interaction promotes professional development and psychological well-being. With repetition, participants gain confidence to put their new concepts into practice.
Conclusion With expert facilitation, clinical review and practice opportunities, QCs can improve the quality of standard practice, enhance professional development and increase psychological well-being in the context of adequate professional and administrative support.
PROSPERO registration number CRD42013004826.

Strengths and limitations of this study
→ This study synthesised over 100 academic papers published in English, German, French and Scandinavian languages, and data from 90 experts and participants from different European countries and healthcare systems.
→ The resulting programme theory reflects and explains the complex process in quality circles in the current context of European primary healthcare and may need to be adapted in response to future changes.
→ The recommendations rely on the detail and depth of the reports we identified in our literature review and on the veracity and adequacy of the information gathered in interviews.
→ We were only able to test a limited set of existing theories to gain insights into how the programme theory's mechanisms work and interrelate.

INTRODUCTION
Quality circles (QCs) are made up of 6–12 primary healthcare (PHC) professionals who regularly meet to reflect on and improve their standard practice. The terms Practice Based Small Group Work, Peer Review Group, Problem Based Small Group Learning, Practice Based Research Group, QC, Continuous Medical Education (CME) Group and Continuous Professional Development (CPD) Group were used interchangeably and varied among countries. The labels suggest the basic, original intent of the group. We decided to use the umbrella term 'QC' to describe all of them.¹ In the UK and Europe, QCs are commonly used by general practitioners (GPs) for CPD. The focus of discussion is usually a critical evaluation of an aspect of quality which participants themselves identify as important to them. GPs seek to improve the quality of their care by linking

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► Prepublication history and additional supplemental material for this paper are available online. To view these files, please visit the journal online (<http://dx.doi.org/10.1136/bmjopen-2021-028453>).

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Purpose and learning objectives these 3 hours

Overall purpose

- What is the evidence behind quality circles and the methods involved?
- What can we learn from international experiences?

Expected insights and skills

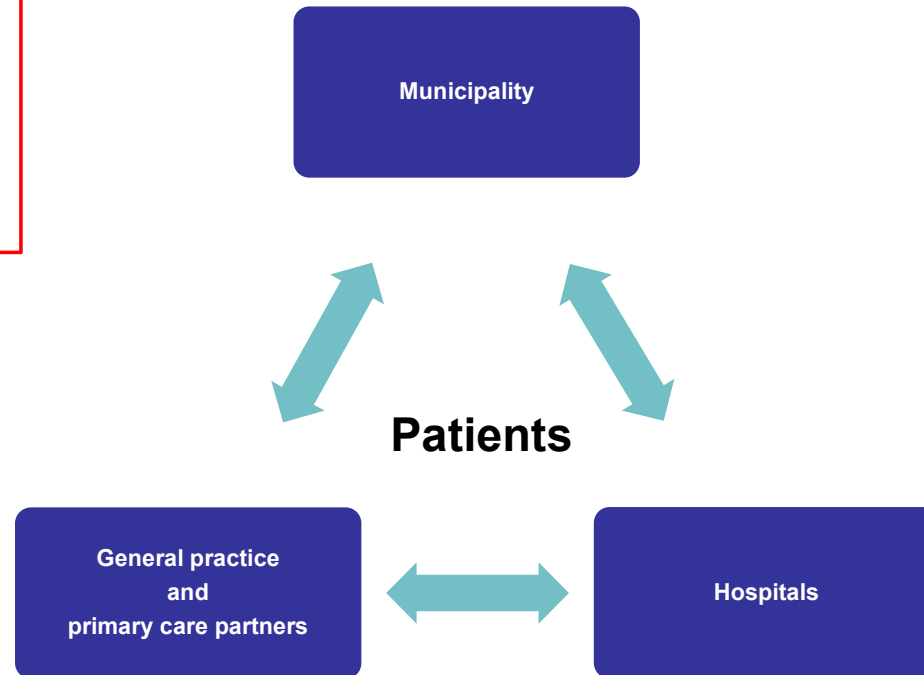
- An overview of current ways of working together in cross-sectoral quality development in Denmark.
- Inspiration to new ways of approaching cross-sectoral quality development through quality circles
- Could quality circles be a model for your own area, i.e. within primary or secondary health care?
- Could quality circles be a general model for cross-sectoral quality development in Denmark?

Program for this masterclass (9:00-12:00)

	Time	Focus	Format
09:00: Welcome and introduction	10 min.	Background, purpose and mutual expectations	Plenary
09:10: Presentation, Q&A	15 min.	Current ways of working together in cross-sectoral quality development in Denmark (TBD)	Plenary including Q&A
09:25: Presentation, Q&A	30 min.	The evidence behind quality circles and the methods involved (AR)	Plenary including Q&A
BREAK	10-15 min.		
10:10: Presentation, Q&A	30 min.	Cross-sectoral quality development through quality circles (AR)	Plenary including Q&A
10:40: Reflection and interactive exercise, Q&A	15-20 min	Could quality circles be a model for cross-sectoral quality development in your own area? In Denmark?	Small groups and plenary including Q&A
BREAK	10-15 min.		
11:10: Reflection and discussion	30-40 min	Plenary discussion	Plenary including Q&A
11:50: Completion and goodbye	5-10 min	Take home messages	Plenary

Experiences in working together

Move knowledge
– not patients

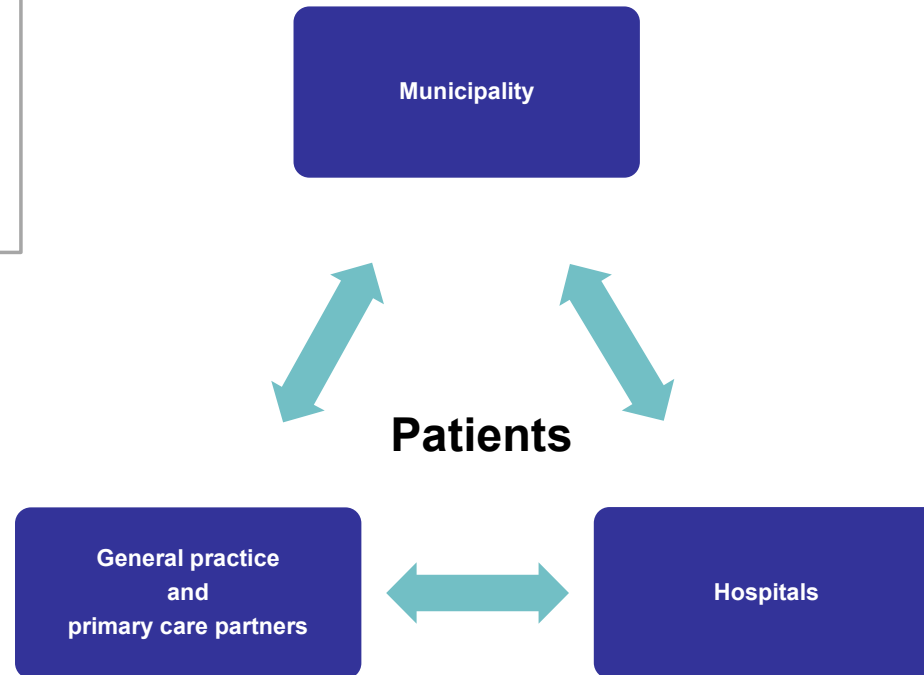


Referrals / epicrisis
Telephone / video
Data
CME
Meetings
Cluster meetings (QC)

Remember:
- time and money!

Experiences in working together

Move knowledge
– not patients



Referrals / epicrisis

Telephone / video

Data

CME

Meetings

Cluster meetings (QC)

Remember:

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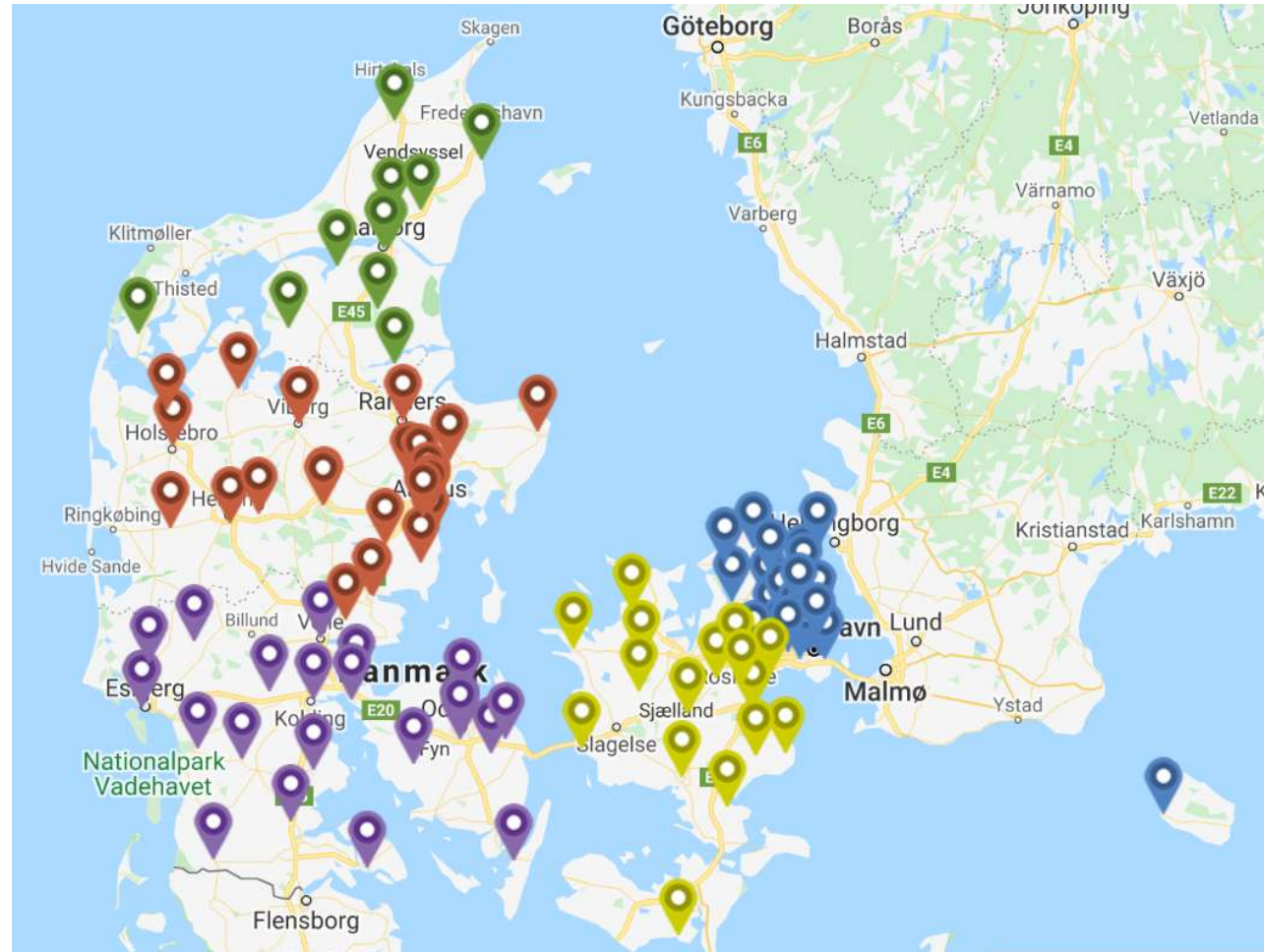


116 clusters established in 2018; 3.256 GPs included (5,5 mill. patients)

98-99 % of PLO-GPs are registered in a cluster

Approx. 30 GPs (11-70) in a cluster

Data central, but doesn't do the job by itself



The GPs approach to quality circles in Denmark

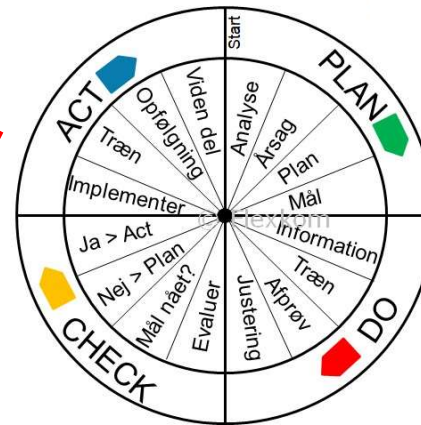
- ✓ Cluster meetings 3-4 times per year in groups of app. 30 (11-70) GPs in a geographic area
- ✓ Attendance rates high (80-100 %)
- ✓ Clusters choose focus areas for the meetings
- ✓ Cognitive dissonance and reflection re. variation in quality are central aspects
- ✓ Time at meetings to discuss and plan how implementation in own clinic can be approached
- ✓ At present an increasing focus on how learning points from cluster meetings can be implemented in own clinic and how staff can be involved
- ✓ Very concrete implementation tools, e.g. fraces, written instructions, videos and guidelines
- ✓ Automatic, systematic follow-up-data



Clusters vs. Quality Circles?!



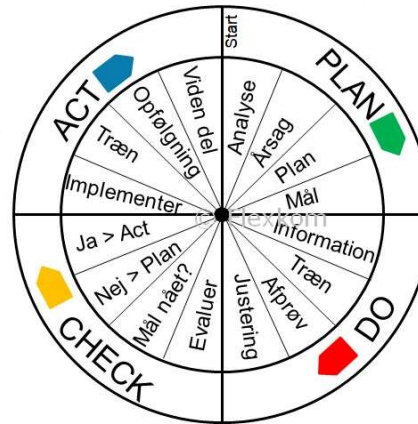
Aim: Contribute to a better treatment of individual patients



Clusters vs. Quality Circles?!



Optimal contribute to a better treatment of individual patients



*Does QC work?! How?
When? Among whom?*



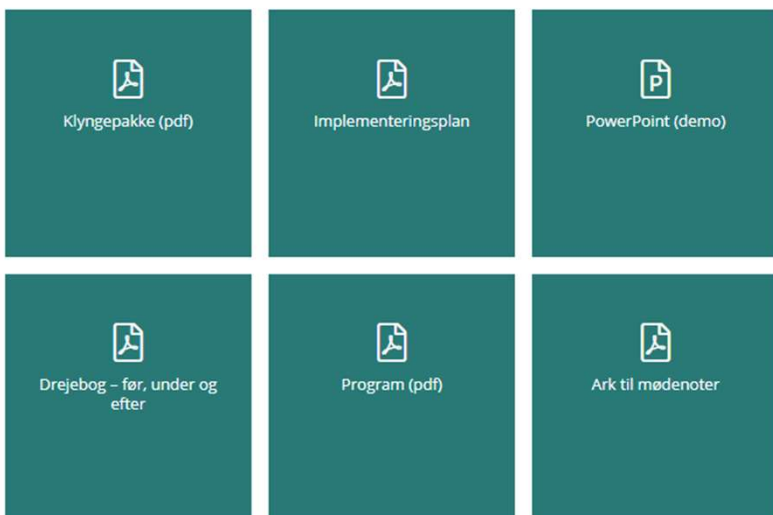
Our approach in KiAP: Is this Quality Circles?

Værd at vide om denne pakke

Materiale og support fra KiAP

- Et forslag til et program for mødet.
- En detaljeret drejebog med aktiviteter før, under og efter klyngemødet for klyngekoordinator og klyngemedlemmer.
- En powerpoint til mødet med opgørelser af klyngens data.
- Uddelingskopier med ydernummerspecifikke data.
- Et ark til at notere de vigtigste pointer under mødet.
- Materiale til implementering i praksis og til opfølgning på et senere klyngemøde.
- En kontaktperson i KiAP.

Hent mødemateriale her



Introduktion til klyngepakken



Bestil klyngepakke

Bestil klyngepakken hos KiAP og modtag en opringning fra en konsulent i KiAP, som vil fortælle dig mere om pakken, og hvor I sammen kan drøfte klyngens ønsker til mødet.

[Bestil klyngepakke*](#)

*Bestil klyngepakken senest 8 uger før den skal bruges på klyngemødet


Lyt til podcast her



www.kiap.dk

Focus areas in our cluster-packages (all with 6-12 months follow-up)

Development from 2018

- 
- Conjunctivitis, CRP, UTI, opioids, upper and lower airway infections
 - COPD, T2DM og IHS ("Forløbsplaner")
 - GPs well-being and job satisfaction

 - Gradually increasingly focus on more complex diseases / problems and cross-sectional areas – areas that are central to GPs:
 - Municipal acute function, municipal rehabilitation, medication dispensing, municipal certifications, dyspepsia, palliation (organ-failure), children well-being, PSA
 - High risk patients:
 - Familiar hypercholesterolemia, Triple Whammy, Metformin/kidney function

to 2025

In 2026: Adult psychiatry (with eKVIS/FAPS), AMR, polypharmacy, lower backpain (with SUND-K)



What is quality?

Patient
experienced
quality



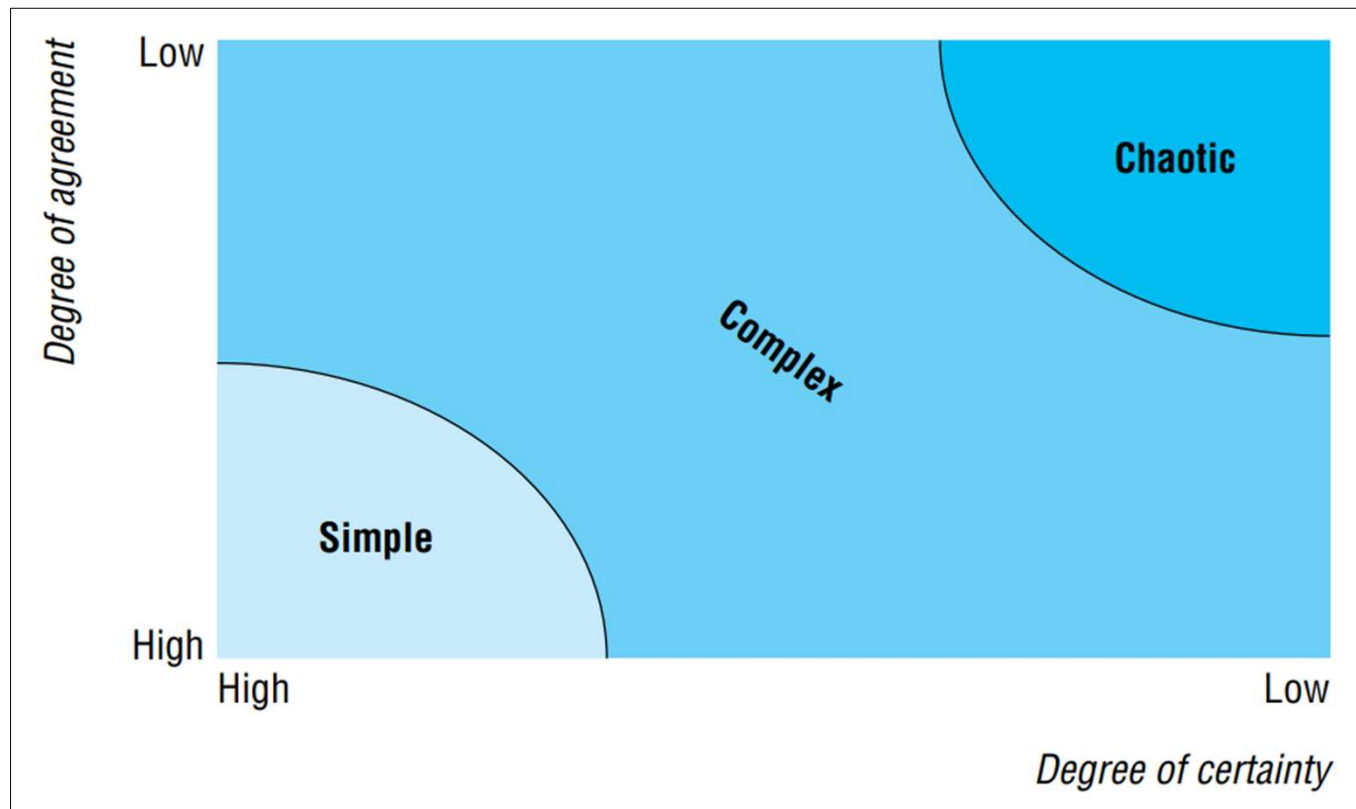
Clinical quality

Organisational
quality



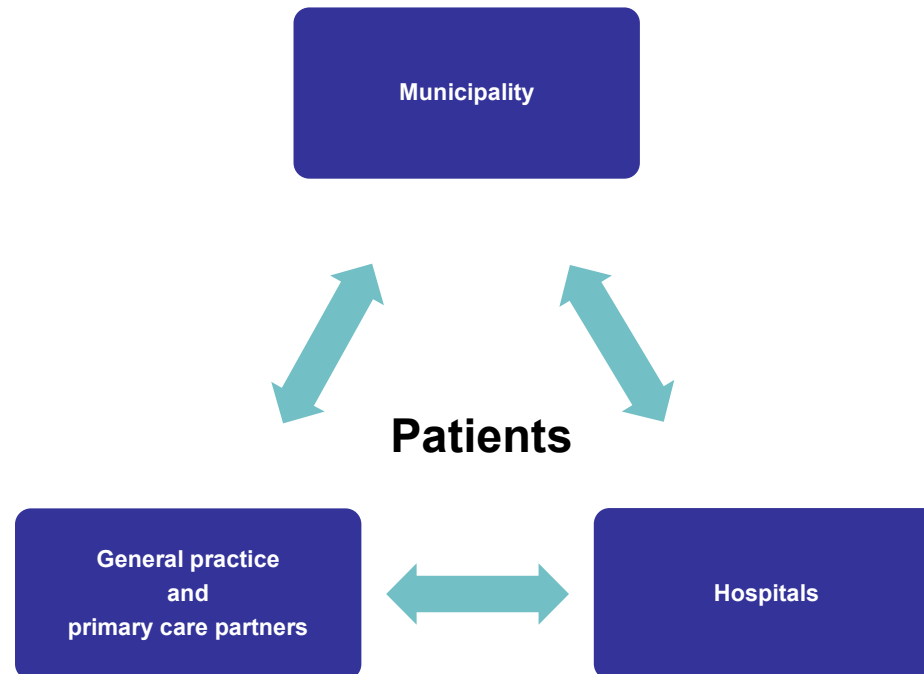
Thomas Drivsholm, lægefaglig leder i KiAP, praktiserende læge,
ph.d., lektor ved afd. for almen medicin i Kbh.

The challenge of complexity in health care



Partners in the public health system in Denmark

How do we improve our cross-sectional work?



Cross-sectional cluster packages (2022 =>)

Working together with the municipals re.

- 1) medication dispensing,
- 2) certifications,
- 3) acute function,
- 4) prevention and rehabilitation measures,
- 5) palliation (can be chosen with the local hospital as well),
- 6) patients with dementia receiving antipsychotic medication,
- 7) children well-being and
- 8) vulnerable COPD-patients

In process

- 1) adult psychiatry / SAD (Stress, Anxiety, Depression) with eKVIS/FAPS,
- 2) lower backpain with SUND-K



New ways of working together: How?

Kommunalt-lægeligt samarbejde

Af Peter Voss og Rie Bengtzen

Kontakt
pvoss@dadnet.dk

Biografi
Peter Voss er praktiserende læge, praksiskonulent v. jobcenter Skanderborg kommune og klyngekoordinator. Rie Bengtzen er udviklingskonsulent ved fagsekretariatet Ældre og Handicap, Skanderborg kommune.

”Manegemodellen”

– en vej til bedre samarbejde mellem kommune og almen praksis. Sådan kan man afholde møde mellem almen praksis og den kommunale samarbejdspartner

En del af vores patienter i almen praksis udfordres af deres komplekse sygdomsbillede og i det komplekse samarbejde med ”de andre”. Hvordan kan vi styrke samarbejdet på tværs mellem almen praksis, kommune, region og andre aktører for at forbedre og dermed sikre den samlede indsats omkring mennesker, hvis livsvilkår stiller krav til alle aktører individuelt og sammen? Læs her, hvordan samarbejdet bærer frugt i Skanderborg Kommune.

I Skanderborg har vi siden kommunesammenlægningen i 2007 haft en tradition for at afholde møde mellem almen praksis og kommunen én gang årligt.

De deltagende praktiserende læger, deltagende vikarer og uddannelseslæger får timehonorar (konsulenttaks) af kommunen for at deltage i mødet, og mødet ligger uden for almen praksis' åbningstid.

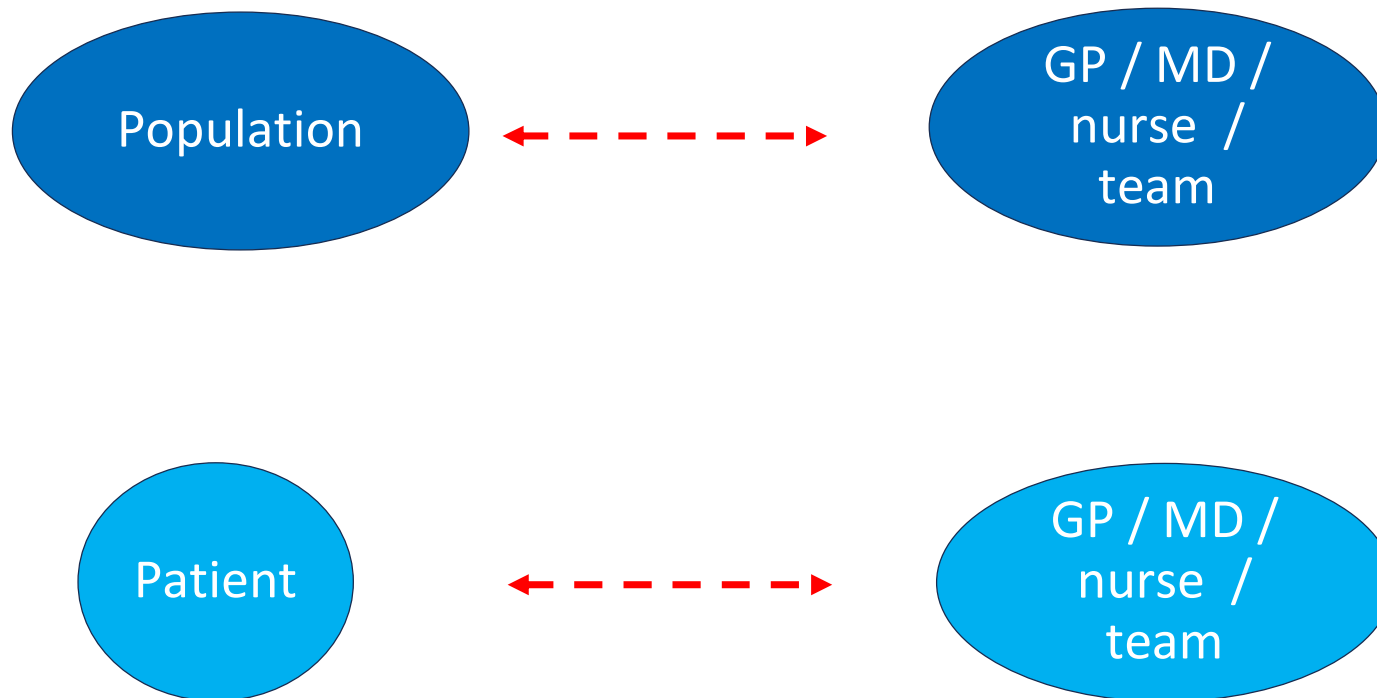
Målet med møderne har været

- at sikre dialog mellem almen praksis og Skanderborg Kommune
- at blive opdateret på aktuelle samarbejdsrelationer
- at sætte fokus på aktuelle emner, som berører begge lejre
- at give almen praksis mulighed (i mindre grad) for at tale direkte med de lokale folkevalgte kommunalpolitikere.

På de sidste tre møder har vi valgt en ny mødeform, der har vist sig at



GP/MD/nurse/team-patient vs. population



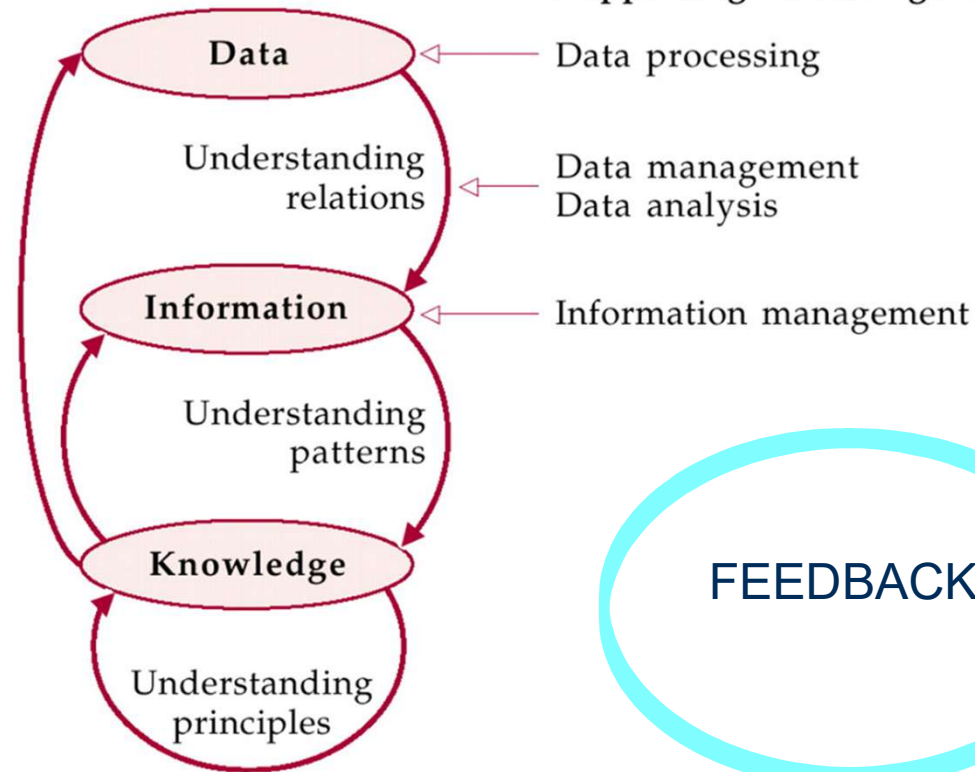
Data – Information - Knowledge

Health Care Professionals

- Data recording during consultations
- Understanding the information
- Developing knowledge in workshops and quality circles

Medbase IT

Supporting technologies



SENSKY, T. 2002. Knowledge management. *Advances in Psychiatric Treatment*, 8, 387-395.

Quality circles as a model for cross-sectorial quality development?



Adrian Rohrbasser
Adrian Rohrbasser, DPhil and MSc in
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General Practitioner – Switzerland

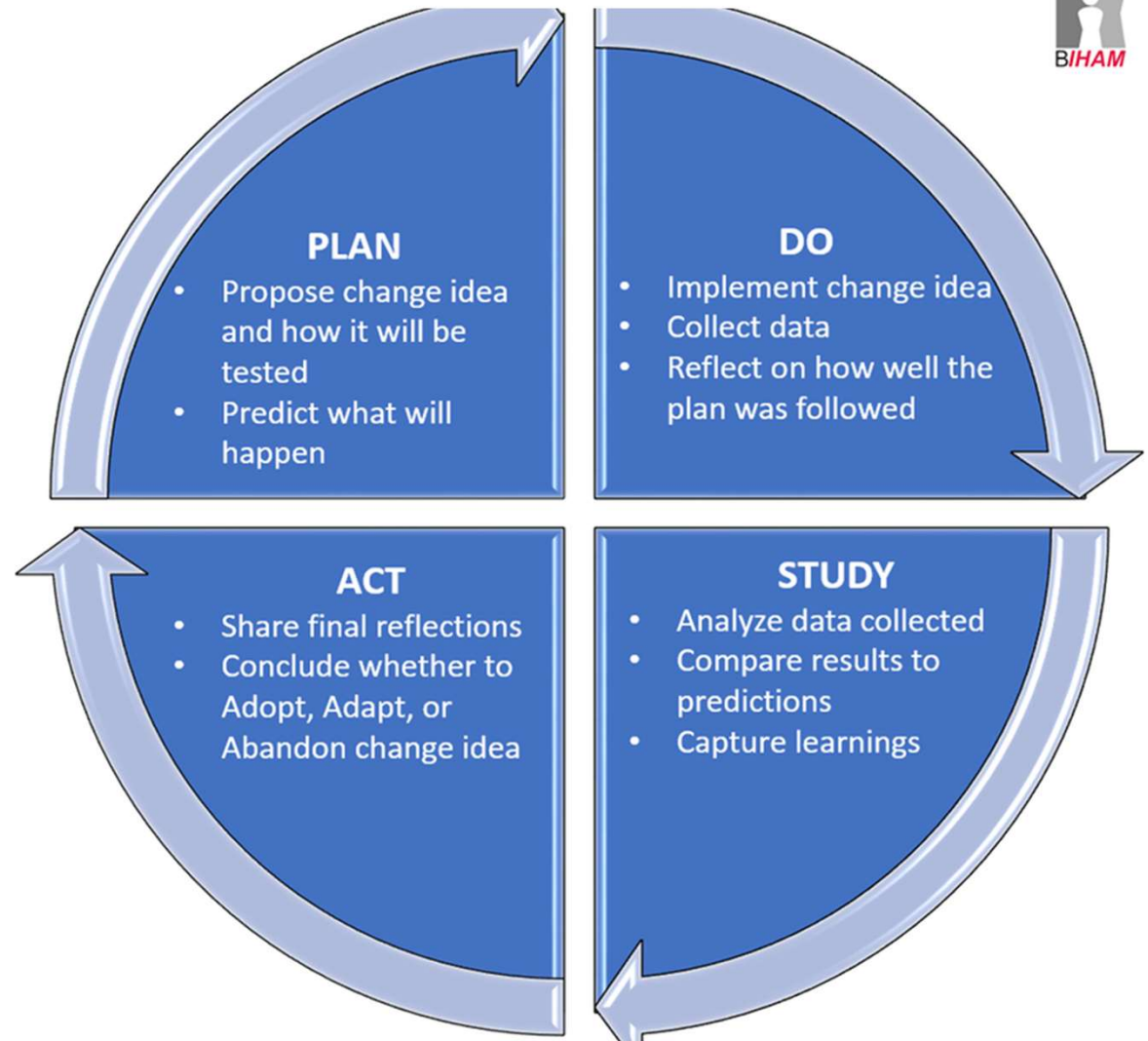
Wil Switzerland
Institute of Primary Care
(BIHAM)
University of Bern



Cross Sectional Quality Circles:

Interprofessional Quality Circles

- QI is about
 - CME
 - CPD
 - **Re organising the context**





Team-work in Primary Health Care – new skill mixes

Interprofessional quality circles

- Shared Purpose: Clear, unified objectives
- Complementary Skills: Diverse talents that enhance performance (the group knows more than the individual)
- Collaboration: Open communication and mutual support
- Trust & Accountability: Reliability and mutual respect
- Adaptability: Ability to respond to change and challenges



The **Forum for Quality Circles CH** is an interest group that aims to preserve the principles of quality circles (QC) and thus keep quality development in the hands of service providers. The following associations belong to the forum:





Basic training for facilitators



Interprofessional
setting



Learning together



Working together

Common understanding about what we do

Common understanding about how we do it as administrators and policy makers

Common understanding about how we do it as participants



Interprofessional Quality Circles

- **Chronic Care** (PCPs, APNs, Physiotherapists, MPA,,Psychologist,...)
 - **Diabetes Mellitus (example)**
 - **Cardiovascular diseases** (example under development)
- **Drug safety** (PCPs, Pharmacists) (**pilot has been completed**)
 - Polypharmacy
 - Drug interaction check
 - Dose adjustment
- **Potentially self-limiting infectious diseases - (example)**
 - (PCPs, Pharmacists, APNs, Hospital based ED)
 - Harmonising the language
 - Harmonising information tools
 - Process: **we are at the stage of QCs with pharmacists (to include them into everyday work)**



BIHAM

	Recommendation	CMO configurations in the programme theory
For the administration at a national level	Invite participants to take responsibility for their QI but let them decide what they do and how they perform QI.	CMO configuration 1 a-c, 4 b
For professional organisations or university departments	Provide information about the basic principles of QI, like the Plan-Do-Study-Act cycle (PDSA) and explain how to implement those principles in QC practice.	CMO configuration 1 b and 1 d
	Give rewards (such as CME credits) to acknowledge that QI work is further education.	CMO configuration 1 b and 2 a
	Provide facilitator training and additional coaching or supervision.	CMO configuration 1 b
	Provide access to knowledge resources like evidence-based information, clinical practice guidelines, and help with gathering practice performance data including their interpretation. Actively involve health-care professionals in collecting the local data needed to address their local priorities; this will increase their motivation and trust in the findings.	CMO configurations 1 b and 2 a
For administrative organisations	Give access to appropriate venues and help them organise meeting times.	CMO configurations 2 b and 2 a
	Integrate and use the new knowledge developed by QCs, so that GPs can see that their efforts have changed practice. Administrations must also accept local adjustments to national solutions or guidance, because QI is a local process and QCs will adapt or devise new interventions and ways of working.	CMO configuration 1 c and 4 a
	Provide protected time, so groups can work during regular working hours or at mutually agreed times. The process should not be disturbed by phone calls or urgent patient problems since these disrupt discussions.	CMO configuration 2 a, 4 a
	Accept that QCs work at different speeds, because excessive demands for rapid results often undermine QI efforts.	CMO configuration 1 c, d, 4 b
	Group size affects the level of cooperation between members. Between six and twelve members is the optimal size for communication.	CMO configuration 2 d



Responsibility for QI – legal code



QI embedded in a S...



Professional self-regul...

Qualität und Wirtschaftlichkeit: Eine Betrachtung der Artikel 58a KVG in Verbindung mit den Artikeln 58g und 58d KVV

Das Schweizer Gesundheitswesen ist bekannt für seine hohe Qualität und Effizienz. Diese Standards werden durch gesetzliche Rahmenbedingungen gewährleistet, die eine kontinuierliche Verbesserung und adäquate Zulassung von Gesundheitsdienstleistern sicherstellen. In diesem Beitrag fokussieren wir uns auf die Artikel 58a des Bundesgesetzes über die Krankenversicherung (KVG) und setzen ihn in Bezug zum Artikel 58g sowie Artikel 58d der Verordnung über die Krankenversicherung (KVV).



Change of regulations: Pharmacies are part of primary health care (Start 2019; extension of what they can do 2025 with start in 2027)



Pharmacists: Pharmacies are part of Primary Health Care

Since the revision of the Therapeutic Products Act came into force in 2019, Swiss pharmacists have been able to dispense certain prescription medicines without a prescription, subject to certain conditions. This enables pharmacists to treat common and easily treatable conditions competently and comprehensively in pharmacies.



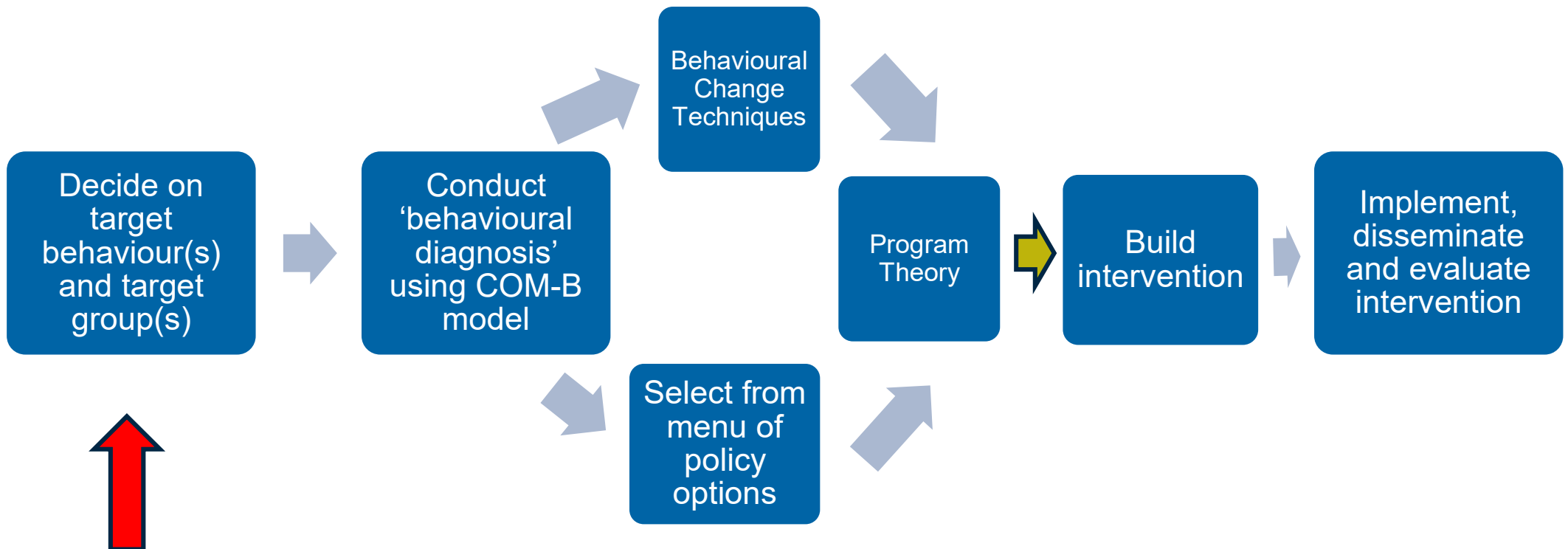
Am 21. März 2025 hat das Parlament eine bedeutende Revision des Krankenversicherungsgesetzes (KVG) verabschiedet. Das zweite Massnahmenpaket zur Kostendämpfung ermöglicht es Apothekerinnen und Apothekern künftig diverse Präventions- und pharmazeutische Leistungen zu erbringen, die zur Optimierung der pharmazeutischen Versorgung der kranken Versicherten beitragen. Ein zentraler Bestandteil ist die Einführung von pharmazeutischen Selbstleistungen, die den Versicherten einen direkten Zugang zu pharmazeutischen Leistungen ermöglichen und die Kosten für die Krankenkassen senken. Dies ist ein wichtiger Schritt zur Stärkung der Grundversorgung der Bevölkerung.

21.03.2025: The second package of cost-containment measures will enable pharmacists to bill various preventive and pharmaceutical services directly through the compulsory health insurance scheme (OKP) in order to optimise drug therapy and improve treatment adherence.

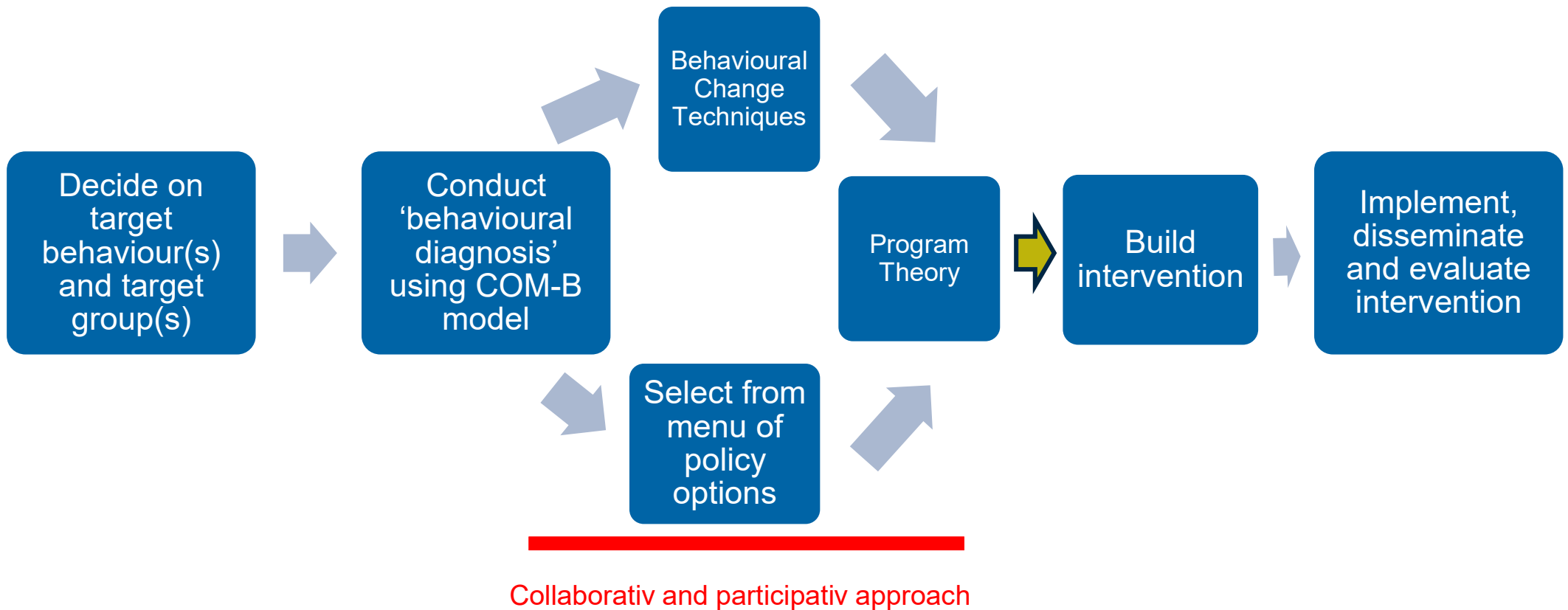
- Responsibility for QI
- QI embedded in a system
- Professional self-regulation
- Collaboration with GPs

Bridging planning and intervention

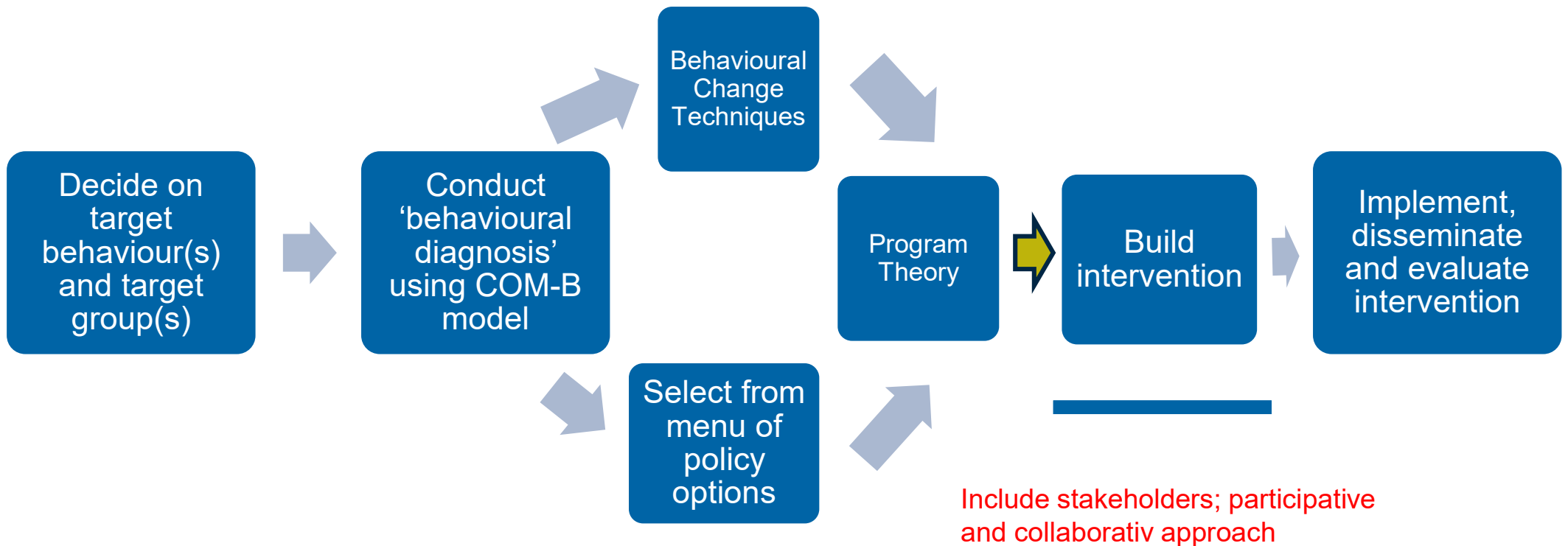
collaborative and participative approach



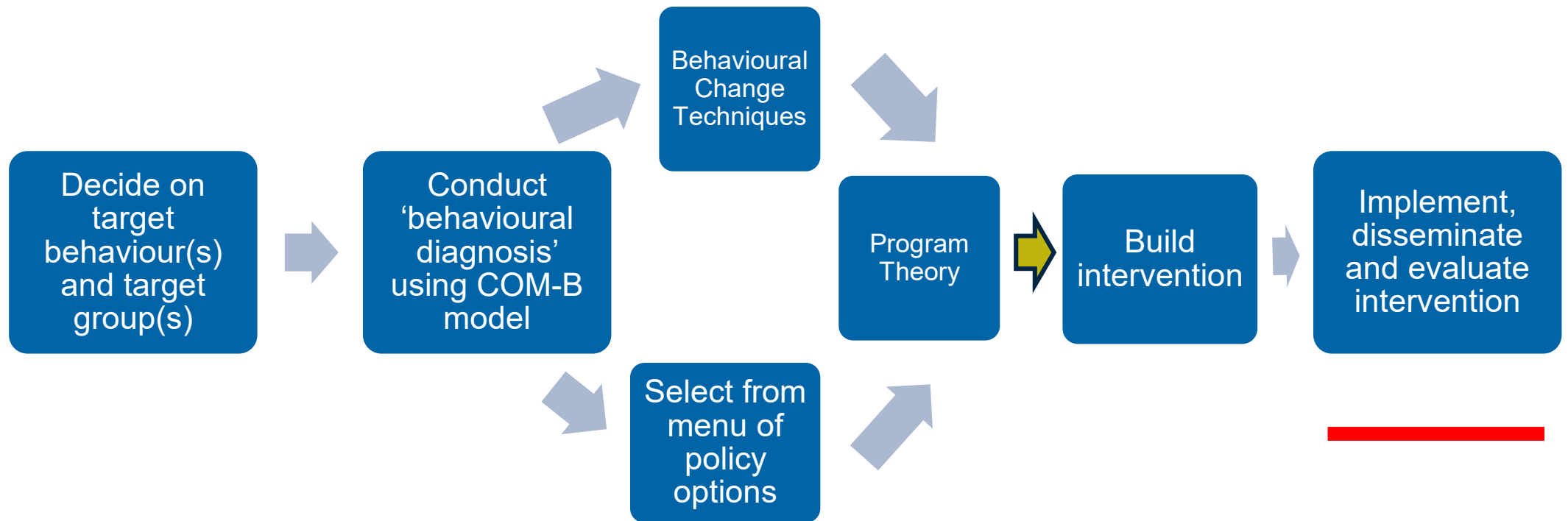
Bridging planning and intervention



Bridging planning and intervention



Bridging planning and intervention





Evaluation

**Health insurance
claims data –
difference in
difference analysis
over time**

**We follow clinical
performance
indicators**

**We plan a realist
evaluation of concepts
concerning people with
chronic diseases such
as diabetes**

Introducing Diabetes Management Concept (Diabetes Management Programme DMP-Cohorts)

– Collaboration SWICA / ZHAW / Medbase

*med***base**

SWICA

*Adrian Rohrbasser, Cornelia Caviglia, Maria Trottmann, Maria Carlander, Christian Frei, Birgitta Rhomberg, Thomas Egger,
Marc Höglinger*

Intervention Medbase

Introducing interprofessional care



SGED Criteria: performance indicators

Number of **consultations**

Lifestyle counselling: **physical exercise, nutrition, smoking** habits, driving,....

Blood Pressure, BMI

HbA1c

LDL

Nephropathy: **S-creatinine, ACR** (Urine albumin to creatinine ratio)

Looking for **Retinopathy** (Ophtalmologist)

Checking feet for neuropathy (**monofilament test**) and vascular problems (**puls**)

Data – Information - Knowledge

Health Care Professionals

➤ Data recording during consultations

➤ Understanding the information

➤ Developing knowledge in workshops and quality circles

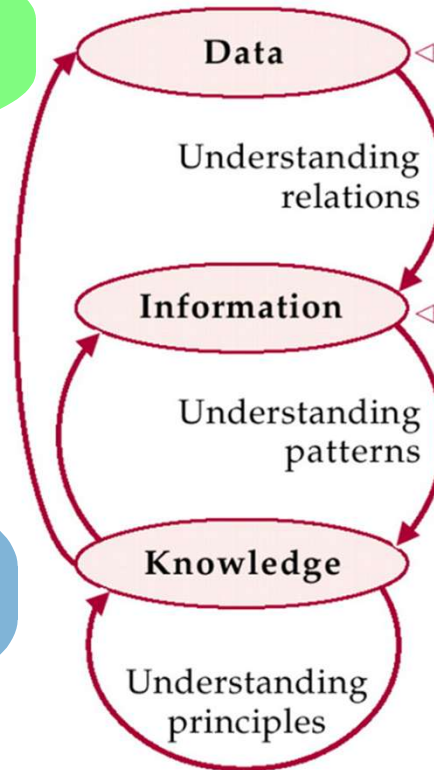
Medbase IT

Supporting technologies

← Data processing

← Data management
Data analysis

← Information management



Adjustment of electronic medical records according to HCPs needs

SENSKY, T. 2002. Knowledge management. *Advances in Psychiatric Treatment*, 8, 387-395.

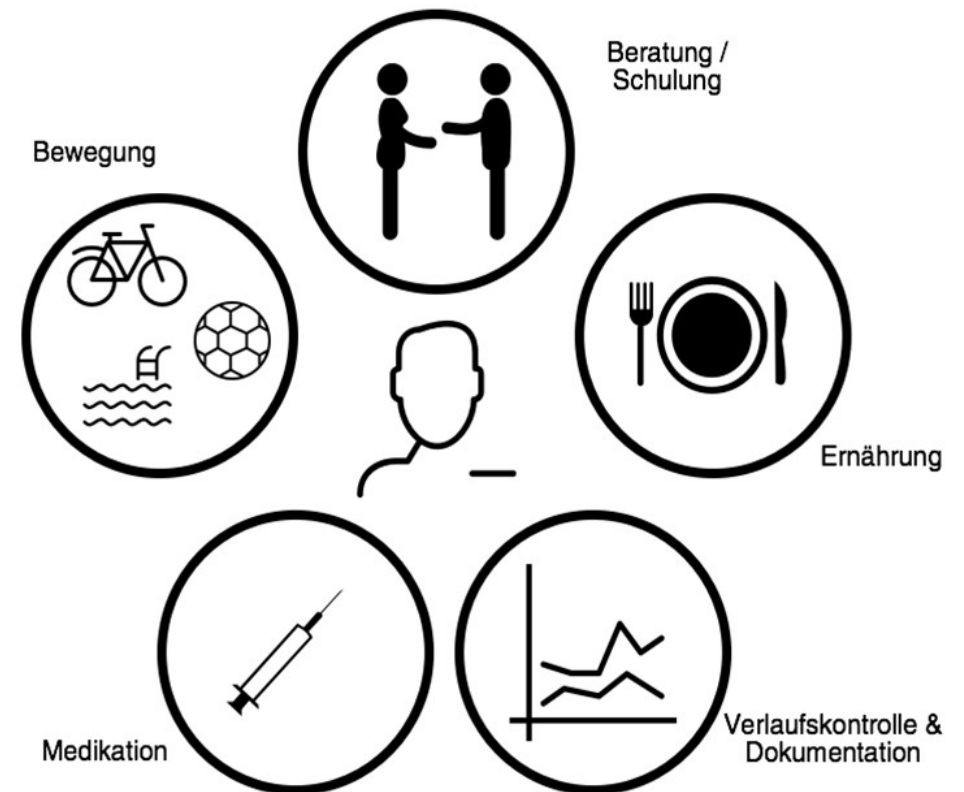


Interprofessional Care

- General Practitioner
- Medical Practice Assistant / Practice Coordinator with clinical training
- Nurse Practitioner
- Physiotherapist
- Other relevant health care professional

Care:

- patient centered
- according to current patient needs
- may differ depending of the state or patient needs

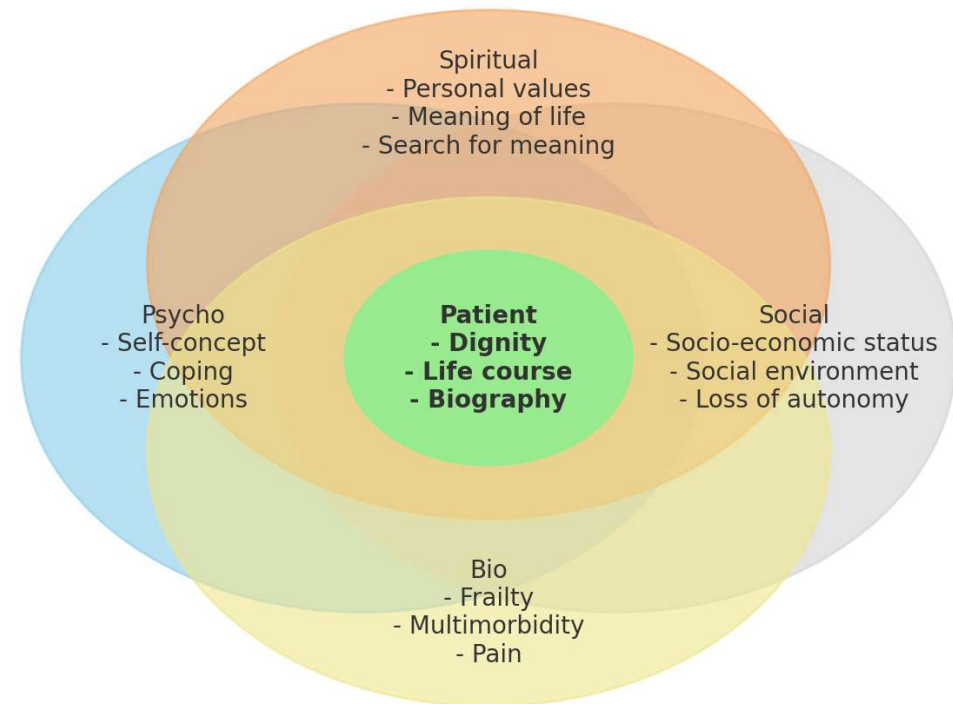


Interprofessional care concept: „co-management“ APN and MPA

- Lower care costs, fewer complications and hospital admissions
- Integration of patients in treatment processes and decision-making based on the bio-psycho-social-spiritual model
- Lower stress levels in teams (improved psychological well-being)
- Prerequisites:
 - mutual respect
 - trust
 - common care / care philosophy
 - **clarified roles**

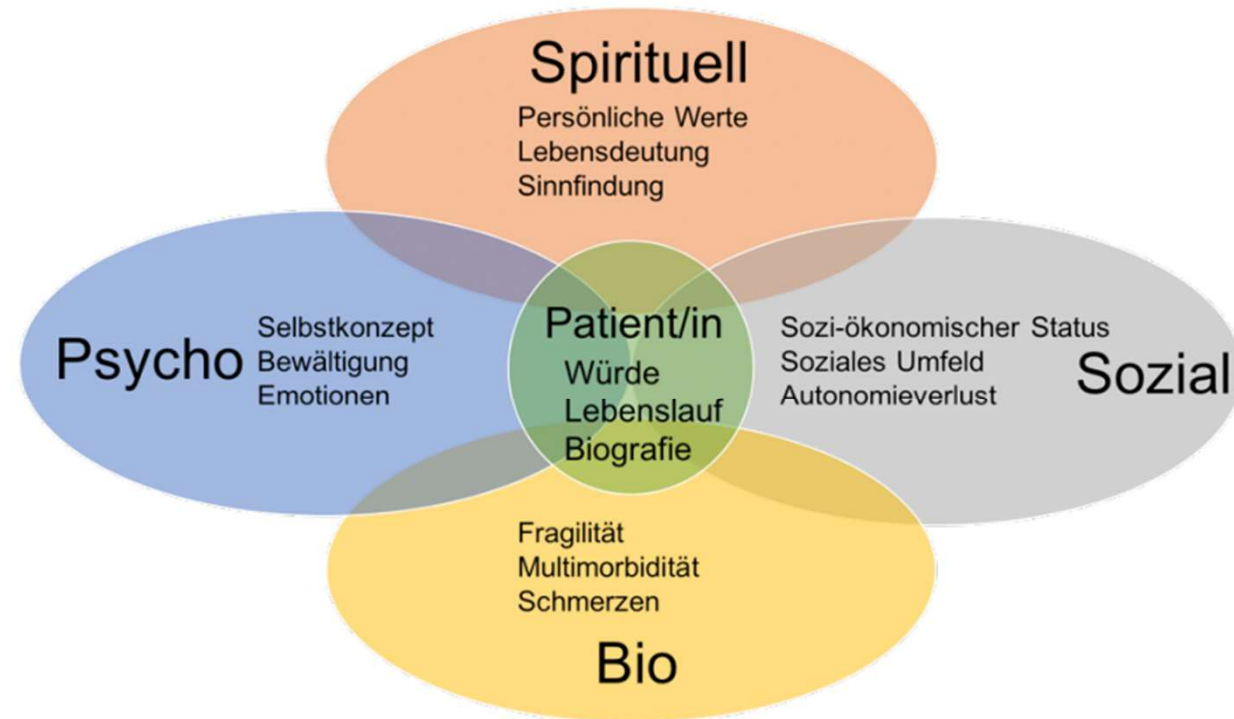
(Norful et al., 2022, Norful et al., 2019)

Bio-psycho-social-spiritual Model



Interprofessional care concept 'Co-management

- -Lower care costs, fewer complications and hospital admissions
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 - -clarified roles



Bio-psycho-sozial-spirituelles Modell. Autor: Gerster.

(Norful et al., 2022, Norful et al., 2019)

Detailed care plan for patients with type 2 diabetes mellitus

First step:

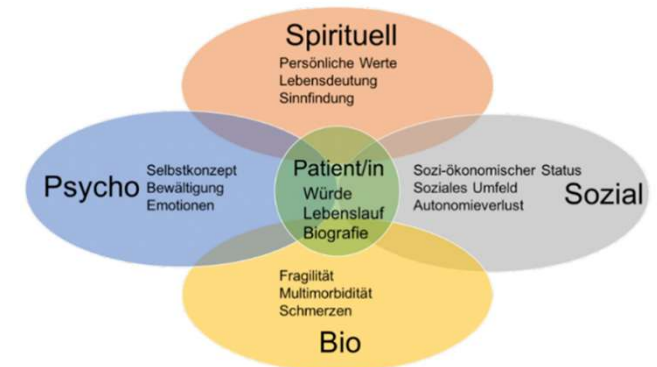
- Agree goals with the patient:
 - what do they want?
 - what's important to them?

Second step: assessing the clinical situation

Assessment of cardiovascular risk factors

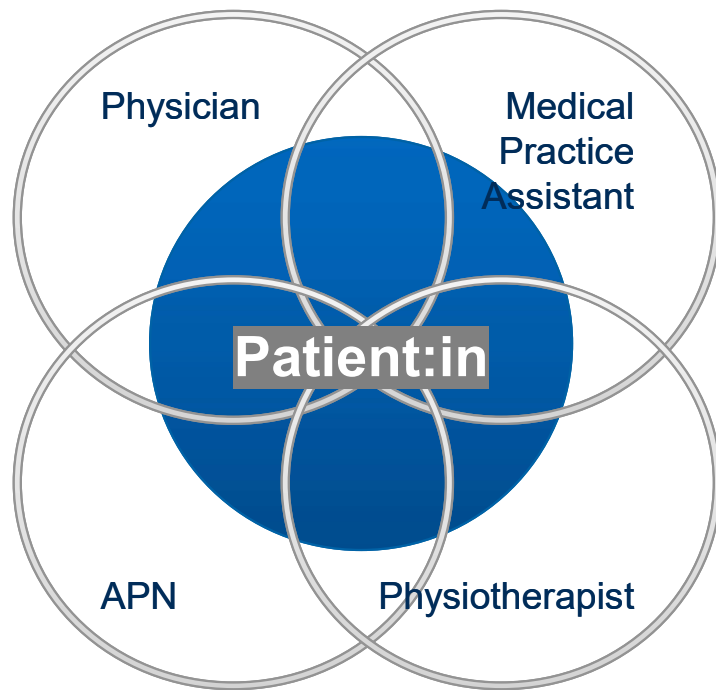
Assess diabetes-associated complications

Blood glucose

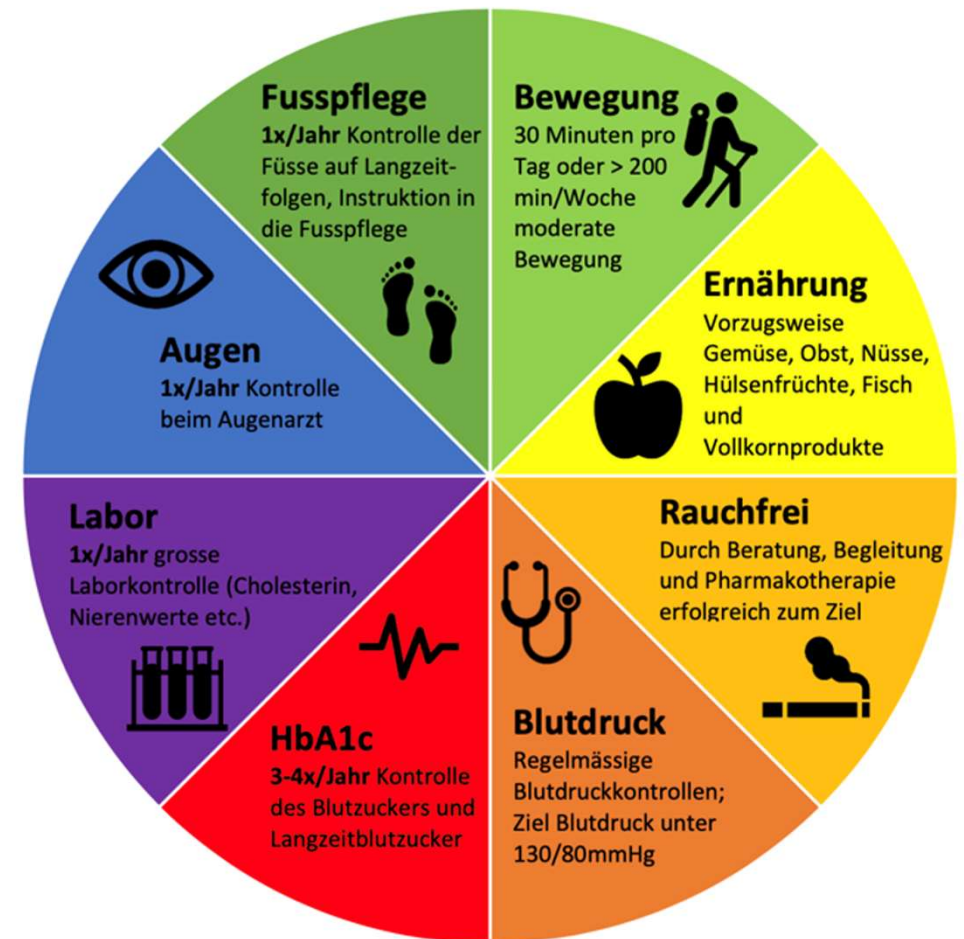


psycho-sozial-spirituelles Modell. Autor: Gerster.

Who is doing what and why?



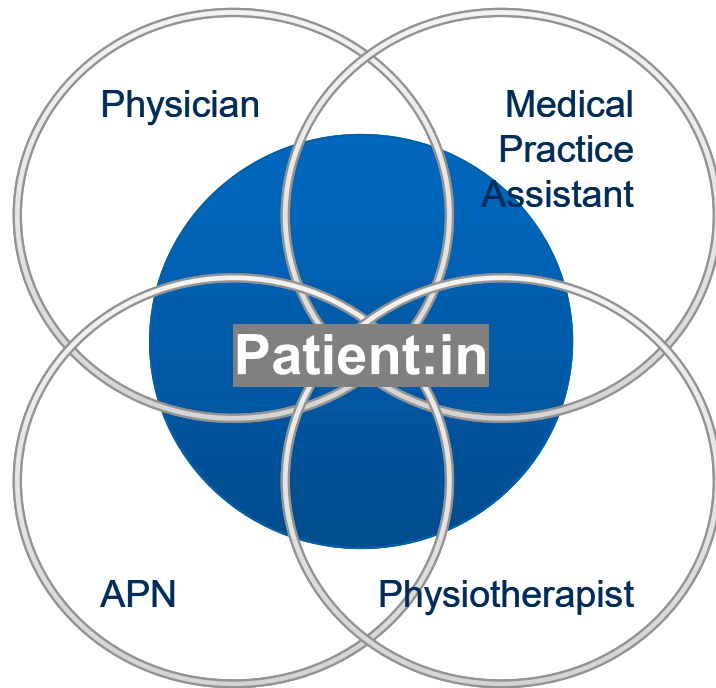
(Graf & Rohrbasser, 2024)



(Eisenegger, 2022)



Who is doing what and why?



(Graf & Rohrbasser, 2024)

Foot Care: 1x/year foot exam for long-term consequences, foot care instruction

Exercise: 30 minutes/day or >200 min/week moderate activity

Nutrition: Prefer vegetables, fruit, nuts, legumes, fish, and whole grains

Smoke-free: Achieve goal with counselling, support, and pharmacotherapy

Blood Pressure: Regular monitoring; goal <130/80 mmHg

HbA1c: 3–4x/year monitoring of blood sugar and long-term blood glucose

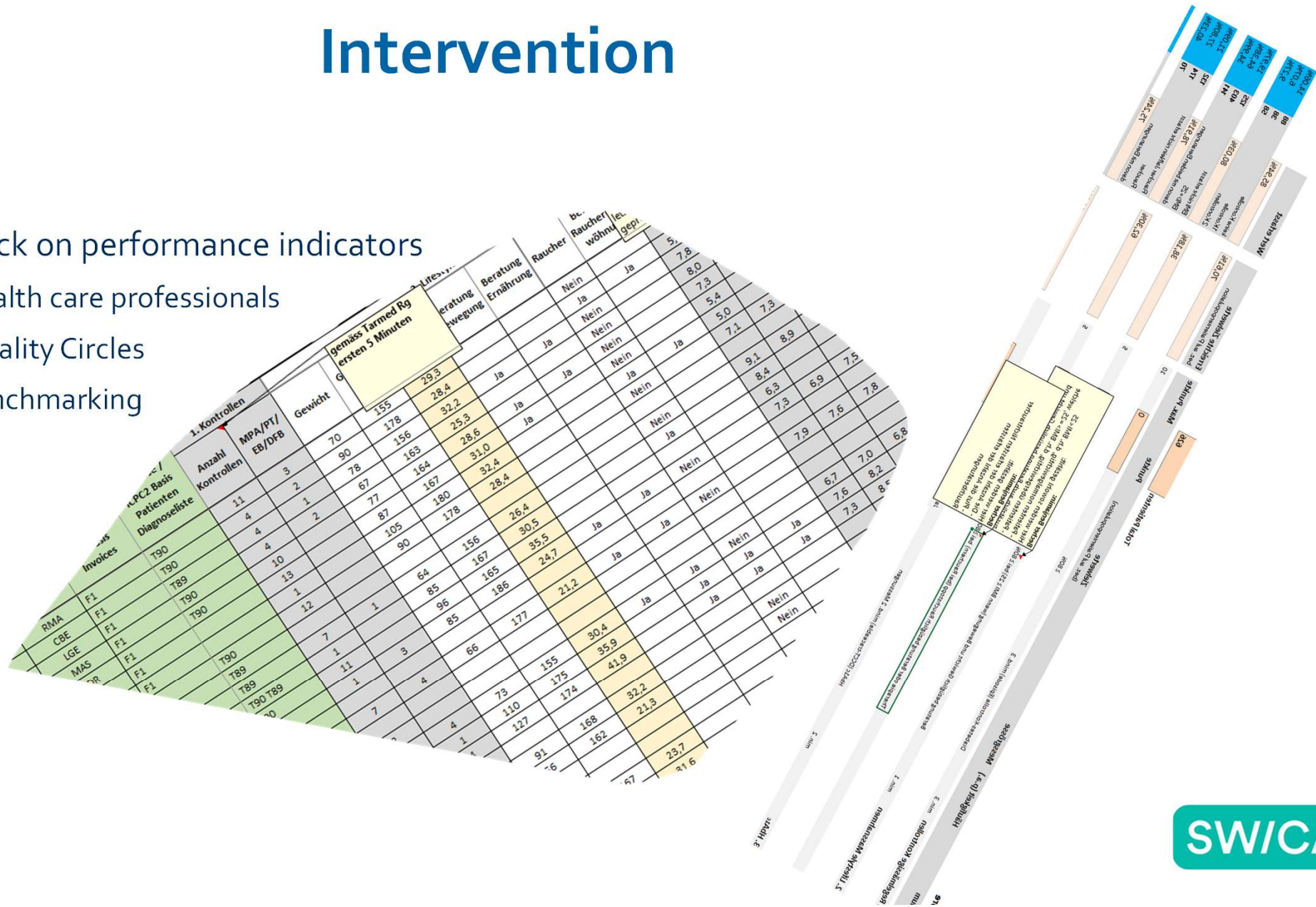
Lab: 1x/year major lab check (cholesterol, kidney values, etc.)

Eyes: 1x/year eye exam by ophthalmologist

(Eisenegger, 2022)

Intervention

- Feedback on performance indicators
 - for health care professionals
 - for Quality Circles
 - no benchmarking



Data – Information - Knowledge

Health Care Professionals

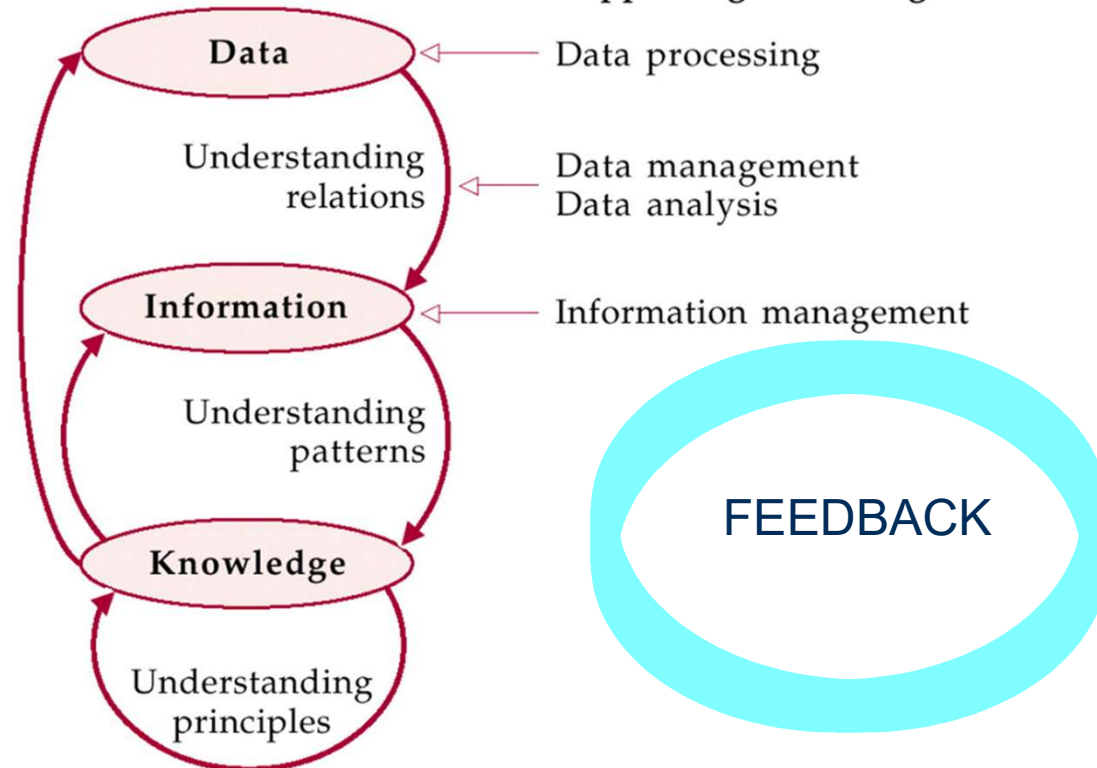
- Data recording during consultations

- Understanding the information

- Developing knowledge in workshops and quality circles

Medbase IT

Supporting technologies



SENSKY, T. 2002. Knowledge management. *Advances in Psychiatric Treatment*, 8, 387-395.

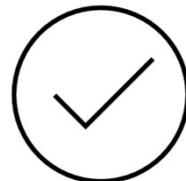


Evaluation

Health insurance
claims data –
difference in difference
analysis over time



We follow clinical
performance indicators



We plan a **realist
evaluation** of concepts
concerning people with
chronic diseases such
as diabetes

Implementing a Disease Management Program in Swiss Primary Care to Improve Diabetes Care: Results and Experiences from a Long-Term Follow-Up Study

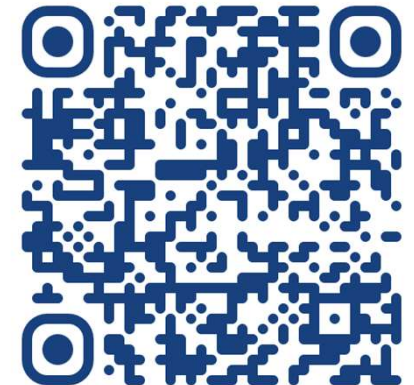
Marc Höglinger¹, Thomas Egger¹, Cornelia Caviglia³, Maria Carlander², Christian Frei², Birgitta Rhomberg², Adrian Rohrbasser^{3,4}, Maria Trottmann²

¹ Winterthur Institute of Health Economics, Zurich University of Applied Sciences, Switzerland

² SWICA Healthcare Organisation, Winterthur, Switzerland

³ Medbase Health Care Provider, Winterthur, Switzerland

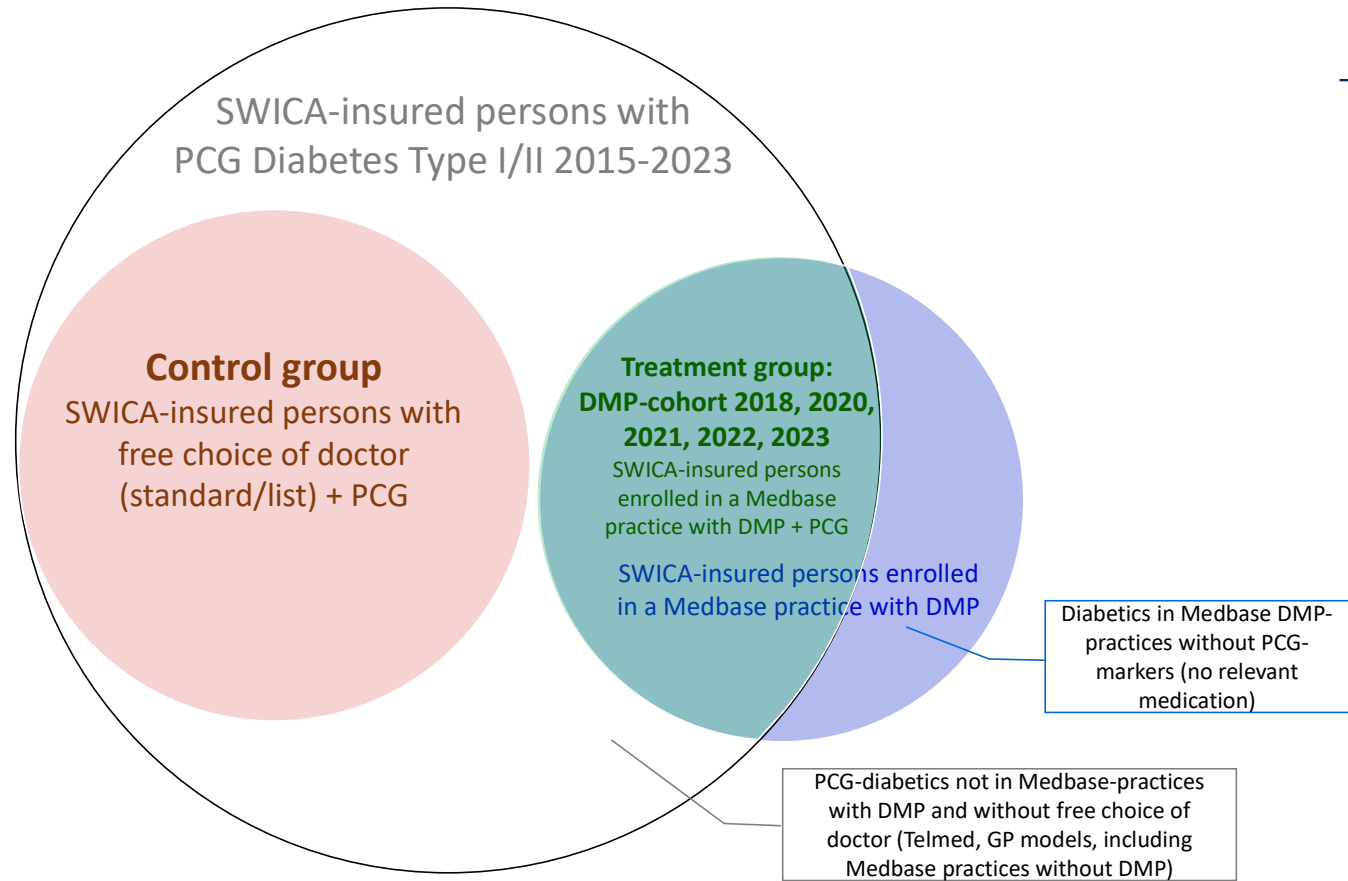
⁴ Institute of Primary Health Care (BIHAM), University of Bern, Switzerland



Thomas Egger & Marc Höglinger

11.09.2025

Population of the claims-data analysis



- SWICA-insured persons with PCG diabetes type 1 or type 2 (at least one year 2015 – 2023, >180 DDD / year)
- Treatment group: patients in Medbase practices that introduced DMP (DMP-cohorts)
- Control group: patients with free physician choice in standard/list insurance model
- Not included:
 - patients in Medbase without DMP
 - patients without free choice of doctor (in other HMO, GP-models)
 - patients with gestational diabetes

Figure 1: Treatment group (green) and control group (red) for the Claims-Data Analyses

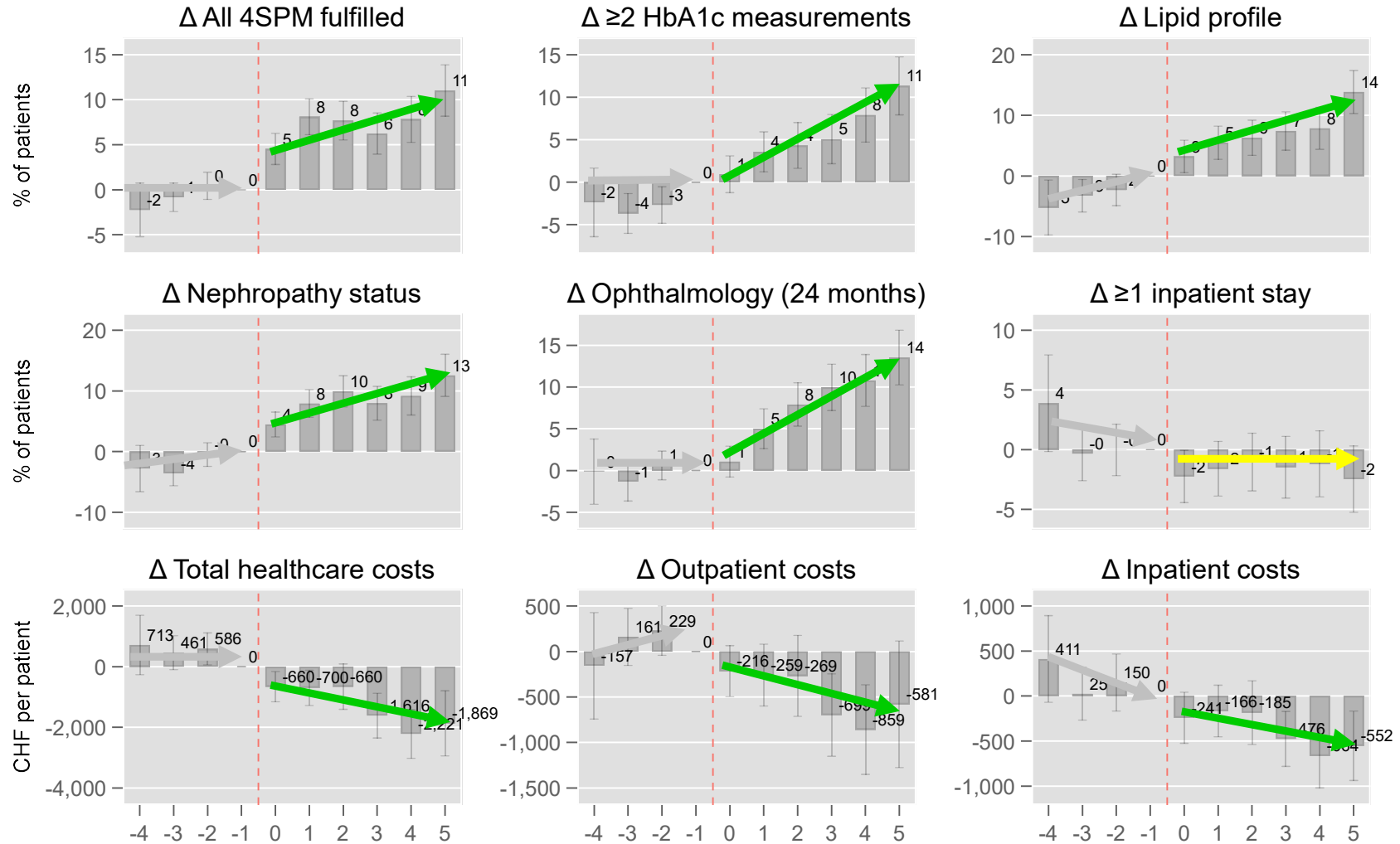
PCG: Pharmaceutical Cost Groups for diabetes-specific medication

Diabetes Projekt	Eintritt ins Projekt	Austritt	Diabetes Patienten 2017	Diabetes Patienten 2018	Diabetes Patienten 2019	Diabetes Patienten 2020	Diabetes Patienten 2021	Diabetes Patienten 2022	Diabetes Patienten 2023*	Diabetes Patienten 2024 (31.12.)	PIS	
St. Gallen Vadian	2018		231	172	250	277	293	383	230	415	Axenita	
Wil	2018		323	299	381	432	453	558	645	633	Axenita	
Winterthur Neuwiesen	2018		298	199	336	358	374	388	426	466	Axenita	
Eglisau	2018		73	81	106	109	134	165	144	171	Axenita	
ZH Oerlikon	2018		224	290	285	322	321	393	375	397	Axenita	
ZH Wiedikon	2018		131	178	155	170	181	201	192	194	Axenita	
Basel Elisabethen	2018		171	164	268	288	297	320	293	307	Axenita	
Kreuzlingen	2020					129	154	257	216	120	139	Axenita
Rorschach	2020					128	151	129	163	175	211	Axenita
Kloten	2020				143	211	233	246	235	240	Axenita	
Wattwil	2021					110	129	156	152	160	Axenita	
Frauenfeld	2021					159	196	192	175	172	Axenita	
Bern Zentrum	2021					141	153	180	98	146	Axenita	
Weinfelden	2022						413	369	381	370	Axenita	
Bischofszell	2022	2023					299	247			Axenita	
Schaffhausen	2022						111	133	227	232	Axenita	
Bern Bahnhof	2023							186	76	90	Axenita	
Kriens Mattenhof	2024								296	210	Axenita	
Baden	2024								108	209	Axenita	
Bern Westside	2024								114	124	Axenita	
Düdingen	2024								128	142	Axenita	
Teufen	2024								168	199	Axenita	
Thun Strättligen	2024								27	28	Axenita	
Uzwil	2024								81	155	Axenita	
Gampelen	2024								12	379	Axenita	
Zug	2024								50	67	Axenita	
St. Gallen Einstein	2025									56	Axenita	
Heerbrugg	2025									81	Axenita	
Winterthur Brunngasse	2025									22	Axenita	
Wetzikon	2025									91	Axenita	
											Axenita	
Anzahl PatientInnen			1451	1383	2181	2882	3973	4496	4928	6106		
Anzahl Standorte			7	7	10	13	16	17	25	29		



Relative improvement with DMP → sustainable & increasing

Effect of DMP on outcomes. DiD-estimates by year since DMP introduction (change to baseline relative to the control group). Point estimates with 95%-CI, 141,604 observations from 20,520 patients (2015-2023)





Effect of the DMP: Relative Δ to baseline in year 5

(“different development of the treatment relative to the control group”)

Positive effect on patient share with
guideline adherent treatment
(4SPM)

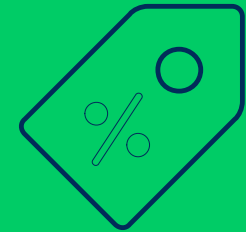
+11%-points



No effect on
hospitalisation rate

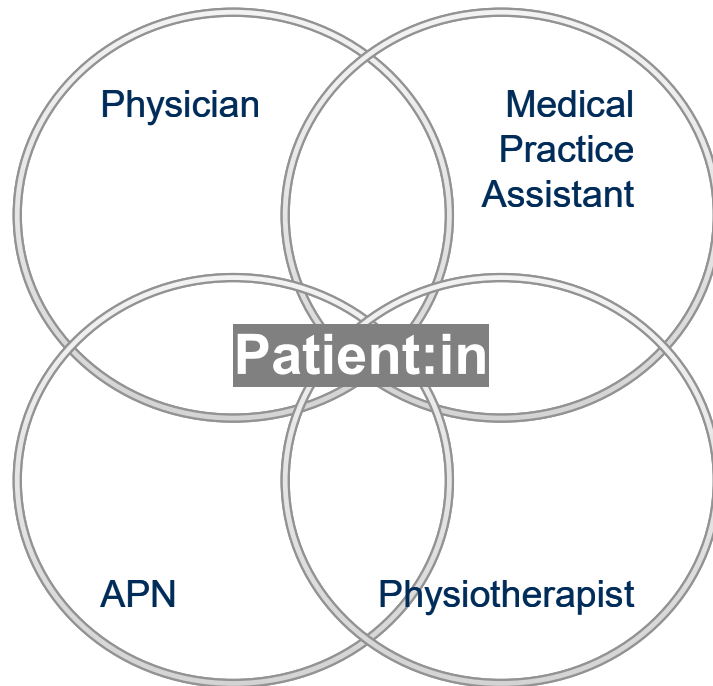


Reduced healthcare cost growth
-1,869 CHF (corresponding to 12%
of control group costs)

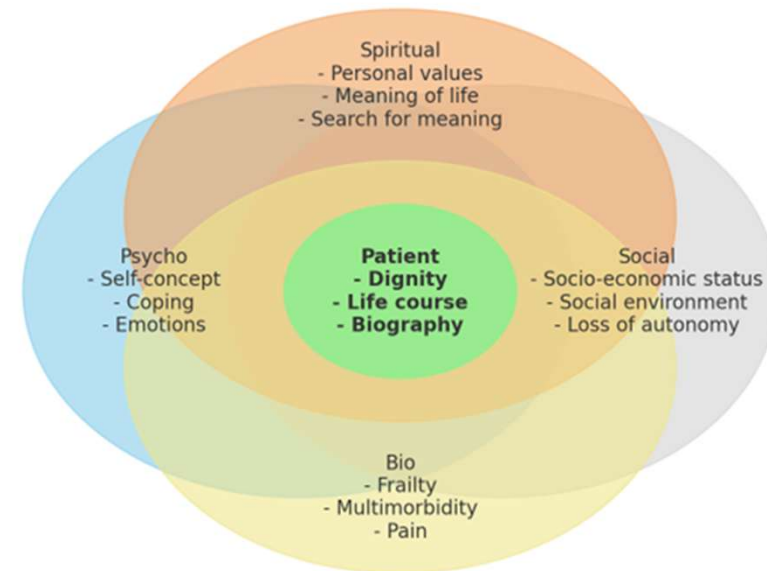




Cardiovascular diseases



Bio-psycho-social-spiritual Model





Data – Information - Knowledge

medbase

Health Care Professionals

➤ Data recording during consultations

➤ Understanding the information

➤ Developing knowledge in workshops and quality circles

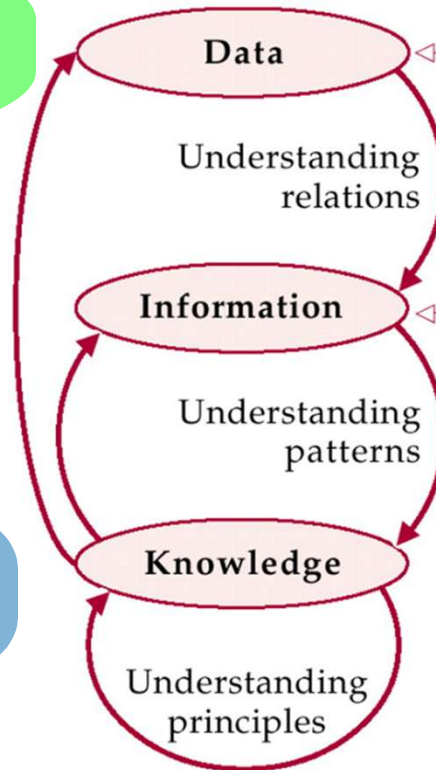
Medbase IT

Supporting technologies

← Data processing

← Data management
Data analysis

← Information management



SENSKY, T. 2002. Knowledge management. *Advances in Psychiatric Treatment*, 8, 387-395.



Evaluation

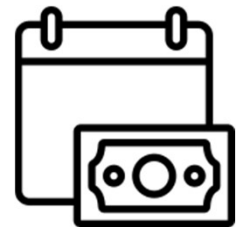
**Health insurance
claims data –
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**We follow clinical
performance
indicators**



**We plan a realist
evaluation of concepts
concerning people with
chronic diseases such
as diabetes**





Antibiotic resistance – the silent pandemic

Strategie Antibiotikaresistenzen



WHO-Bericht nennt Antibiotikaresistenz eine globale Bedrohung

Jährlich über 1,3 Millionen Menschen sollen laut der WHO durch antibiotikaresistente Keime sterben. Sie registrierte seit 2017 etwa 15 Prozent mehr solcher Infektionen.

Antimicrobial resistance is one of the **top-10 global public health threats** facing humanity.

Antibiotikaresistenzen nehmen weltweit zu, doch die Schweiz ist vorbildlich



**Résistance aux antibiotiques : comment
lutter contre la « pandémie silencieuse »**

u^b

b
UNIVERSITÄT
BERN



Schweizerische Eidgenossenschaft
Confédération suisse
Confederazione Svizzera
Confederaziun svizra

Eidgenössisches Departement des Innern EDI
Bundesamt für Gesundheit BAG

med**base**



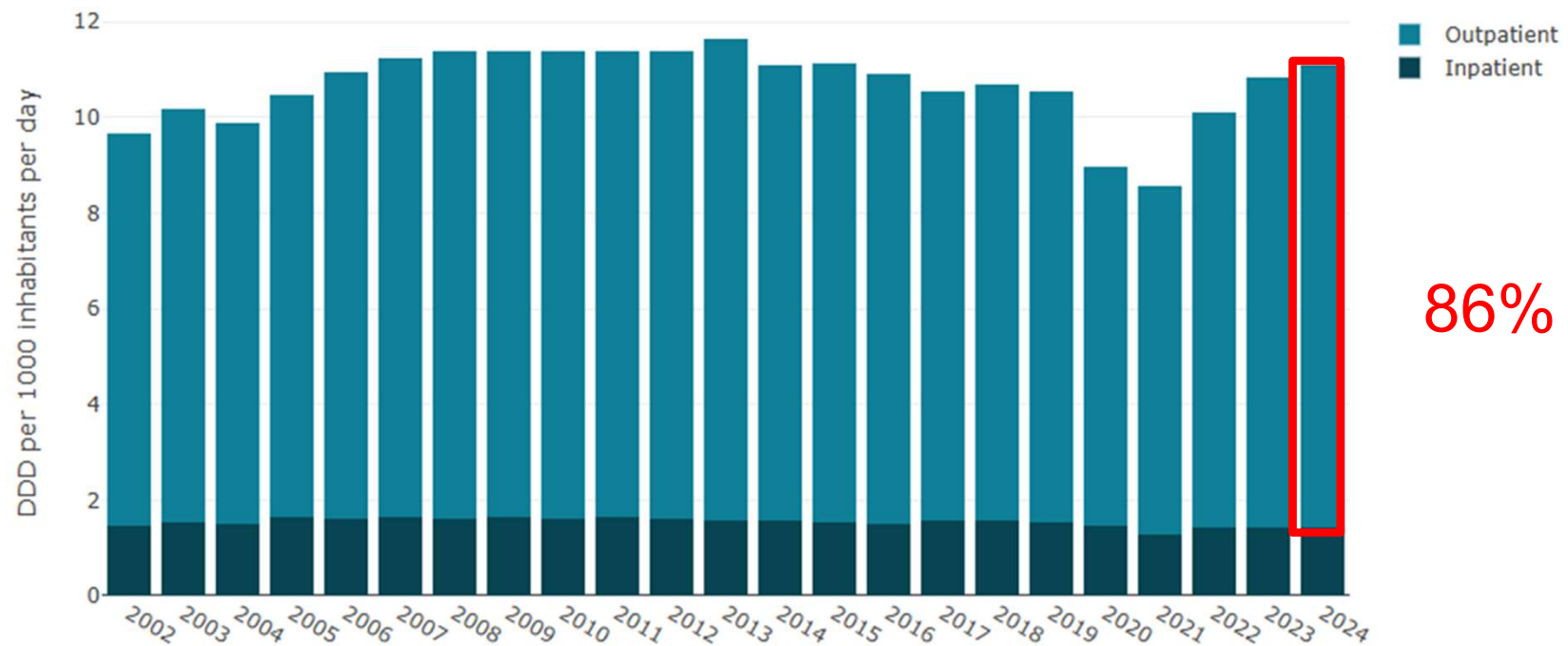
Shared decision-making in guideline-based treatment of self-limiting infectious diseases in Swiss general practices: *a new approach to reducing excessive antibiotic prescribing*

Adrian Rohrbasser^{1,3}, Deborah Holzer¹, Tamara Scharf¹, Lena Zwicker¹, Philipp Aebi¹, Beatrice Metry¹,
Kali Tal¹, Reto Auer^{1,2}

¹Institute of primary health care (BIHAM), University of Bern, Switzerland, ²Center for Primary Care and Public Health (Unisanté), Lausanne, ³Medbase, Wil

Shared decision-making in guideline-based treatment of self-limiting infectious diseases in Swiss general practices: 2024

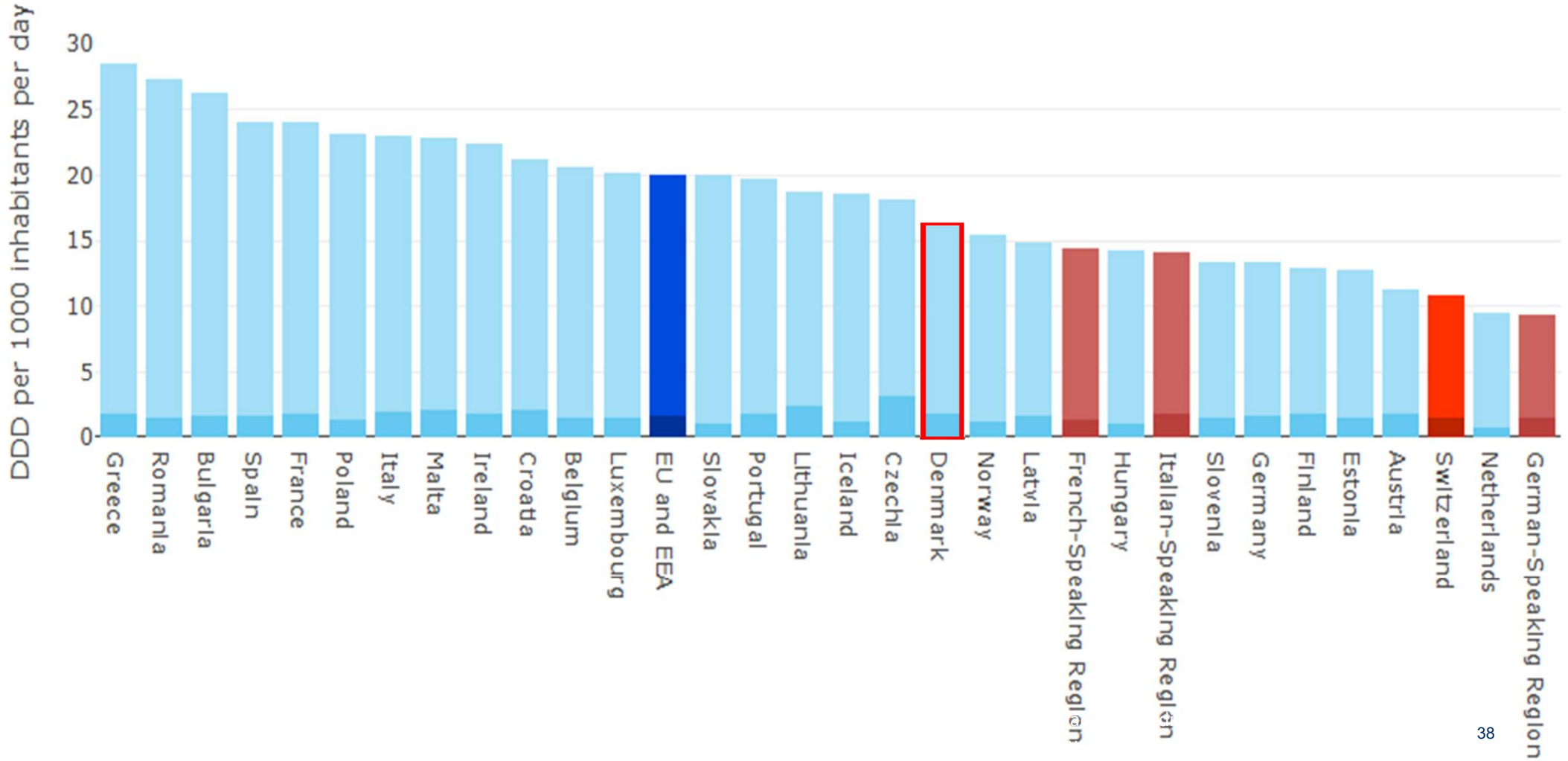
an approach to reducing excessive antibiotic prescribing



Datasource: IQVIA™ Sales Data (Sell-In) from pharmaceutical industries to public pharmacies, self-dispensing physicians and hospitals.



Switzerland uses few antibiotics in primary care 2023



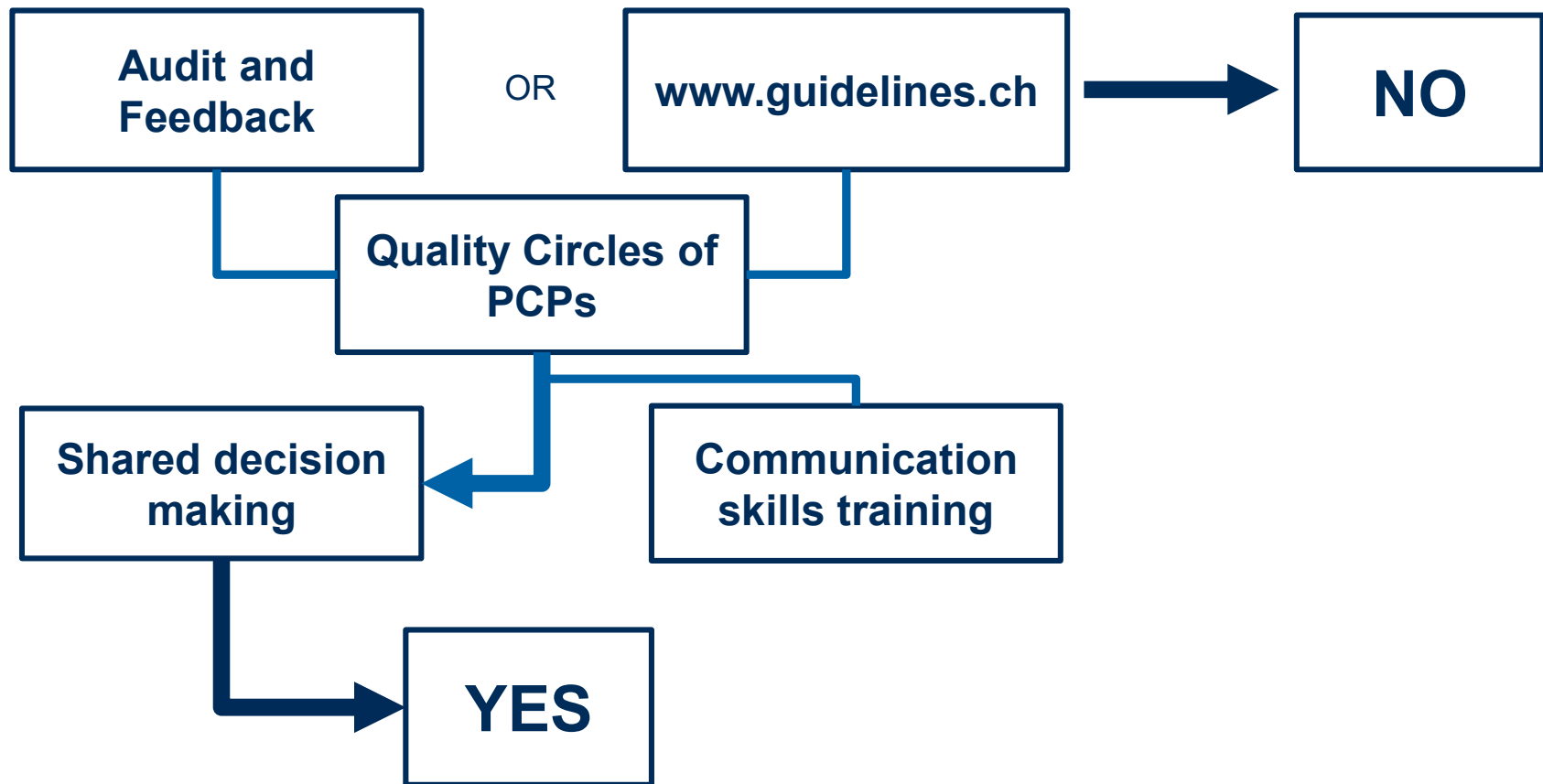
Overuse of antibiotics and antibiotic resistance

- If primary care physicians (PCPs) prescribe fewer antibiotics, this should **lower the rate of antibiotic resistance**
- Five self-limiting infections account for 80% of antibiotic prescription in ambulatory care:
 - **acute otitis media**
 - **tonsillopharyngitis**
 - **uncomplicated urinary tract infection**
 - **infectious cough (bronchitis)**
 - **sinusitis**

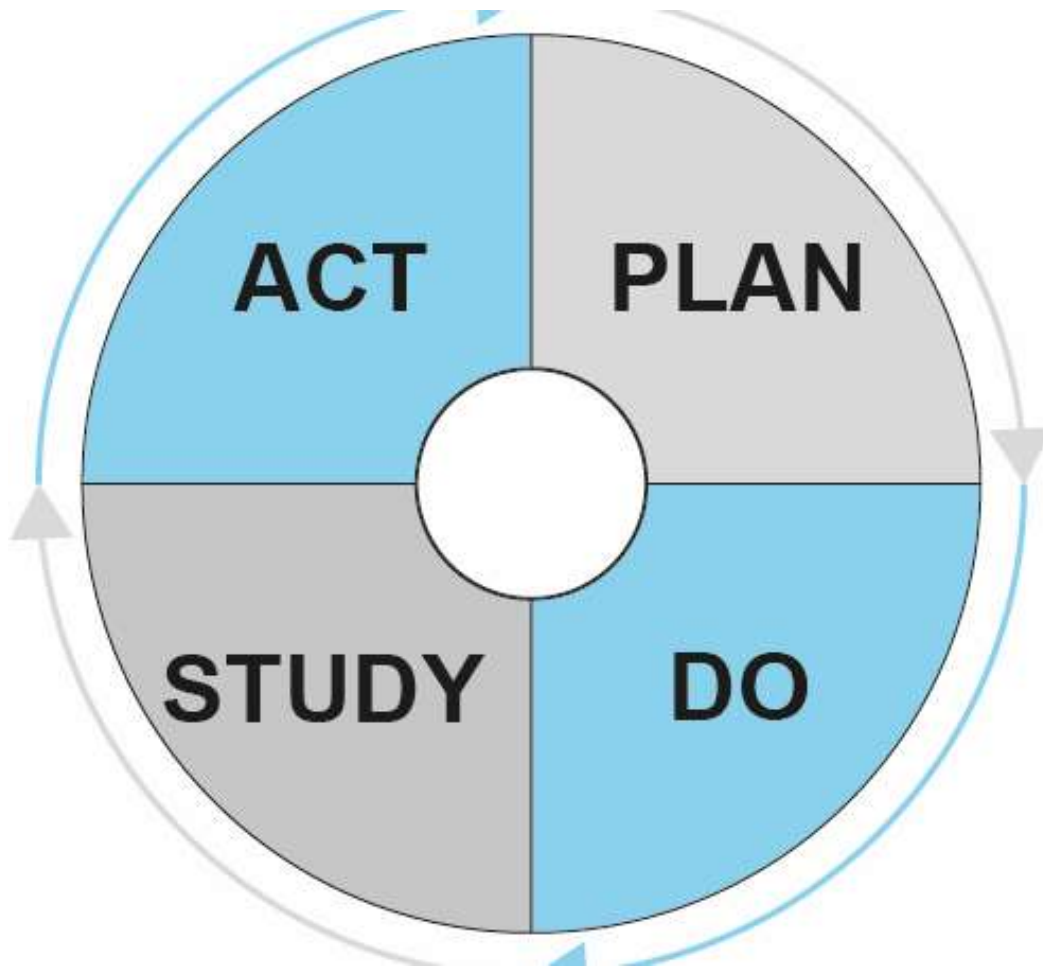
Hamm, R.M., R.J. Hicks and D.A. Bembem, 1996; Coxeter, P., et al., 2015; Glinz, D., et al., 2017, Glinz, D., 2018; Glinz, D., et al., 2021. Anresis 2023/ BAG Sentinella Meldesystem



Change of prescription patterns



Development the tools



Develop and test evidence-based summary information (EBSI) for PCP and SDM instruments over four Plan-Do-Study-Act (PDSA) cycles:

- 1) Literature review
- 2) Feedback from PCPs in three focus groups
- 3) Feedback experts and patients
- 4) Feedback form PCPs in focus groups
- 5) Testing the documents in consultations

Quality circles served as focus groups

Tools



PCPs: information on treating self-limiting infections with and without antibiotics



Patients need visual support during consultation

Process in Quality Circles: PCPs, Pharmacists, APNs

Using clinical cases to discuss:

- natural course
- complications
- antibiotic treatment
 - impact on symptoms and natural course
 - Impact on complication rate
- symptomatic treatment
- Training communication skills



(Rohrbasser et al., 2022)

Intervention



Online tool to learn about clinical assessment, treatment effectiveness, complication rate and clinical signs that suggest a patient in a potentially dangerous situation needs prompt investigation and treatment (red flags).



Quality circle sessions (on the topic of self-limiting infectious diseases and shared decision making).



Use of tools in consultations (information for HCP and consultation aid)

Evaluation

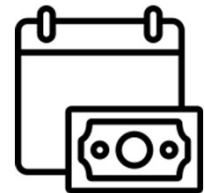
**Health insurance
claims data –
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**We follow
prescription patterns**



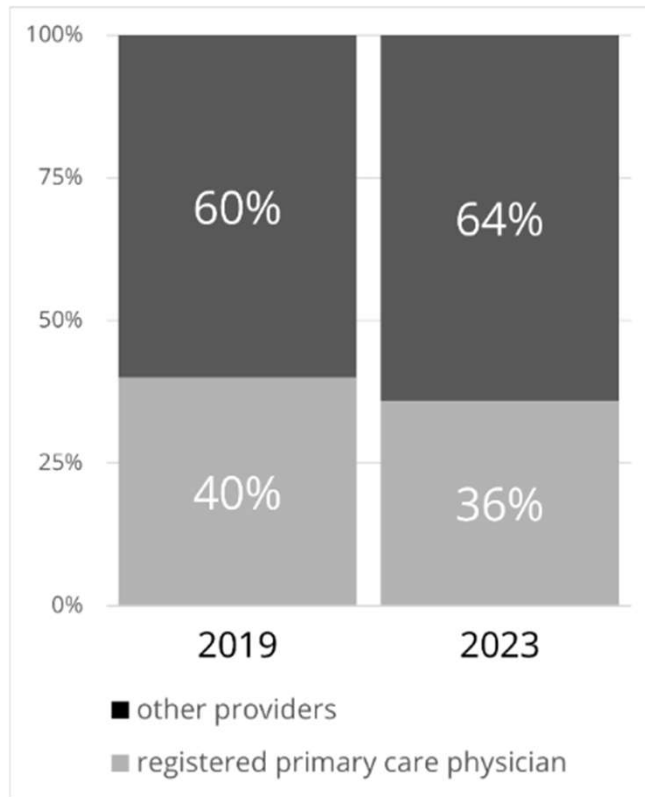
We plan a realist
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chronic diseases such
as diabetes



Intervention: 18 medical centers 132 000 patients - *prescriptions of antibiotics in outpatient setting*

medbASE

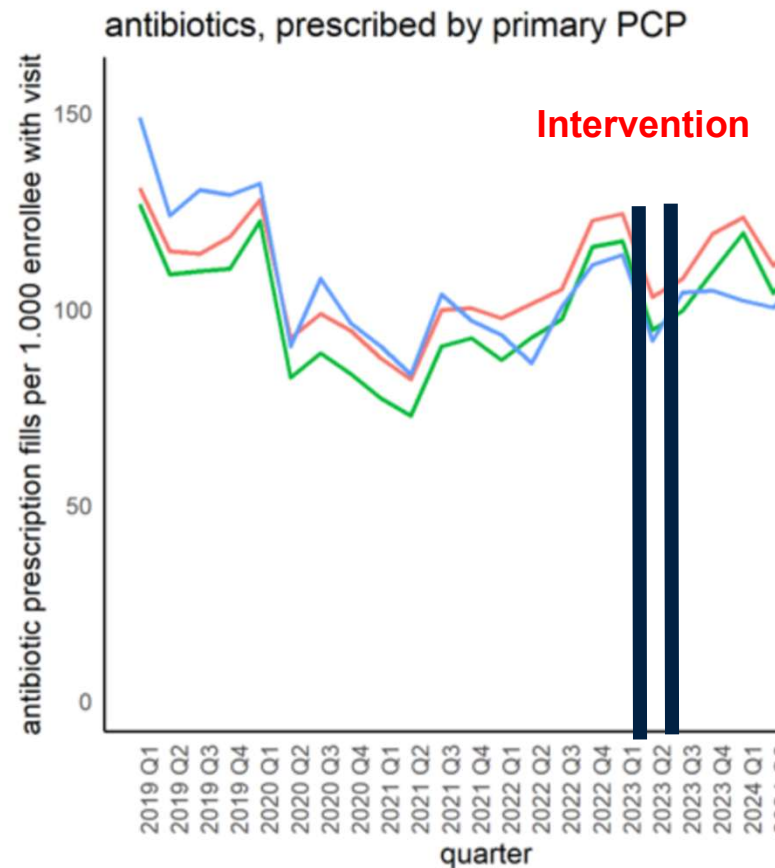
Baseline Analysis



Intervention in 18 medical centers 132 000 patients – DiD analysis medBASE

Probability of a patient receiving at least one antibiotic prescription in a quarter:

- Without intervention 1.54%
- With intervention 1.35%
- **This corresponds to an absolute decrease of 3.8 prescriptions per 1,000 insured individuals annually.**
- Reduced Likelihood of Antibiotic Prescribing Among Participating GPs (OR = 0.86)



Sore throat

For children over 1 year old and adults

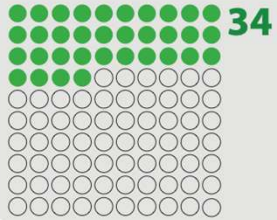
What causes a sore throat?

It can be caused by a viral, or rarely, by a bacterial infection in school children 15-30% and in adults 5-15% group A streptococci.

How long does a sore throat last?

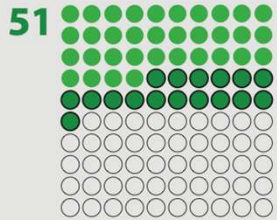
Improvement of sore throat in 2-3 days, regardless of whether the infection is bacterial or viral.

100 affected persons who don't take antibiotics

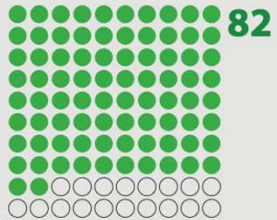


With antibiotics, 17 more people will be pain free after 3 days

100 affected persons who do take antibiotics

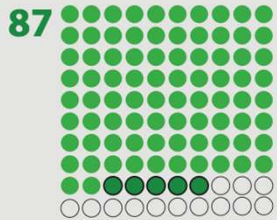


100 affected persons who don't take antibiotics

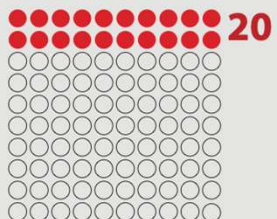


With antibiotics, 5 more people will be pain free after 7 days

100 affected persons who do take antibiotics



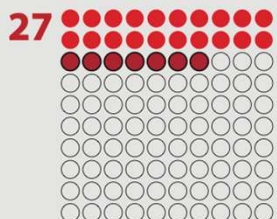
100 affected persons who don't take antibiotics



Side effects from antibiotics

With antibiotics, 7 more people will have symptoms like vomiting, diarrhoea and/or skin rash.

100 affected persons who do take antibiotics



Tools

- Languages:
- German, English, French, Italian





Thank you

*med*base

