Quality circles to identify barriers, facilitating factors, and solutions for high-quality primary care for asylum seekers

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Background

In 2015 Germany received more than 476,600 asylum applications.1 Incoming asylum seekers are accommodated in reception centres (RCs) for up to 6 months before they are dispersed to other federal states or districts. Due to the high immigration since the end of 2014, many federal states established new RCs to expand their capacities in hosting asylum seekers. Baden-Württemberg, for example, one of the largest federal states receiving about 13% of incoming asylum seekers, expanded its capacity from one RC up until 2014 to five RCs thereafter. Since there are no nationwide standards in place, healthcare provision in RCs is highly heterogeneous and fragmented.2 In Heidelberg, former barracks of the US army were reorganised as an RC in August 2015 and hosted about 6500 asylum seekers. The concentration of asylum seekers in the RC, linked with insufficient provision of primary health care, led to an unmanageable number of consultations in emergency departments of nearby hospitals. Asylum seekers have specific healthcare needs due to exposure to pre-, peri-, and postmigration health risks. These include traumatic events,3 endemic infectious diseases in the countries of origin or transit,4 and chronic conditions which may have been exacerbated during the migration process. They are also at higher risk of developing psychological distress5 and acquiring infectious diseases in the host country due to mass accommodation.6

To address both the shortcomings in primary care provision and the special needs, a walk-in clinic jointly led by the university hospital, the public health services, and the local physicians’ association was established in the RC with funds from the state government and the university hospital. The clinic provides general medicine as well as gynecological, paediatric, and psychiatric and psychosomatic health care.

The aim of this article is to report challenges and solutions of establishing high-quality primary health care for asylum seekers and meeting their specific needs in the particular setting of a large RC.

Although other countries may not have similar RCs, the situation may change as the contemporary migration flows are very dynamic. Thus, this report may be useful for GPs to gain an insight into possible ways of managing these highly vulnerable people whose complex health needs often present a challenge in conventional healthcare settings.
Analysis of current care

After a negotiation and planning period of 8 months, medical services were initiated in February 2016. In July 2016 a group discussion among 24 healthcare professionals working in the clinic was organised to conduct a situation analysis and to identify barriers and solutions for the provision of high-quality care. Emerging issues could be assigned to 10 major themes (Box 1). The cooperation of different professions in the clinic was seen as advantage but due to a high turnover of staff assuring continuity of care was challenging. In this context, the need for improved documentation of medical data was raised. Medical treatment was perceived more difficult than usual due to high numbers of patients with special needs (for example, drug-addicted patients or patients with infectious diseases such as tuberculosis or hepatitis) and lack of country-specific diagnostic algorithms. A lack of resources, especially of assistants, interpreters, and medical supplies, affected the provision of care. Yet the general infrastructure of the clinic including the in-door-pharmacy was considered an advantage. Legal aspects were also mentioned as aggravating factors: The German Asylum Seekers Benefits Act limits the provision of care to acute and painful conditions, maternity care services, preventive medical checkups, vaccinations, and so called ‘indispensable services’. This vague definition created uncertainties among providers about the scope of care provided in the clinic: acute and emergency care or continuous primary and specialised care. Thus, the scope of care provided was highly dependent on the personal attitude of the individual physician. However, the strong commitment of all staff who perceived their tasks as being meaningful was considered a facilitating factor.

Solutions to address barriers and facilitating factors

The findings of the situation analysis led to the joint agreement to introduce a quality circle (QC). QC can be defined as autonomous peer groups of healthcare professionals who meet on a regular basis and aim at assessment and improvement of quality of care in their own practices. They are characterised by a result-oriented approach identifying quality problems and strategies to address these problems. QC have become a globally recognised instrument for quality improvement in Europe and are partly even obligatory for GPs in South Germany.

Two measures were undertaken to support the implementation of a regular and effective QC for clinic staff: the participants themselves decided on the frequency, the course and content of the meetings (bottom-up approach). The QC was accredited and the participants received credits for their continuous medical education.

Four QC meetings were held so far in intervals of 6–8 weeks. Each took approximately 2 hours and was marked by vivid discussions. With, on average, 24 participants from different professions and disciplines participation was continuously high. Although we did not conduct a systematic evaluation of the QC, we monitored the target achievements as this is part of the QC concept. Several solutions have been elaborated and implemented so far (Box 1). Measures on an organisational level such as creating checklists for the equipment and standardising procedures were implemented successfully. Difficulties were faced when barriers on a legal, political, or national level had to be addressed; for example, to create guidelines for frequent reasons for counselling in accordance with national guidelines and the entitlements covered by the Asylum Seekers’ Benefits Act.

Discussion

When establishing healthcare services for asylum seekers many quality issues — partly similar, partly distinct from usual care — arise. Our experiences show that QC, which have proved a suitable instrument for quality improvement in German primary care over years, are also helpful to foster quality improvements in special settings such as RCs for asylum seekers. However, structural barriers such as legal restrictions, financial limitations, or a lack of national clinical guidelines for the specific setting of RCs limit the full potential of QC to improve care. Beside local initiatives national endeavours are necessary to assure high standards of health care for asylum seekers and to avoid harm, as the medical code of ethics demands. Health care for asylum seekers in Germany is currently characterised by an overwhelming heterogeneity due to decentralised organisation and responsibilities. We argue that measures to assure high quality standards should be enforced in healthcare services for asylum seekers just as in regular care. QCs may be an effective instrument for
quality improvement beyond conventional audit approaches. We recommend to establish QCs in respective institutions.

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References