Measuring patient experiences in the Netherlands

Diana Delnoij
OECD, Paris
17 November 2011
Overview of the presentation

- Dutch system for measuring patient experiences
- Principles of patient experience measurement
- Use of patient experience data
- OECD questions
Dutch system (1)

Consumer Quality Index (CQI or CQ-index)
Trademark owned by Centre for Consumer Experience in Healthcare (CKZ)

Measures:
• What patients find important aspects of healthcare quality?
• What their experiences are with these aspects?
• How they rate the overall healthcare quality

Data collection:
• Mail surveys
• Online surveys
• Face-to-face interviews
Dutch system (2)

31 CQI instruments covering:
• Preventive care
• Acute curative care
• Chronic care
• Longterm care / care for the elderly
• Social care
• Palliative care

Scope of CQI instruments:
• Disease: e.g. diabetes, asthma, heart failure, cancer
• Treatment: e.g. cataract surgery, THA/TKA, varicose veins
• Provider: e.g. GP, physiotherapist, hospital, nursing home
Principle 1: Patient measurement should be patient-based

- Instruments developed according to a CQI Manual
- Manual prescribes that items are based on:
  - Existing questionnaires
  - Study of the literature
  - **Focusgroup discussions with patients** from target group
  - Discussion with stakeholders:
    - providers
    - health insurers
    - **patient organisations**
- The importance of items is measured in so-called “importance questionnaires”
Principle 2: The goals of patient measurement should be clear

- CQI serves multiple purposes:
  - Consumer choice
  - Selective contracting by insurers
  - Quality improvement
  - Inspection & regulation by Inspectorate for Healthcare
  - Policy monitoring
- Single data collection, multiple information products
- Goal-specific suitability of CQI instruments is assessed by Scientific Advisory Board of Centre for Consumer Experience in Healthcare
Principle 3: Tools should undergo cognitive and psychometric testing

CQI Manual prescribes:

- Cognitive testing
  - Currently working on more elaborate instructions
- Psychometric testing, e.g.:
  - Skewness
  - Item non-response
  - Factor analysis
  - Reliability analysis
Principle 4: Measurement and analysis should be standardised

CQI Manual prescribes

- Phrasing of questions and response categories
- Obligatory questions
- General principles of sampling (including privacy regulation), data collection, analysis and reporting
- Detailed instructions per CQI instrument about:
  - Sampling and sample sizes
  - Data collection
  - Analysis:
    - Construction of scales
    - Case mix adjustment
Principle 5: Reporting method should be chosen with care

- CQI Manual prescribes\(^1\) presentation of data for consumer information:
  - Star ratings reflecting relative performance (* below average, ** average, *** above average)
  - Barcharts reflecting frequencies of positive and negative experiences

- CQI Manual suggests methods of presenting data for:
  - Selective contracting by insurers
  - Internal quality management

\(^1\) These prescriptions are evidence-based; but research takes place continuously, so revision of the instructions in the manual is an ongoing process
Principle 6: International comparability should be enhanced

• Several CQI questions ‘imported’ from CAHPS, e.g.:
  • How often did your doctor / nurse / physiotherapist spend enough time with you?
  • How would you rate your XXX on a scale from 0 to 10 where 0 represents the worst possible XXX and 10 represents the best possible?

• Presentation formats derived from:
  • CAHPS (consumer information)
  • Picker Institute (feedback for providers)

• International learning is promoted through:
  • Scientific publications and PhD-theses about CQI;
  • Presentations & workshops on international conferences;
  • Study tours from NL to UK and USA; from UK, USA and Finland to NL.
Principle 7: National systems should be sustainable

- Annual budget Centre for Consumer Experience in Healthcare:
  - 2011: € 735.000
  - 2012: € 588.000 (-20%)
  - 2013: € 441.000 (-40%)

- Willingness of insurers and providers to pay for data collection is diminishing

- Support for national measurement among providers is feeble
Use of CQI data

Data are used in/on/for:
• Consumer information on website
• Advocacy by patient/consumer groups
• Strategic contracting by health insurers
• Priority setting by Inspectorate for Healthcare
• Public accountability of providers
• Monitoring of quality of care on national level

And –not often enough- for:
• Quality improvement by professionals and managers
OECD questions in CQI

- 2011: three questions about financial access in CQI survey Care and Health Insurance
- Sample: enrollees of health insurers (≈general population)
- Broad coverage of insurers
- Yearly survey since 2005
- Suitable vehicle for OECD questions

BUT
- Future of survey is uncertain due to budget cuts
OECD Questions in CWF International Health Policy Survey 2010 and in CQI 2011

<table>
<thead>
<tr>
<th>Percent “yes” to:</th>
<th>NL in CWF</th>
<th>NL in CQI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did not fill prescription or skipped doses</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>Had a medical problem but did not visit doctor</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Skipped test, treatment, or follow-up</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>“Yes” to at least one of the above</td>
<td>6</td>
<td>11</td>
</tr>
</tbody>
</table>

Explanation of difference?
• Mode effect (telephone versus mixed mode)?
• Different samples?
• Decrease in financial access 2010-2011?