Quality of care assurance in long-term care in the Netherlands

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Summary: This article summarises the status and history of quality of care assurance in long-term care in the Netherlands. To achieve this end, an inventory of stakeholders, documents, websites, databases, analysis methods and the scope of quality of care assurance in the Netherlands were analysed. The quality of care assurance system in 2010 is reported on from the perspective of an individual involved in its development and implementation and links are made with quality assurance systems in other European and North American countries. Overall, the Netherlands has developed an elaborate, well structured quality of care assurance system; however, the collection of data and its content can be improved on.

Key words: quality of care assurance, long-term care, quality of care indicators, Consumer Quality Index, Netherlands

Quality indicator collection, analysis and publication

From 2001 to 2003, the Organisation of Care Entrepreneurs in the Netherlands (ACTIZ, formerly ARCARIES), initiated a Benchmark for Nursing Homes, Residential Homes and Home Care (Benchmark VV&T). The benchmark served as a research tool to compare similar health care facilities with each other and provide health care facility management staff with data on quality and efficiency of care. It was financially supported by the Ministry of Health. About 400 facilities participated in this benchmark during the initial three-year period. All participants received reports about their own facilities and a summary report on the whole benchmark. The results were only available for ACTIZ members.

The benchmark consisted of five modules which assessed: (i) efficiency; (ii) consumer satisfaction; (iii) staff satisfaction; (iv) quality of care indicators; and (v) facility management. In 2004, ACTIZ adopted the Benchmark VV&T as a permanent research tool exclusively for its member facilities. The Ministry of Health, however, decided that public, not proprietary, information on quality of care and consumer satisfaction was required and therefore started a new initiative.

The Quality Framework Responsible Care programme

To gain access to information on quality of care in health care facilities the Dutch parliament voted for implementation of a Quality Framework Responsible Care programme. This fell under the responsibility of the Ministry of Health, Welfare and Sports and started in 2005. The programme’s report marked the beginning of the mandatory collection of data on quality of care and consumer experiences in all health care facilities in the Netherlands. It is available on a dedicated website, with the final report available in English.

Since 2005, the Quality Framework Responsible Care programme has contracted major research organisations to develop tools and databases for different sectors of health care that are covered by the Health Insurance Act for Special Medical Costs (AWBZ). These organisations: NIVEL – Netherlands Institute for Health Research, Plexus, the Institute of Health Policy and Management (IBMG) at Erasmus University, RIVM – the National Institute for Public Health and the Environment, and Kiwa Prismant – publish information on their websites regarding their involvement in specific activities.

Furthermore, the Quality Framework Responsible Care programme set up a new independent institute, the Dutch Centre for Consumer Experience in Health Care (Centrum Klantvervaring Zorg, CKZ). CKZ’s aim is to ensure that the collection and publication of consumer experiences with health care is systematic and scientifically reliable. In its short existence its impact on the measurement of consumer quality in the Netherlands has been considerable. It makes research on consumer quality operational and supports fundamental research. An example of the latter is a recent thesis ‘Public reporting about health care users’ experiences: the Consumer Quality Index’. The thesis answers three research questions: (i) which case-mix adjustment strategy should be applied to ensure fair comparisons between health care plans or providers?; (ii) how are different types of comparative health care information presented on the Internet?; and (iii) which presentation formats of comparative health care information support health care users?

To disseminate the results of the mandatory quality indicator (QI) collection, the Ministry of Health established...
a website (www.kiesbeter.nl), where the results of annual assessments on QIs in every health care facility in the Netherlands are published. To apply this information in care practice, the Ministry of Health has set up yet another website (www.zorgvoorbeheer.nl) in cooperation with umbrella organisations in health care. Its main aim is to stimulate improvements in care.

**Quality indicators: the InterRAI approach versus the Dutch approach**

QIs for monitoring quality of care in nursing homes have been developed using assessment data from the widely implemented Resident Assessment Instrument (RAI) for nursing homes. Routine monitoring of these QIs led to QI reports being used for best practice comparisons between nursing homes. A study commissioned by the US Centers for Medicare and Medicaid Services (CMS) demonstrated that the items from routine use of the RAI in US nursing homes are reliable and that they can be used for the stimulation of improvement of care and reporting to the general public. For most of the QIs some indicator specific risk adjustment is necessary to allow useful comparison of QIs between facilities. Although the relationship between outcomes and good and bad care practices are not equally strong for all available QIs, ten QIs have a good relationship between identifiable proactive and responsive care practices. Those are the QIs that have been selected by CMS for periodically public reporting on a facility level.

InterRAI, an international group of researchers that includes the original developers of the RAI for nursing homes, developed a Home Care instrument, with the same design and structure as the RAI, for assessment and care planning for people living in their own homes. InterRAI also developed QIs for the evaluation of the quality of formal care services provided to individuals in their own homes.

A four step approach was used in the development and validation of QIs for nursing homes and for home care.

1. **Selecting indicators of quality of care.** Using large datasets gathered from routine practice, focus groups discuss which assessment items or combination of items may indicate dimensions of quality of care (face validity). QIs are then defined together with the method for calculating numerator and denominator values (construct validity). To be meaningful the indicators must show enough variance between facilities/agencies, have high enough prevalence and show sensitivity to change when care practices change.

2. **Correlating indicators with quality of care.** Experts must agree that high (or low) scores on the indicators in a facility or agency correspond to good (or bad) quality of care. This is formalised by research that identifies care practices that correlate well with indicator scores pro-actively (i.e., prevent problems) or responsively (i.e., remedy problems).

3. **Identifying person level risk factors.** Factors that legitimately increase or reduce the likelihood of an individual scoring on the indicators are identified by regression analysis of client characteristics. Once these risk factors are established over a large enough database, for example, from a large number of care providers across countries, they are incorporated into the calculation of the QIs.

4. **Identifying service level bias.** Service level bias (ascertainment bias) manifests itself in two related forms: service/facility admission practice, as well as staff competence in observation and recording. Home care services or nursing homes that admit a relatively large number of clients with specific indicator problems often continue to score high on these indicators at follow-up, despite risk adjustment. When experts examine the practice of these services/facilities, the quality of care in these indicators areas is not necessarily poor. To resolve this matter a Facility Admission Profile (FAP) covariate was developed for nursing homes and the Agency Intake Profile (AIP) for Home Care.

In the Netherlands, the Quality Framework Responsible Care programme followed, to some extent, a similar approach. It focused more on the organisation and the required conditions to assure the continued existence of a quality of care indicator system. It compared different approaches in nine countries: Australia, Canada, Denmark, France, Germany, Sweden, Switzerland, the UK and the US. It compared the implementation in these countries of six process steps and drew conclusions about what would be best for the Netherlands, see Figure 1 above.

An ‘indicator team’ was put in charge of the choice of QIs to be adopted for nursing homes, residential homes and home care. The team consisted of representatives of the following stakeholders:

- ACTIZ: Organisation of Care Entrepreneurs
- V&VN: Nurses and Caregivers Association in the Netherlands
- LOC: National Organisation of Clients’ Councils
- NVVA: Professional Association of Nursing Home Physicians
- STING: National Professional Care Association
- IGZ: Health Inspectorate
- VWS: Ministry of Health, Welfare and Sports
- ZN: Dutch Care Insurers Organisation

The indicator team was assisted by experts and used the RAND modified Delphi method to reach consensus. It produced ten ‘themes for responsible care’, see Table.

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**Figure 1**

Maintain the indicator set (periodic assessment of earlier decisions and adding/removing indicators)

Select the subjects (medical conditions/procedures) for which indicators (sets) need to be developed

Publish the results of the indicators to providers, patients, government and others

Objectively assess the quality aspects of the selected subjects by developing a set of indicators

Collect data, check the quality of the data and calculate the indicator

Register data needed to calculate the indicators

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For each theme, one or a number of indicators of three types were distinguished:

1. Client-bound indicators that are measured by consulting clients (CQI-index), performed by an independent agency;
2. Indicators assessing the content of care at an organisational level, collected by the organisation itself; and
3. Indicators measuring the content of care at the clients’ level, assessed by the organisation itself.

For each care theme at least one indicator type was assessed. Only the third type of indicator is comparable to the InterRAI QIs described earlier. Most of the indicators that measure the personal content of care are explicitly borrowed from the QI sets of the InterRAI Long Term Care and Home Care instruments (for example, falls, depression, behaviour symptoms, weight loss, time spent lying down, psychotropic use).

Because the Dutch government chose not to make the use of InterRAI instruments mandatory, many items have been simplified, for instance with fewer response categories. While RAI data are continuously collected for care planning purposes, data to measure content of care in the Netherlands according to the ‘Dutch approach’ are collected once a year in a ‘measurement week’. These concessions in the Dutch approach decrease the quality and reliability of collected data. When the benchmarking method to assess quality of care started, items from RAI were used in the ACTIZ Benchmark to risk adjust individual indicators. Later on, these items were substituted by items from the Care Dependency Scale for a one-suits-all ‘case-mix adjustment’.

Conclusions
In a relatively short time the Ministry of Health, Welfare and Sports in the Netherlands has developed an elaborate, highly structured quality of care assurance system for most health care services, beginning with long-term care and home care. It has defined what is to be collected (customer experience data, content of facility care delivery and persons’ care characteristics), mandated its use and developed structures, supported by websites, to ensure that data are collected, properly uploaded to databases, carefully analysed and published for the general public and others to make use of. Together with umbrella organisations, it has set out to stimulate the improvement of care based on the results of the quality of care measurement.

The collection of data and the content of information on the quality of personal care in the Netherlands are still not ideal when compared with how this is done using the interRAI instruments, for example in Canada and the US and in other parts of Europe (for example, Finland). The process to develop the content of care QIs has been achieved through the building of consensus rather than being scientifically based.

Secondly, data collection is not part of the routine collection of data for management information and quality improvement projects, but instead singled out within a ‘measurement week’. It may be easier to organise data collection this way, but it carries the danger of upcoding, i.e., scoring to obtain false but better results.

Thirdly, instead of having QI specific risk adjustment, the choice has been made for a general case-mix risk adjustment which is, at least for some of the QIs, inappropriate.

REFERENCES
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