National Health Care Institute

# Working method for the Zinnige Zorg (appropriate care) Programme

23 AUGUST 2018

## Zorginstituut Nederland and Zinnige Zorg

*Zorginstituut Nederland*'s motto is "Taking care of good health care: no more and no less than necessary". Every citizen must be able to count on receiving good health care. No more and no less than is necessary, while also avoiding unnecessary costs.

As a public organisation, the *Zorginstituut* assesses health care systematically. We assess whether diagnostics and (therapeutic) interventions are being deployed in a patient-oriented, effective and cost-effective manner.

We discuss our findings with care professionals, patients, care institutions, health insurers and colleague governmental agencies. Together with them, we examine what is needed to improve patients' care and avoid unnecessary costs.

The parties in health care are responsible for improving that care. *Zorginstituut Nederland* provides an overview of points for improvement, promotes cooperation and monitors the results.
This is how we contribute to good and affordable health care for everyone.

More information about the activities of *Zorginstituut Nederland* and Zinnige Zorg can be found on www.zorginstituutnederland.nl.

# Content

# 1 Points of Departure

The *Zorginstituut* designed a systematic working method for the Zinnige Zorg Programme in order to examine the degree to which care in the insured package is used. The key is to identify and combat ineffective and/or unnecessary care, thus improving the quality of care for patients, increasing health gains and avoiding unnecessary costs. We carry out a systematic assessment for a field of disorders as defined in the ICD-10 classification system. A systematic assessment is carried out based on a number of points of departure.

## 1.1 Central role for patients

When assessing care, we give patients and the care path they follow a central role. The underlying question is always how much do patients benefit from the care supplied? Do they receive care that is appropriate to their situation, or perhaps too little care (under-treatment) or too much care (over-treatment)?

## 1.2 Shared decision-making

Care must be in keeping with the personal circumstances of patients. Apart from the established indication, patient-related matters also play a role in the choice of treatment, such as patients' expectations, their professional situation, impact on social functioning, pain perception, motivation, etc. For some diagnoses it is clear which treatment options have to be deployed. Often, however, various treatment options exist, each with their pros and cons and the choice of a given treatment will depend more on the preferences of patients and their carers. Shared decision-making is a way of arriving at an optimum treatment pathway  together with a patient. Various instruments exist that can support shared decision-making of doctors and patients effectively, such as decision aids, option grids and patients' versions of guidelines; these can increase the quality of the decision-making process.

## 1.3 Stepped care

We assume that courses of treatment are started based on the stepped care principle. According to this principle, care is offered based on a step-by-step plan: the least burdensome effective treatment is used first, and only when this gives insufficient results are more complex or more invasive interventions offered. Stepped care is a general point of departure, not a mandatory requirement. The 'start moment' is not necessarily step 1, as steps may be skipped as necessary, according to the symptoms with which a patient presents.

## 1.4 Parties in health care are involved throughout the entire process

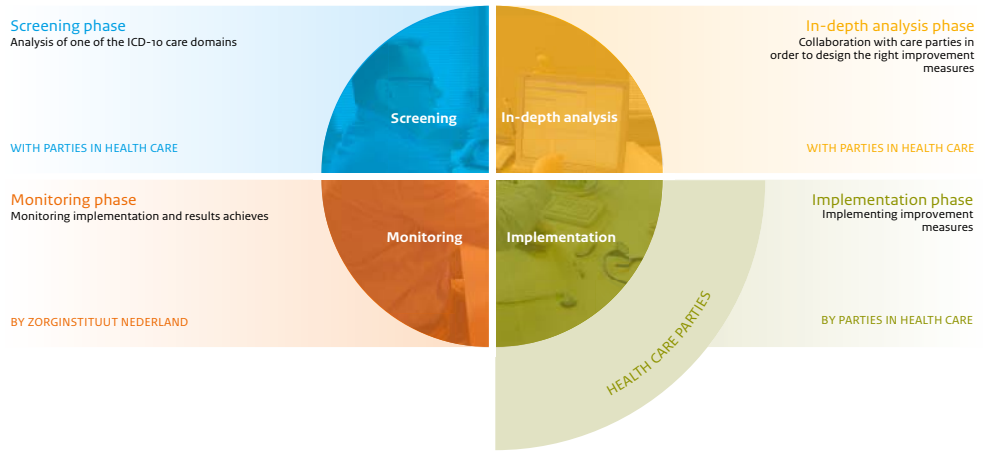
The objective of the *Zorginstituut* is to realise active agreement with the parties in health care. This will benefit the quality of the analyses and the basis of support for improvement measures. We involve the parties responsible in all phases of the systematic assessment.
The parties are invited to attend various consultations via umbrella arrangements. They are also given an opportunity to participate in supervising the research of external research bureaus. Lastly, we ask parties for comments on the draft versions of reports.

# 2 Phases of systematic assessment

In order to promote good care, we carry out a systematic assessment according to a quality circle, or improvement circle, as illustrated in the following figure. This circle is comprised of four sequential phases:

1. Screening phase
2. In-Depth Analysis phase
3. Implementation phase
4. Evaluation phase

Figure 1: Zinnige Zorg's circle of improvement




*Zinnige Zorg*'s circle of improvement starts with a screening phase, in which we analyse how care is currently being given ('photo'). Based on this, a number of topics are chosen for in-depth analysis. In the second phase, the in-depth phase, we determine the potential for improvement, per topic. In the third phase (implementation) it is mainly up to the parties in health care to implement the agreed improvement measures. Lastly, in the evaluation phase we examine the extent to which the goals set have been achieved and whether a new circle of improvement should start, possibly using different instruments for improvement. Where necessary, the *Zorginstituut* can make use of its statutory instruments (e.g., clarification, advising on inclusion in – or exclusion from – the package, powers of persistence within the framework of the Multi-Year Agenda[1]) if insufficient results are realised. Below we describe the four phases of the improvement circle in more detail.

## 2.1 Screening phase

The objective of the screening phase is to select a number of topics for in-depth analysis with a possible potential for improving the quality and effectiveness of care by using care more appropriately. These topics are recorded in a report that is sent, together with the underlying analysis, to the parties in health care and to the Minister of Health Welfare and Sport.

Figure 2 shows how we arrive at a good substantiation of the in-depth topics by consulting various sources in an systematic analysis. Sources include the quality standards (guidelines, care standards and care modules), scientific literature, claim data and other data, and the parties in health care. This involves

1 *The Multi-Year Agenda offers an overview of fields of care which have priority in the development of quality standards, measuring instruments and information standards (hereafter: quality products). If the Zorginstituut sees that the parties involved are in default, after the periods in the Multi-Year Agenda have lapsed, the Zorginstituut will take over the initiative or the coordination of developing a quality product. This is referred to as powers of persistence.*

collecting and analysing not only all the information in great detail, but also searching for signals from daily practice in order to obtain a succinct picture of the care provided in the current situation. We look at the care pathway that a patient follows from the perspective (the "spectacles") of the *Zorginstituut*, with the elements that the *Zorginstituut* defines as good and appropriate care (see explanation below).

Figure 2: From sources to in-depth topics in the screening phase


The choice of in-depth topics is based on the systematic analysis (based on the elements of good and appropriate care), the size of the topic (number of patients, burden of disease, budget impact), possible improvements and what the parties in health care feel is important.

## 2.2 In-Depth Analysis Phase

The screening phase is followed by the in-depth phase. The objective of this phase is to give as concrete as possible an indication of which potential improvements can be achieved.
Per topic, based once again on the elements of good and appropriate care, we carry out an in-depth study and we supply any missing knowledge in the form of extra data-analyses, scientific reviews, studies of daily practice and/or literature studies.

The final results are recorded in a so-called Improvement Report. This states which improvements in care and in health the *Zorginstituut* feels are possible, in respect of both content and amount, and provides an estimate of the total sum of costs involved (budget impact). We try to make agreements with the parties on improvement measures as concrete as possible. The Improvement Report is also sent to the parties in health care and to the Minister of VWS.

## 2.3 Implementation phase

The implementation phase is primarily a task for the parties in health care: patients, care professionals, institutions and health insurers. It takes place based on agreements made in the in-depth phase. In the implementation phase the *Zorginstituut* can play a supportive and facilitative role, for instance, by organising meetings, providing data and feedback, and by carrying out additional research. In order to guarantee compliance with agreements, both in respect of content and time, the *Zorginstituut* can place action points from the Improvement Report that relate to quality standards and measuring instruments on the Multi-Year Agenda.
Periodically, the *Zorginstituut* reports progress made to the accountable parties and to the Minister of VWS.

## 2.4 Evaluation phase

During the evaluation phase, the *Zorginstituut* examines, together with the parties involved, whether the results mentioned in the Improvement Report have been achieved. Based on this, we determine whether a new circle of improvement should start, possibly using different instruments for improvement. During this phase, we also examine whether all necessary information is structurally available.

# 3 Elements of good and appropriate care

We carry out an analysis of care both in the screening phase and in the in-depth phase. To do this, we use the "elements of good and appropriate care". Together, these give an idea of what the *Zorginstituut* regards as good and appropriate care. They are also in keeping with our quality and package management tasks. The analysis scheme used is as follows:

## 3.1 Knowledge about good care

A description of what we know about the availability of (inter)national quality standards (such as guidelines), measuring instruments (questionnaires and indicators) and information standards. We see whether these can be found in, e.g., the *Zorginstituut*'s Register. Their entry in the Register shows that they fulfil the procedural criteria of the Assessment Framework. We try to ensure that everything that can be found is included in Zorginzicht.nl.
Does patients' information exist, such as a patients' version of guidelines, or information about diagnosis and treatment on the website of a patients' association or on KiesBeter or thuisarts.nl?
Are there decision aids, option grids or outcome indicators which are relevant to patients, such as measures of quality of life, PROMs and PREMs? On which websites (public database and public information) can they be found?

In addition to procedural matters, we also look at the content of standards and guidelines: what recommendations are made that are relevant to our topic and are the (recommendations in the) guidelines sufficiently scientifically substantiated? Lastly, we look at the agreement between primary care and hospital care guidelines.

## 3.2 Application in practice

This is where we use various sources (such as claim data, publications, formal and informal consultations) to look at how care takes place in practice (including agreement between primary care and hospital care) and what the experts think about it.
We compare this to what we found in practice on recommendations in quality standards.

## 3.3 Care outcomes

Do patients benefit from the treatment? Is information available about quality of care and the outcomes of care, and can it be found by care providers, patients and citizens? For instance, is there a complication register, statistics on post-surgery mortality, experiences of patients with outcomes or experiences (measured with PROMs and PREMs)? And where can we find this information, e.g. on websites such as ZorginZicht.nl (public database), Kiesbeter.nl or Zorgkaartnederland.nl?

## 3.4 Effectiveness

Is the care effective? If we feel that the scientific substantiation of the guidelines (as assessed under element 1, Knowledge about good care) is of sufficient quality, we use the recommendations from the guidelines as point of departure for good care. If the guidelines are of insufficient quality, or are dated, then we can let the parties know that the guidelines need to be updated. A formal assessment based on the criteria established by the *Zorginstituut*, including a systematic review based on the GRADE system[2], only takes place if demanded by bottlenecks and there are no recommendations in the guidelines or they seem to be insufficiently scientifically substantiated.

An important part of an assessment of effectiveness are the starting questions, as described in the so-called PICOT: Patient – Intervention – Comparator  Outcome – Time. For which group of patients is the care intended and is that the group for which research is available? Which treatment or care is being offered and has this care been studied? With which control treatment (regular care, standard therapy) was that care compared and what is the added value of the recommended care? And which outcomes relevant to patients were examined in order to determine whether the care was effective and for how long?

2 *Zorginstituut Nederland. Assessment of established medical science and medical practice. Final updated version. Diemen, 2015.*

## 3.5 Cost-effectiveness[3]

Cost-effectiveness shows whether the (added) costs of treatment are reasonably in proportion with the added effectiveness. We look at whether the guidelines have anything to say about cost-effectiveness and we look at the (scientific) literature. Where we feel it is necessary, we carry out our own cost-effectiveness study.

## 3.6 Necessity

This is where we examine whether a form of care should be part of the basic health insurance and whether it involves costs that people could pay for themselves. Weighing this up involves two different aspects: the severity of the disease (burden of disease) and the societal necessity of actually insuring the treatment concerned. Whereas the emphasis with burden of disease is on medical necessity, with 'necessity to insure' the emphasis is on whether insurance is actually necessary.

## 3.7 Feasibility

Care cannot be supplied if it is not feasible. The feasibility element indicates whether the preconditions have been fulfilled and how sustainable it is to include an intervention in the basic package. Relevant to this are, e.g., basis of support, organisation (of care, indication and administration), funding, jurisdiction and ethics. This also involves, for instance, whether a funding formula (intervention description) exists for an intervention that should be included in the basic package.

## 3.8 Consistency in quality circles

This is where we look at whether quality circles are used which focus on improving care, who uses them and what interdependence exists between the quality circles.

3 *Zorginstituut Nederland. Cost-effectiveness in practice. Diemen, 2015.*

# 4 Difference in the screening phase and the in-depth phase

The spectacles we use to look at care are, in principle, the same for all phases of the assessment, based on the eight elements mentioned above. Sometimes there is a difference in the nature and intensity of the systematic analysis in the screening phase and in the in-depth phase. The terminology itself shows that the first involves a global inventory, at the level of a disorder (ICD-10), and that the selected topics are examined in more detail during the in-depth phase. This phase often also combines various data sources.

# 5 Use of data in the analysis

The *Zinnige Zorg* programme makes regular use of quantitative data. Using these data meticulously is particularly important for the quality of the analysis, acceptance of the findings and the protection of privacy. The *Zorginstituut* explicitly recognises the importance of this and takes all necessary measures for processing the available data meticulously. The following is an explanation of key elements of how we process quantitative data.

Based on care-related questions, the *Zorginstituut* carries out data research into how care from the basic package is used in daily practice.[4] To do this we collect information from many sources: from discussions with interested parties to scientific publications, from RIVM statistics to claim data.

These are in part quantitative data, often claim data such as those of the Declaration Information System (DIS), Care Interventions and Claims (ZPD), and the Medicines and Medical Device Information Project (GIP). When using data, we take various measures to ensure that security and privacy are guaranteed optimally. For example, the *Zorginstituut* uses pseudonymised personal data over several years and from various sources, which are combined for a specific problem.

We used claim data to get an idea of daily practice in health care. Claim data reflect registration practices and not always the care actually provided. Nevertheless, these data do form an important source of information, sometimes the only one, and can provide valuable signals relating to quality of care. An in-depth exploration of the possibility of using other data sources is currently being studied, in collaboration with VWS and other parties in health care.

Safeguarding privacy is of paramount importance. Personal data used are therefore pseudonymised and cannot be traced back to individuals. Nevertheless, they are regarded as sensitive personal data so we are extremely meticulous in carrying out the analyses and we comply with current legislation. The data are only used for research goals/analyses defined in advance, they are not made available/used for other objectives and they are not disseminated. The results of the analyses are published at a level that precludes any tracing back to the level of individual persons, patients, insurers or care providers.

4 *This may involve related fields, such as prevention, self-care and other forms of care not included in the basic package, based on the point of departure that we examine the care pathway integrally.*