GGZNEDERLAND Dutch Association of Mental Health and Addiction Care

Quality of mental health care - A perspective from the Netherlands

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Landschafts Verband Rheinland

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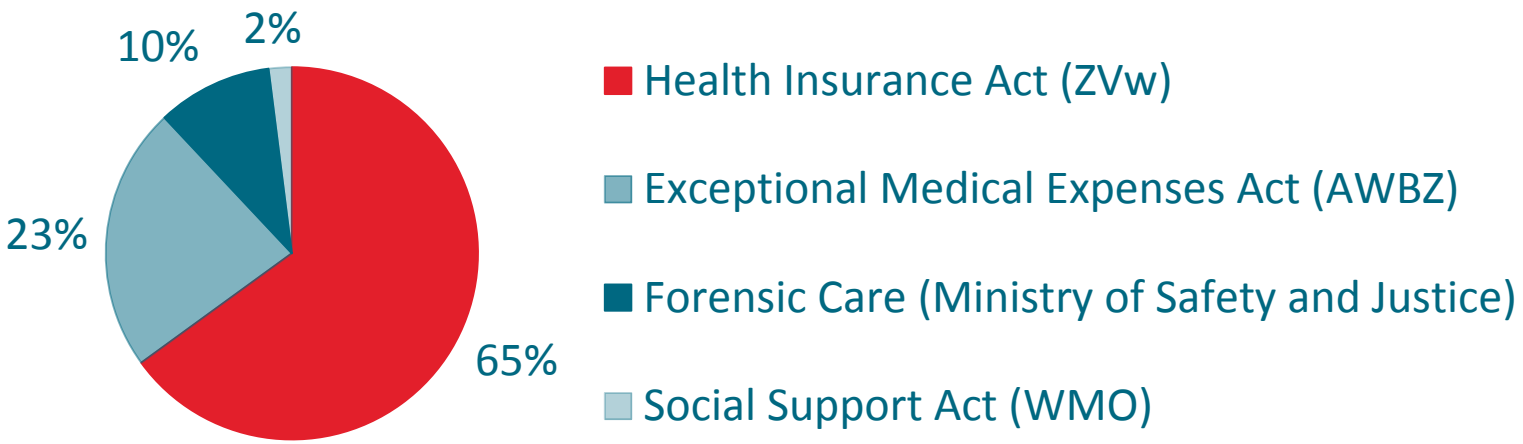
The Netherlands are a densely populated and economically well developed country

Population:	**16.8 million**	**(2013)**
Population density:	**400/square kilometre**	
GNP per citizen:	**7th economy**	**(2009)**
Human Development Index:	**4th place**	**(2013)**
Health care spending:	**€ 90 billion**	**(2011)**
	(12% of GNP; 2nd after USA)	
Per person:	**€ 5,392 per year**	**(2011)**
Mental healthcare:	**€ 5.82 billion**	**(2012)**
	(6.1% of spending)	
Return on Investment for society	**€ 14.78 billion**	

Sources: IMF, 2012; RIVM, 2013; UNDP, Human Development Report 2013.

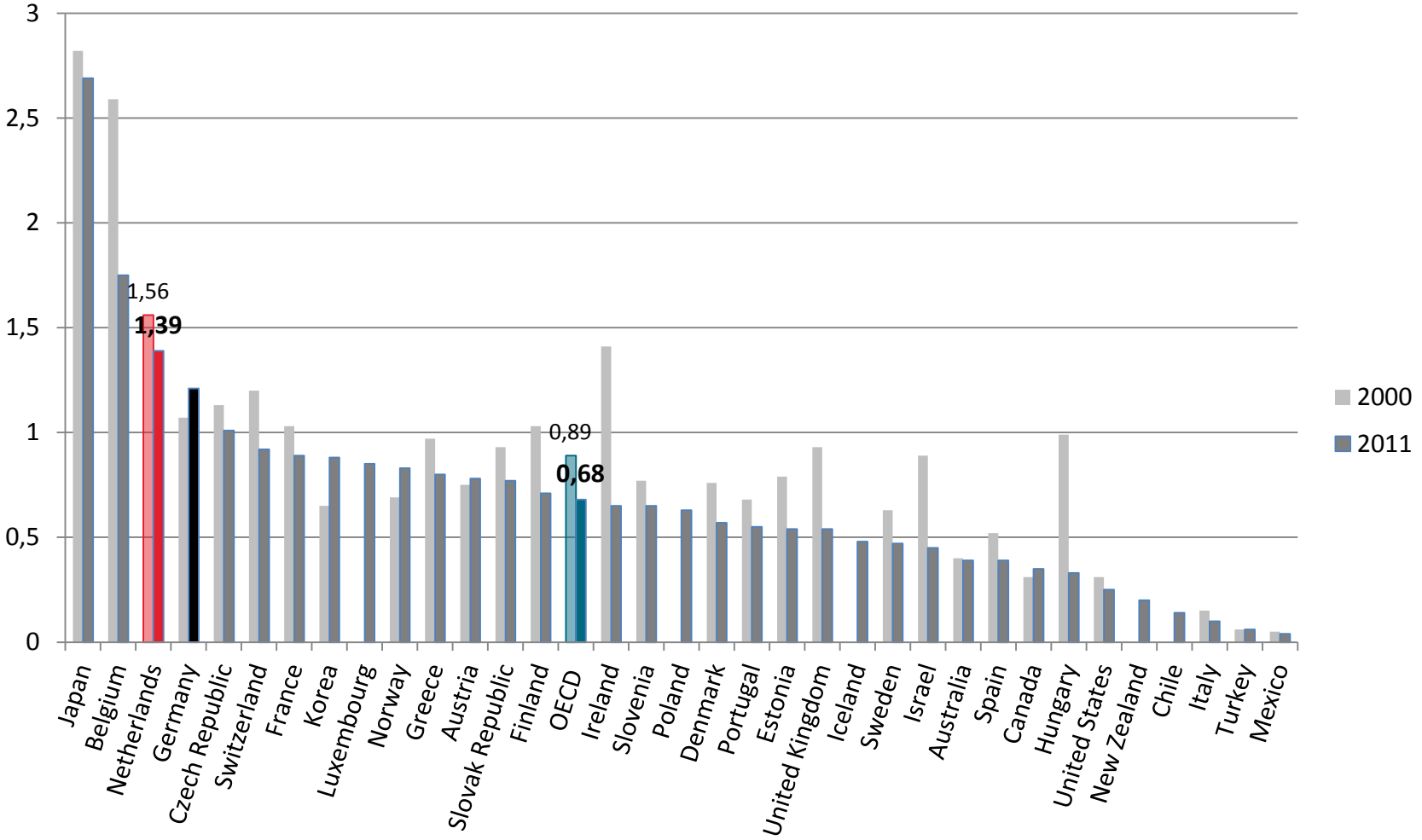
Funding of specialist mental health care until 2015 mainly by health insurance and taxes

The Health Insurance Act (ZVW) covers curative care. This includes almost all outpatient mental health treatment as well as the first year of inpatient mental health care. Long term mental health care is funded under the Exceptional Medical Expenses Act (AWBZ). In order to be eligible for care under the AWBZ, a person has to pass an objective assessment by the National Care Assessment Centre (CIZ). The total budget in 2012 for mental health care was € 5,82 billion.



Sources: State Budget Ministry of Health, 2012; Ministry of Safety and Justice, 2012; NZa, 2014.

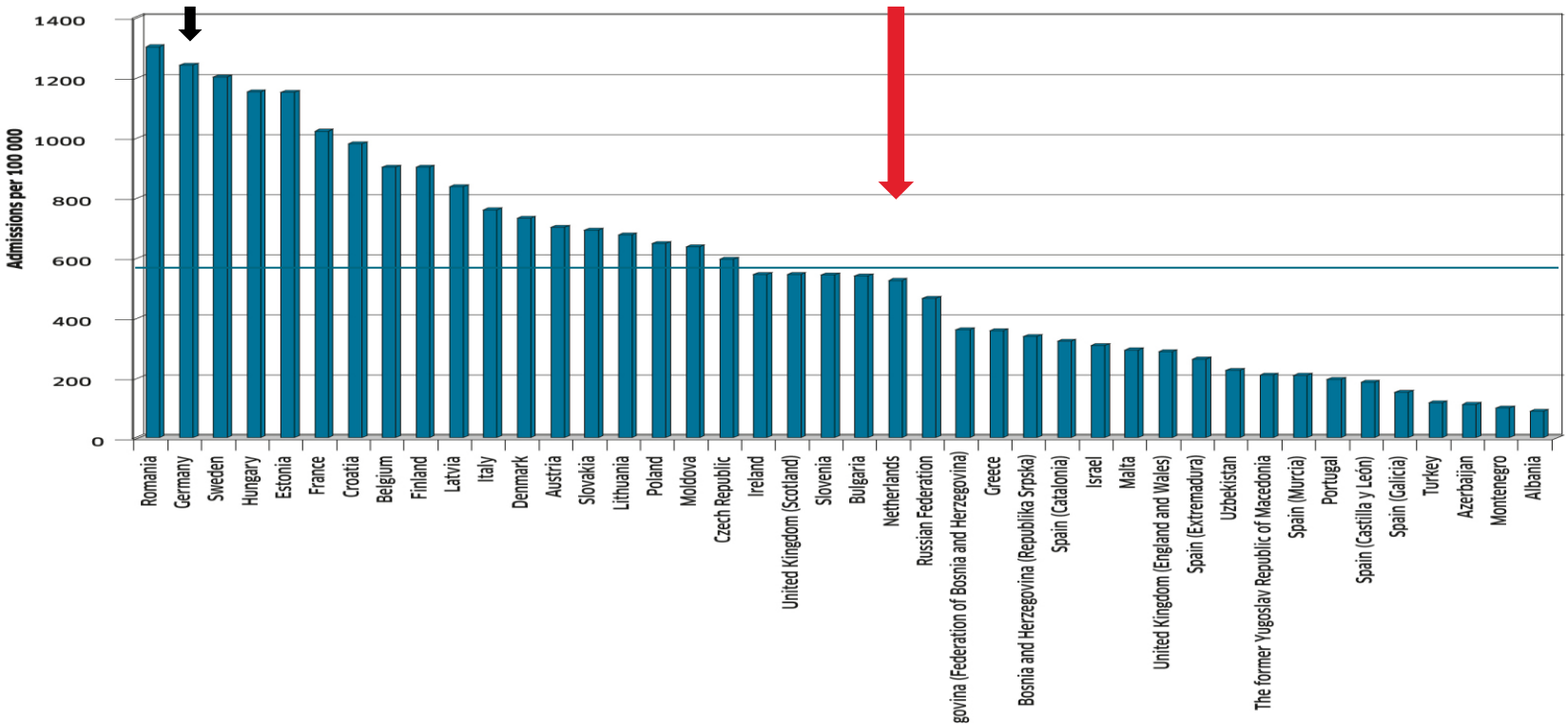
While the number of psychiatric beds is still very high in the Netherlands…



Source: OECD health database. [Online] Available http://dotstat.oecd.org/Index.aspx. Accessed 05 October 2013.

… the Netherlands have an average admission rate to inpatient units …

Rates of admissions to inpatient units per 100 000 population in WHO Europe countries vary from 1301 in Romania and 1240 in Germany to 87 in Albania. The median rate of admissions is 568 per 100 000 population.

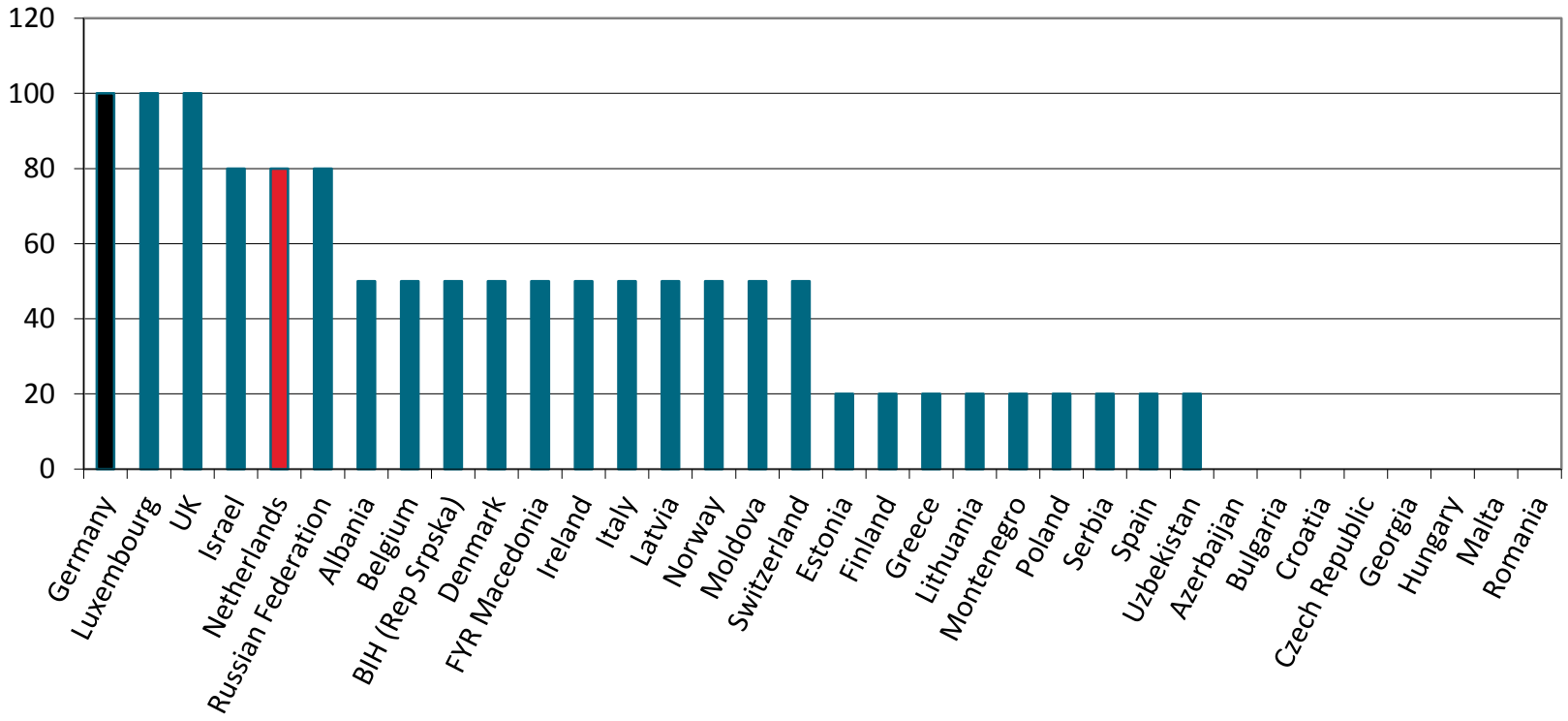


Source: Presentation by WHO Matthijs Muijen at GGZ Kennisdag, February 7th, 2013. WHO (2014) accessed on July 18th 2014 at http://www.euro.who.int/en/health-topics/noncommunicable-diseases/mental-health/data-and-statistics

… and the percentage ambulatory treatment is 92%

Despite the high number of places in inpatient settings, data on the utilisation of mental health specialist services show that 92% of people in contact with specialist services in 2010 receive care in outpatient settings.

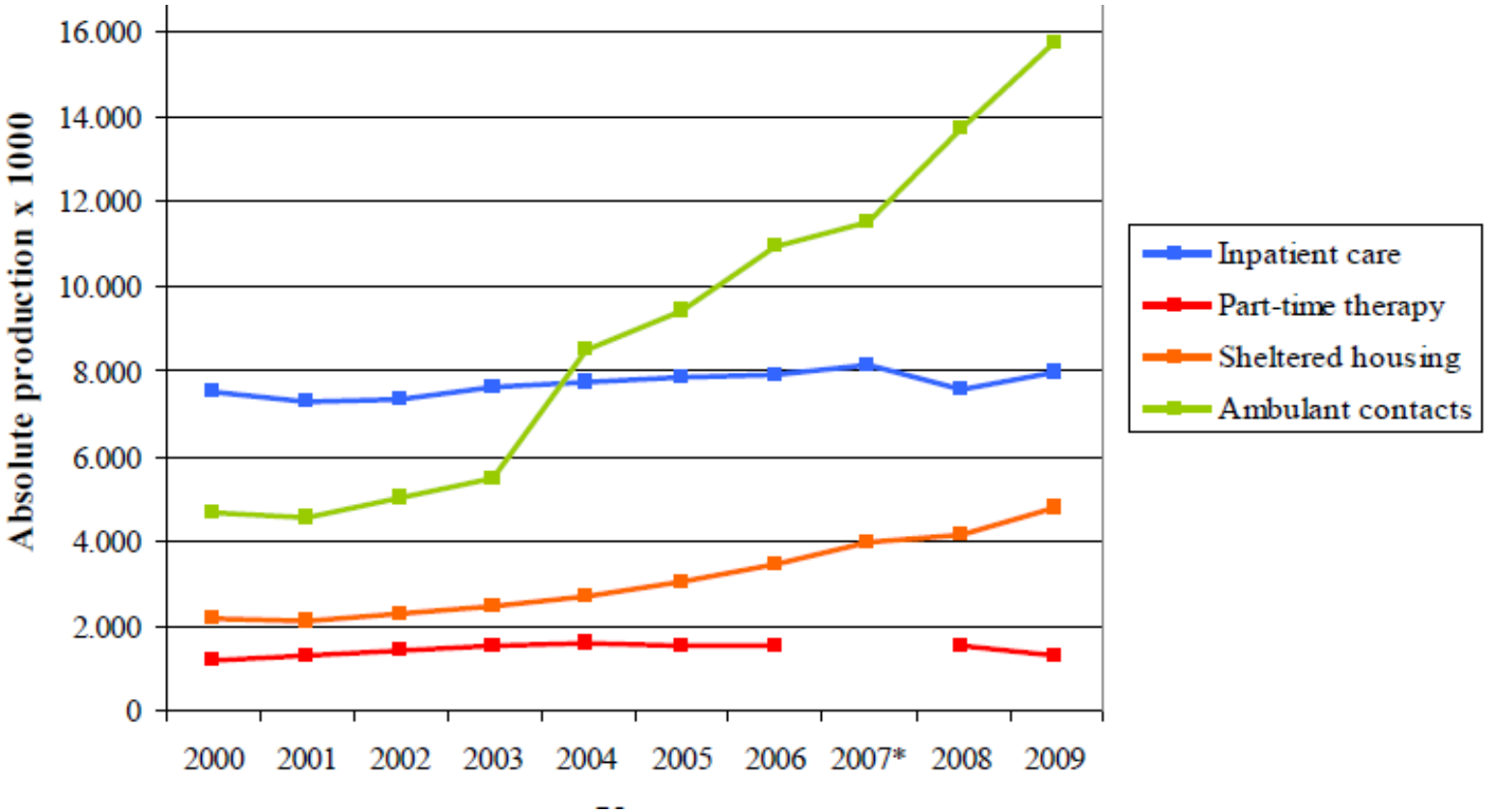
Percentage of home treatment in WHO Europe per 100 000 population



Source: Presentation by WHO Matthijs Muijen at GGZ Kennisdag, February 7th, 2013; GGZ Nederland (2013) GGZ in de Zorgverzekeringswet, tabellen over de jaren 2008-2010. [Mental health care in the Health Insurance Act, tables over the years 2008-2010]

Reducing stigma and improving access led to higher demand in Noughties, especially out-patient care…

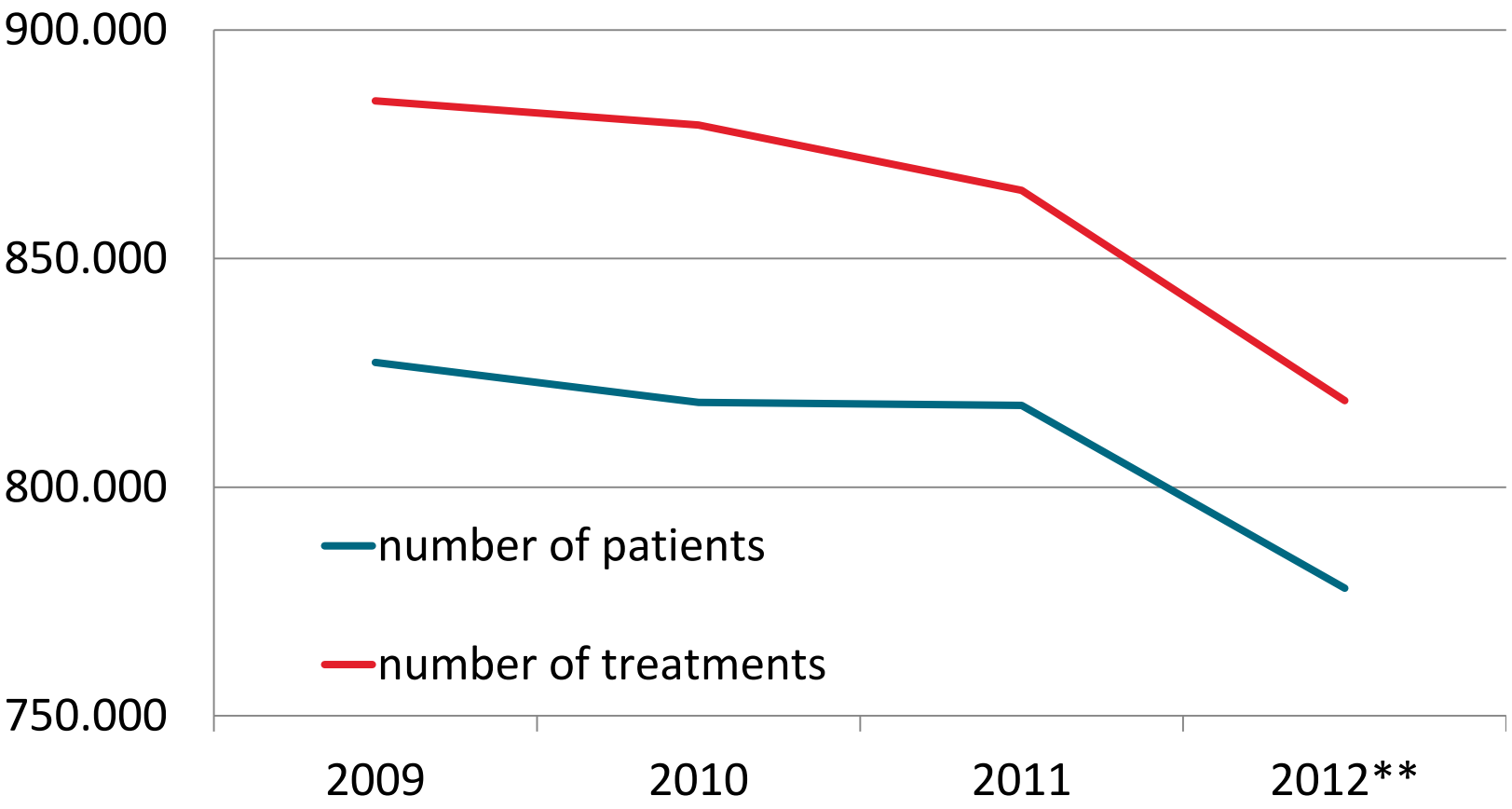
Absolute production of mental health care organisations (expressed in inpatient days, part-time therapy, days of sheltered housing and ambulant contacts)



Source: Van Dijk, S., A. Knispel, et al. (2011). GGZ in tabellen 2010. Utrecht, Trimbos-instituut: 112.

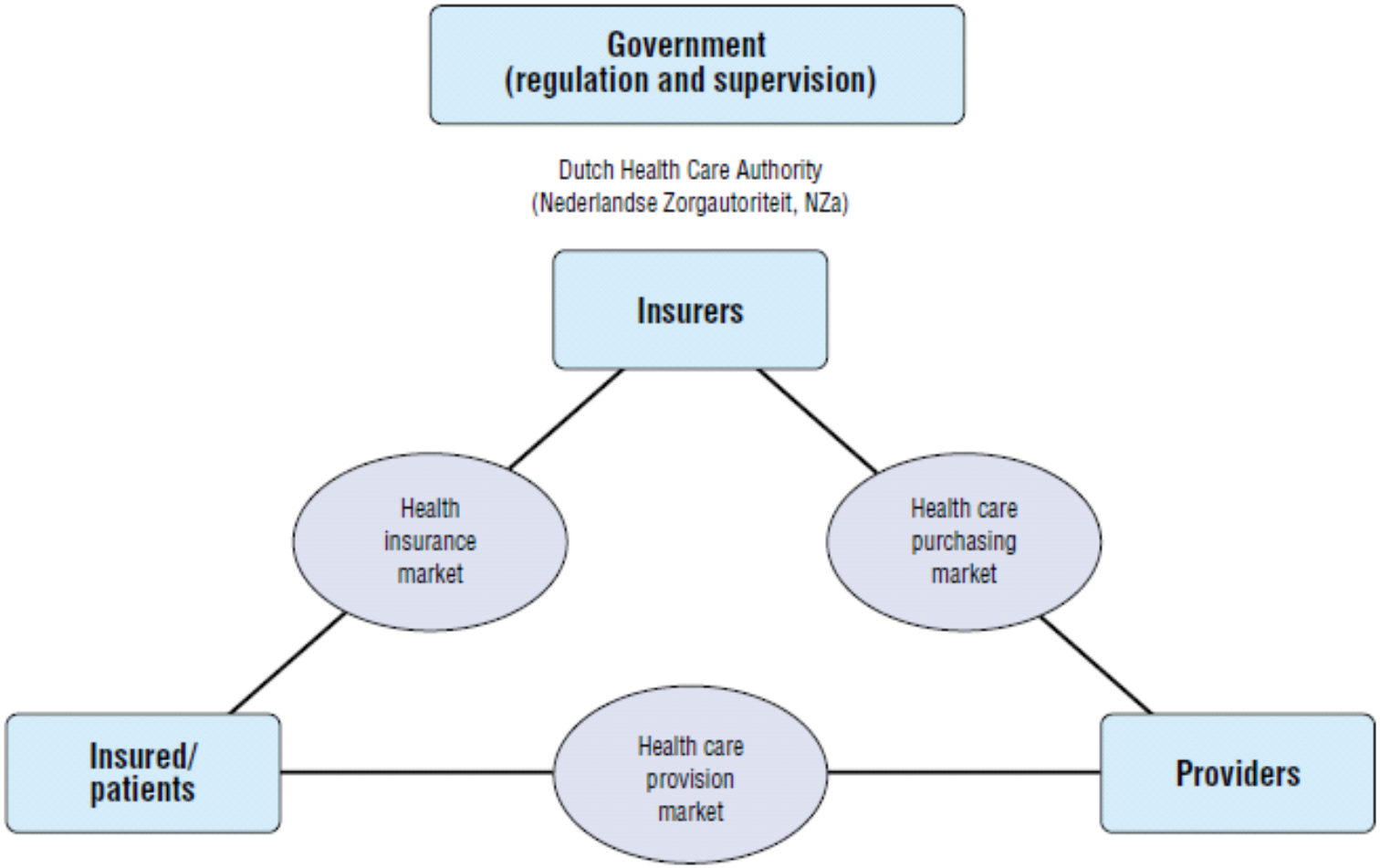
… but recent budget cuts on mental health care and introduction of co-payments led to fewer patients.

Number of unique patients and treatments in specialist mental health care



Source: GGZ Nederland (2014), Sectorrapport 2012: feiten en cijfers over een sector in beweging [Mental health industry report 2012, facts and figures on an industry in transition].

The Dutch health system is for the biggest part a “managed competition” in 3 markets



Source: Schäfer W, Kroneman M, Boerma W, van den Berg M, Westert G, Devillé W and van Ginneken E. The Netherlands: Health system review. *Health Systems in Transition*, 2010; 12(1):22

The critical success factor “transparency” needs four cornerstones on service provider level

Cost effectiveness

=

Efficiency

+

Performance

=

Safety

+

Client opinion

+

Outcomes

Photo: Terra cotta studies of four Caryatides, Artus Quellinus (I), 1650 , Rijksmuseum Amsterdam

Together, these cornerstones are an integral system for performance assessment

Providers collect data on **client** level.

Before sending data to **national databases**, they are encrypted

Results are **public** and presented on level of service providers.

It is **mandatory by law** for service providers to collect these data and present them publicly.

Cornerstone 1: DRG based financial system, fully operational since 2013

- Parity of esteem between physical and mental health
- Only for Health Insurance Act (now 60% of market)
- Episode based system
- 140 DRG's for treatment
- 7 DRG's for stay
- Provider sends invoice to health insurer:
  - diagnosis (DSM IV)
  - time spent by professionals
  - price of services delivered

Nederlandse Zorgautoriteit

Pagina
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BIJLAGE 1: DBC- zorgproducten

Deelprestaties Behandeling			Tarief
Bijzondere productgroepen			
	Diagnostiek		
	007	Diagnostiek - vanaf 0 tot en met 99 minuten	€ 187,83
	008	Diagnostiek - vanaf 100 tot en met 199 minuten	€ 291,82
	009	Diagnostiek - vanaf 200 tot en met 399 minuten	€ 581,87
	162	Diagnostiek - vanaf 400 tot en met 799 minuten	€ 1.102,77
	163	Diagnostiek - vanaf 800 tot en met 1.199 minuten	€ 1.893,93
	262	Diagnostiek - vanaf 1.200 tot en met 1.799 minuten (alleen jeugd)	€ 2.871,75
	263	Diagnostiek - vanaf 1.800 minuten (alleen jeugd)	€ 4.343,59
	Crisis		
	013	Crisis - vanaf 0 tot en met 99 minuten	€ 139,67
	014	Crisis - vanaf 100 tot en met 199 minuten	€ 307,63
	015	Crisis - vanaf 200 tot en met 399 minuten	€ 574,51
	016	Crisis - vanaf 400 tot en met 799 minuten	€ 1.073,18
	165	Crisis - vanaf 800 tot en met 1.199 minuten	€ 1.814,87
	213	Crisis - vanaf 1.200 tot en met 1.799 minuten	€ 2.710,29
	214	Crisis - vanaf 1.800 minuten	€ 4.262,81
Productgroepen Behandeling Kort			
	215	Behandeling kort - vanaf 0 tot en met 99 minuten	€ 133,07
	216	Behandeling kort - vanaf 100 tot en met 199 minuten	€ 318,67
	217	Behandeling kort - vanaf 200 tot en met 399 minuten	€ 612,74
	264	Behandeling kort - vanaf 400 minuten	€ 1.022,32
Productgroepen Langdurende of intensieve behandeling			
	Aandachtstekort- en gedragsstoornissen		
	027	Aandachtstekort - en gedrag - vanaf 250 tot en met 799 minuten	€ 1.182,49
	169	Aandachtstekort - en gedrag - vanaf 800 tot en met 1.799 minuten	€ 2.533,49
	030	Aandachtstekort - en gedrag - vanaf 1.800 tot en met 2.999 minuten	€ 4.518,89
	031	Aandachtstekort - en gedrag - vanaf 3.000 tot en met 5.999 minuten	€ 7.396,58
	131	Aandachtstekort - en gedrag - vanaf 6.000 tot en met 11.999 minuten	€ 15.155,32
	170	Aandachtstekort - en gedrag - vanaf 12.000 tot en met 17.999 minuten	€ 22.944,86
	221	Aandachtstekort - en gedrag - vanaf 18.000 tot en met 23.999 minuten	€ 35.417,16
	222	Aandachtstekort - en gedrag - vanaf 24.000 minuten	€ 42.667,19

Source: Nza, 2014

Cornerstone 2: Patient safety is particularly important for the Health Inspectorate

- Somatic screening (all patient admitted to clinical facilities)
- Medication safety
  - Availability up-to-date medication list during prescribing
  - Information on side effects of medication (CQ Index)
- Timely contact following discharge from a clinic
- Coercion (mandatory)
  - restraint
  - seclusion
  - forced medication
  - forced feeding

Photo: Parnassia, comfort room (2012)

Restraint (separation, isolation, fixation, medication) decreased between 2009 and 2012 with 22%

Restraint in mental health care for every 1000 admissions between 2009 and 2012 and the absolute number in 2012.

	Aantal interventies per 1000 opnamen [b]					Absoluut aantal [b]
Jaar	2009	2010	2011	2012	verandering over 4 jaar (%) [c]	2012
Aantal opnamen	31.393	39.273	55.824	75.794		75.794
Aantal instellingen	8	14	31	55		55
Interventies						
Separatie	152,5	147,5	133,1	122,7	-20,2	9.469
Afzondering	64,2	59,1	42,8	56,1	-19,8	4.251
Insluiting in overige ruimten	84,1	46,4	48,6	48,3	-43,5	3.647
Dwangmedicatie met fysiek verzet	96,1	61,0	65,7	52,5	-43,1	3.336
Fixatie	[d]	59,1	30,6	38,5	-38,8	2.928
Toediening van vocht/ voeding met fysiek verzet	te kleine aantallen voor zinvolle presentatie					405
Overige interventies met fysiek verzet	te kleine aantallen voor zinvolle presentatie					55
Totaal aantal interventies [e]	354,9	311,9	277,8	283,7	-21,6	20.933

Source: Janssen W, et al (2014) Zes jaar Argus. Vrijheidsbeperkende interventies in de GGZ in 2012 en ontwikkelingen ten opzichte van voorgaande jaren. Den Dolder: Expertisecentrum Agressie management, 2014; Casusregister Argus, 2014.

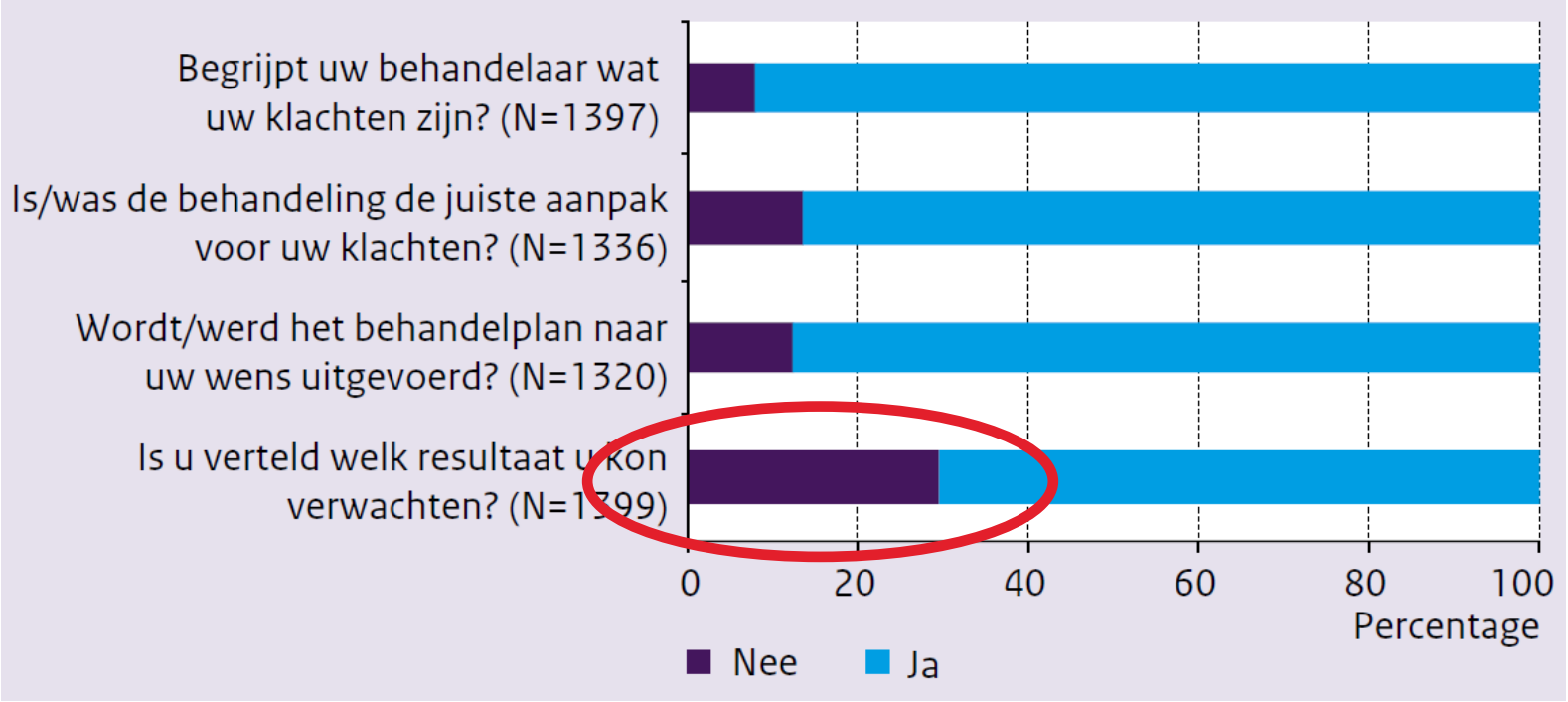
Cornerstone 3: client opinions, measured by CQ Index

CQ-index: standardised questionnaire

- freedom of choice between professionals/treatments
- informed consent
- fulfilment of wishes in care delivered
- evaluation/adjustment of treatment/support
- coordination of care
- housing and living conditions in a clinical setting or sheltered housing
- approach of clients by professionals

More than 85% of people using out patient mental health care find their treatment appropriate according to wish

Percentage of answers to questions about shared decision making and execution of treatment plan in out-patient care for common mental disorders in 2009.



Source: RIVM (2014), Zorgbalans 2014

Cornerstone 4: outcomes of mental health care

- Distinction between different groups
  Children/youth, adults (common mental disorders/ severe mental illness), elderly, addiction, forensic care
- Symptom reduction
  - Too much instruments to mention separately
- Daily functioning
  - OQ 45; HoNOS-12; CANSAS; HoNOSCA; Mate-7; HoNOS65
- Quality of life:
  - EQ5D, SF36, L-QOL, MANSA (7, 12ph, 12vn, 16), Kidscreen
- Risk (forensic care)
  - HKT30, IFBE, START, DROS, RAF GGZ-vw HCR20, SVR20, LSCMI

Stichting Benchmark GGZ (2014) , SBG zorgdomeinen, meetdomeinen, meetinstrumenten.

Four national organisations participated in the nationwide project Routine Outcome Monitoring

Nederlands Instituut van Psychologen Gezondheidszorg NIP

NEDERLANDSE VERENIGING VOOR PSYCHIATRIE

LPGGz

GGZNEDERLAND Dutch Association of Mental Health and Addiction Care

Original assignment: collect enough comparable outcome data in one place

- Collect enough data to have meaningful discussions
  - All clients are offered standardised questionnaires, unless…
  - Providers and health insurers agreed on minimum percentage
- Collect comparable data
  - Come to a national standard for questionnaires (instead of 170 different ones)
  - And standardise the data set for each case
- Collect data in one central place
  - Send, receive, process, save, report
  - Guarantee privacy of clients: encryption of data
  - Health insurers do not have direct access to client data

Between 2009 and 2011, the nationwide ROM project delivered these results

- Shared ambition of patients, professionals and providers: “every client will use outcome measures, unless… “;
- National standard for questionnaires, covering 9 major groups that make up 80 to 90% of the client population;
- Trusted Third Party collects and analyses outcome data and present benchmarks;
- Study on the nationwide costs of ROM;
- National convention on ROM;
- State of the art book (50 authors)
- Eigth short instruction movies for clients, client representatives and professionals.

Estimated costs of development and deployment of ROM in 2014: € 27 million

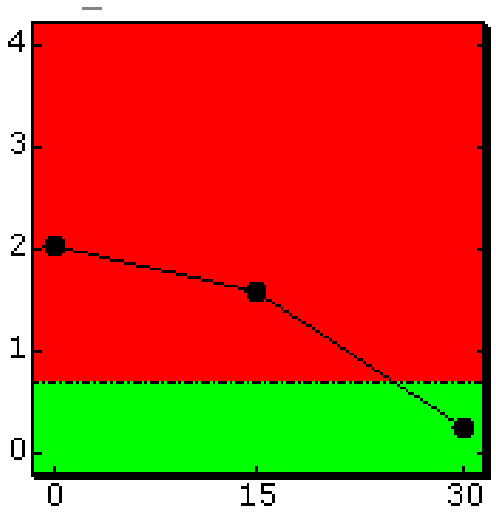
- Cost analyses by 55 service providers.
- Excluding sheltered housing, forensic care, benckmark institute
- Fixed and variable costs of
  - Service providers
  - Joint ventures of service providers
  - National organisations
- Costs per client decrease
  - in 2010 € 147
  - in 2014 € 57
- Compensation: significant reduction number of performance indicators (from 28 to 10)

The four partcipants shared a vision on outcome measurements in mental health

- Treatment/ support
- Learning
- Transparency
- Research

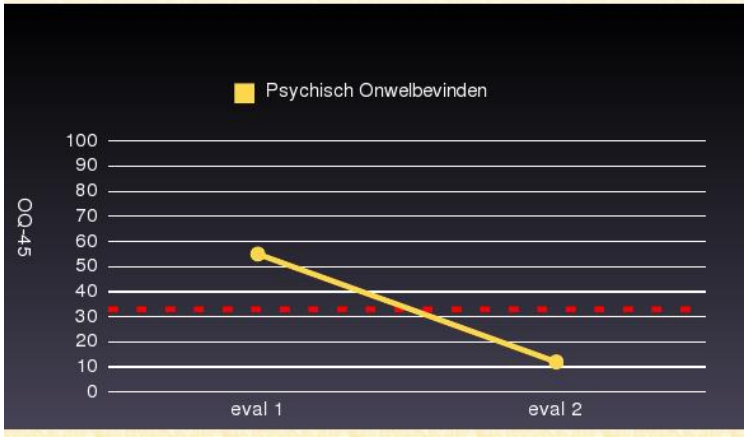
Outcome measurement is first and foremost an aid for clients and professionals in mental health

Clients fill in questionnaires at the beginning, during and end of treatment or support.



Measuring:

- reduction of symptoms
- functioning in daily life
- quality of life

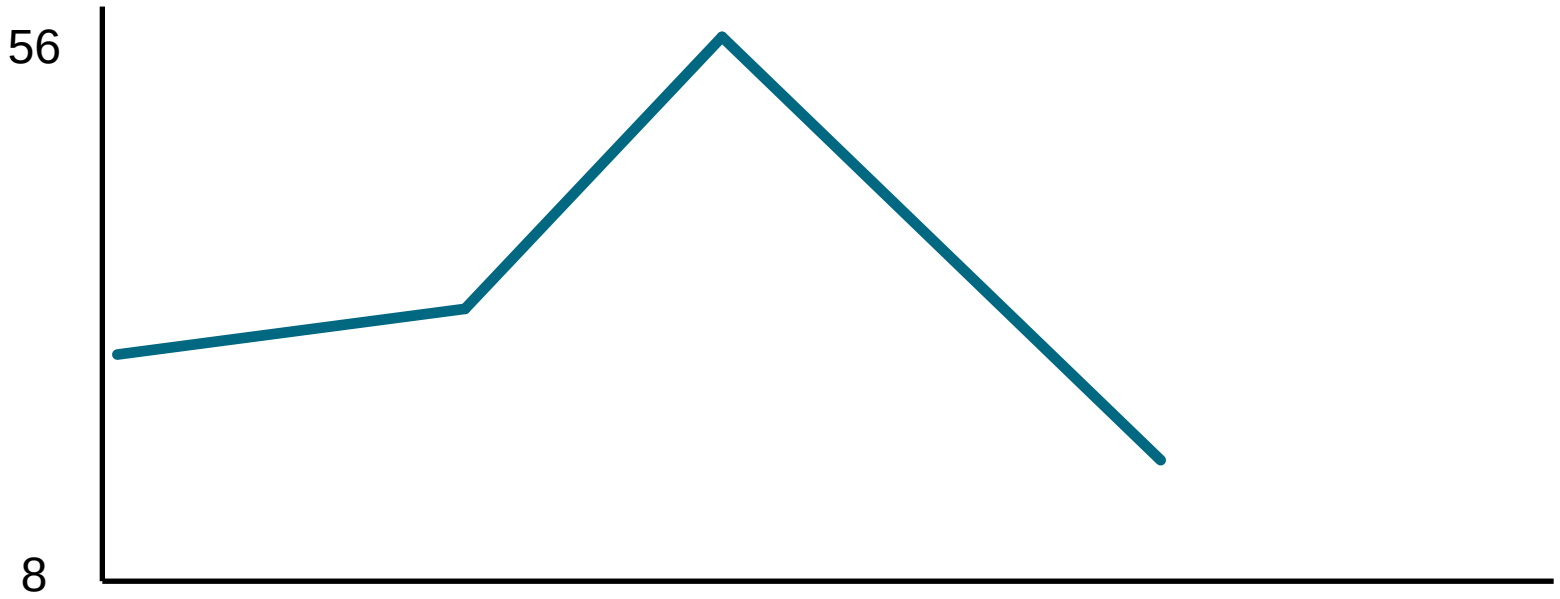


Quality of Life questionnaire (QoL+)

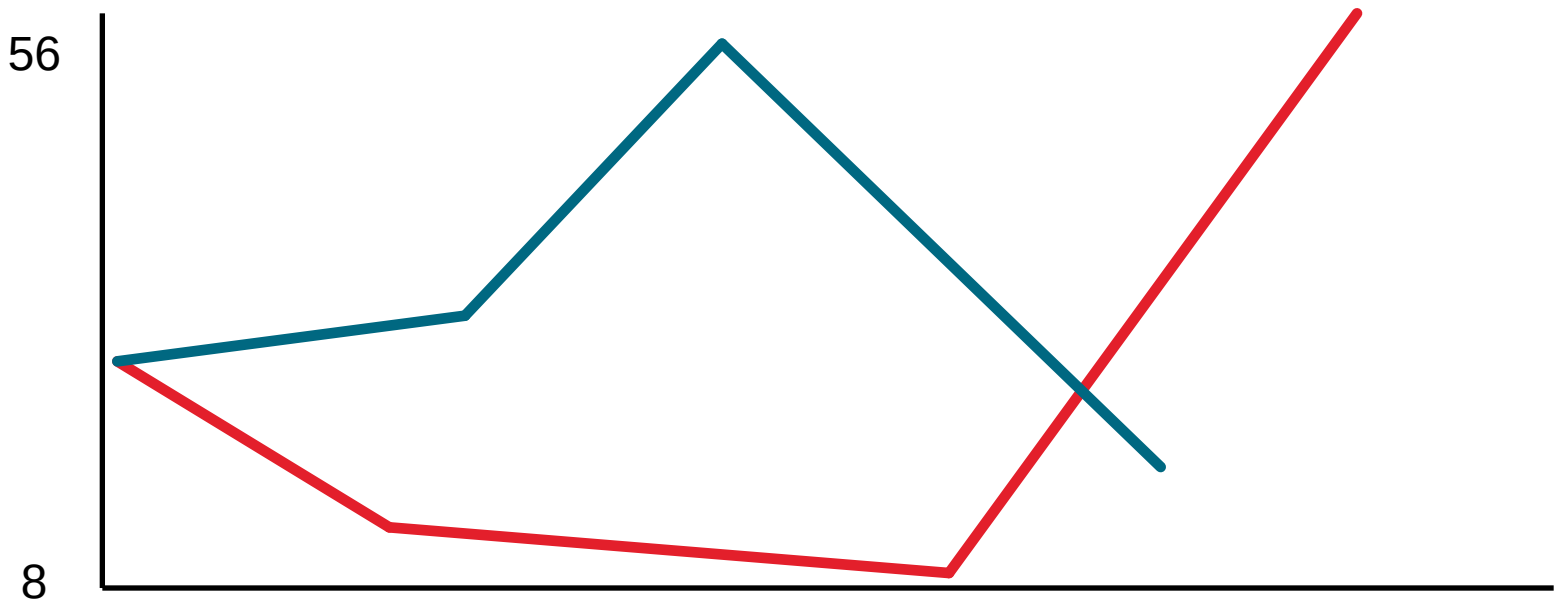
Could you please tell how satisfied you are with …..

1)	…. your housing situation?	1 2 3 4 5 6 7
2)	…. your relations with people?	1 2 3 4 5 6 7
3)	…. your physical health?	1 2 3 4 5 6 7
4)	…. your mental health?	1 2 3 4 5 6 7
5)	…. your financial situation?	1 2 3 4 5 6 7
6)	…. your work?	1 2 3 4 5 6 7
7)	…. your life in general?	1 2 3 4 5 6 7
8)	…. the support you receive?	1 2 3 4 5 6 7

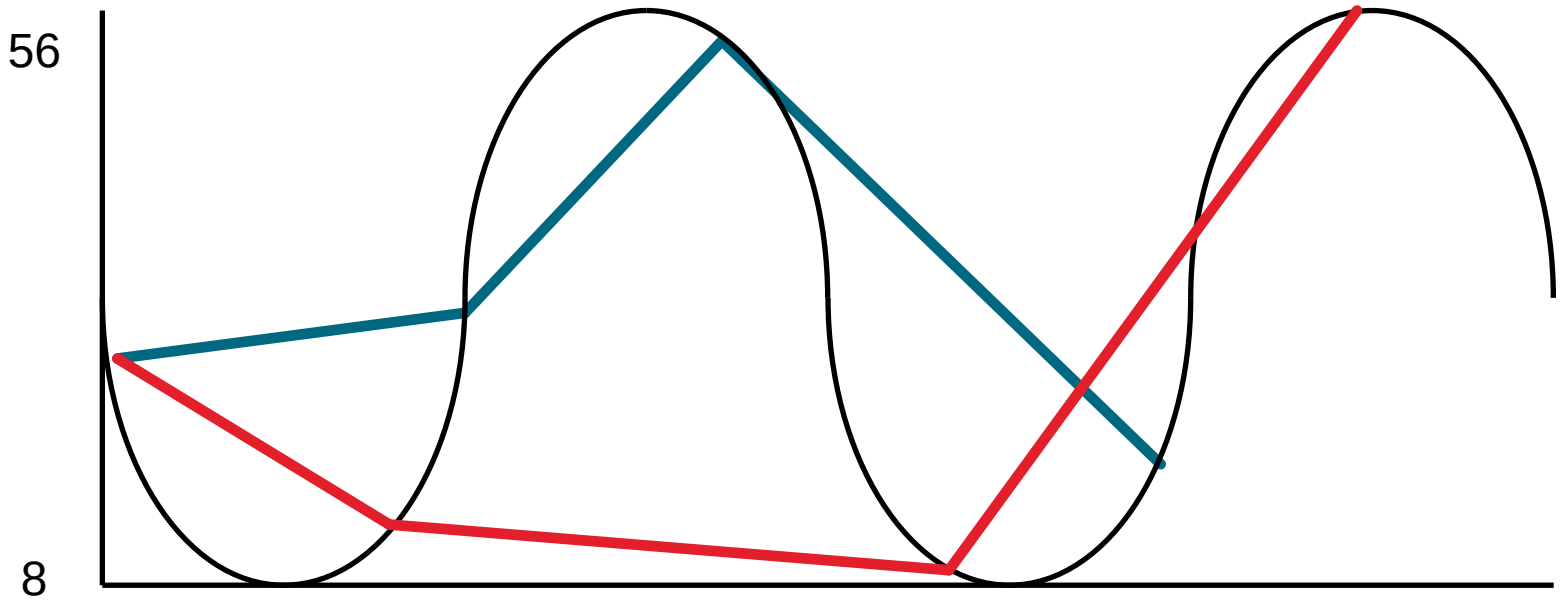
What does this QoL+ scores tell us about the quality of life of a person?



What does 2nd QoL+ base line say about the recovery of this person?



Outcome measurement provides a base for shared decision making



Collecting and analysing outcome data is possible and meaningful …

Clinical recovery (according to RCI)	A	B	C	D
% Recovered	31%	39%	23%	28%
% Reliable improved	11%	13%	19%	21%
% No change	55%	43%	50%	43%
% Reliable aggravated	4%	6%	9%	8%

Results of pilot in 2011 of 4 mental health service providers in long term mental health care on the basis of HONOS questionnaires. Not corrected or standardised for case mix. RCI = Reliable Change Index (RCI).

… as shown by this comparison of the aggregated outcomes.

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Results of pilot in 2011 of 4 mental health service providers in long term mental health care on the basis of HONOS questionnaires. Not corrected or standardised for case mix. RCI = Reliable Change Index (RCI).

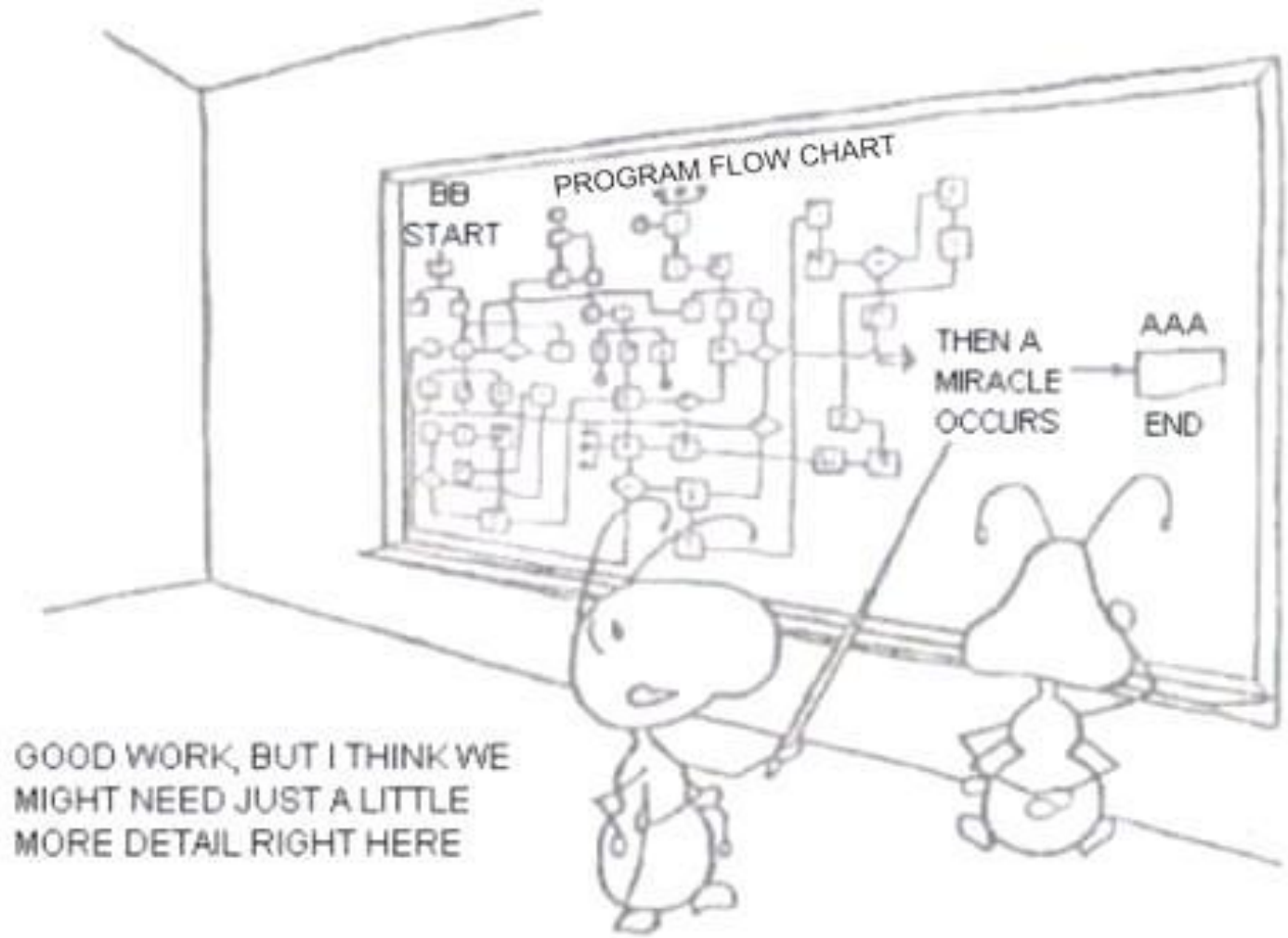
Accumulation of outcome data are an opportunity to discuss performance

- The Mental Health Benchmark Institute collects outcome data nationwide (pseudonymized)

STICHTING BENCHMARKGGZ

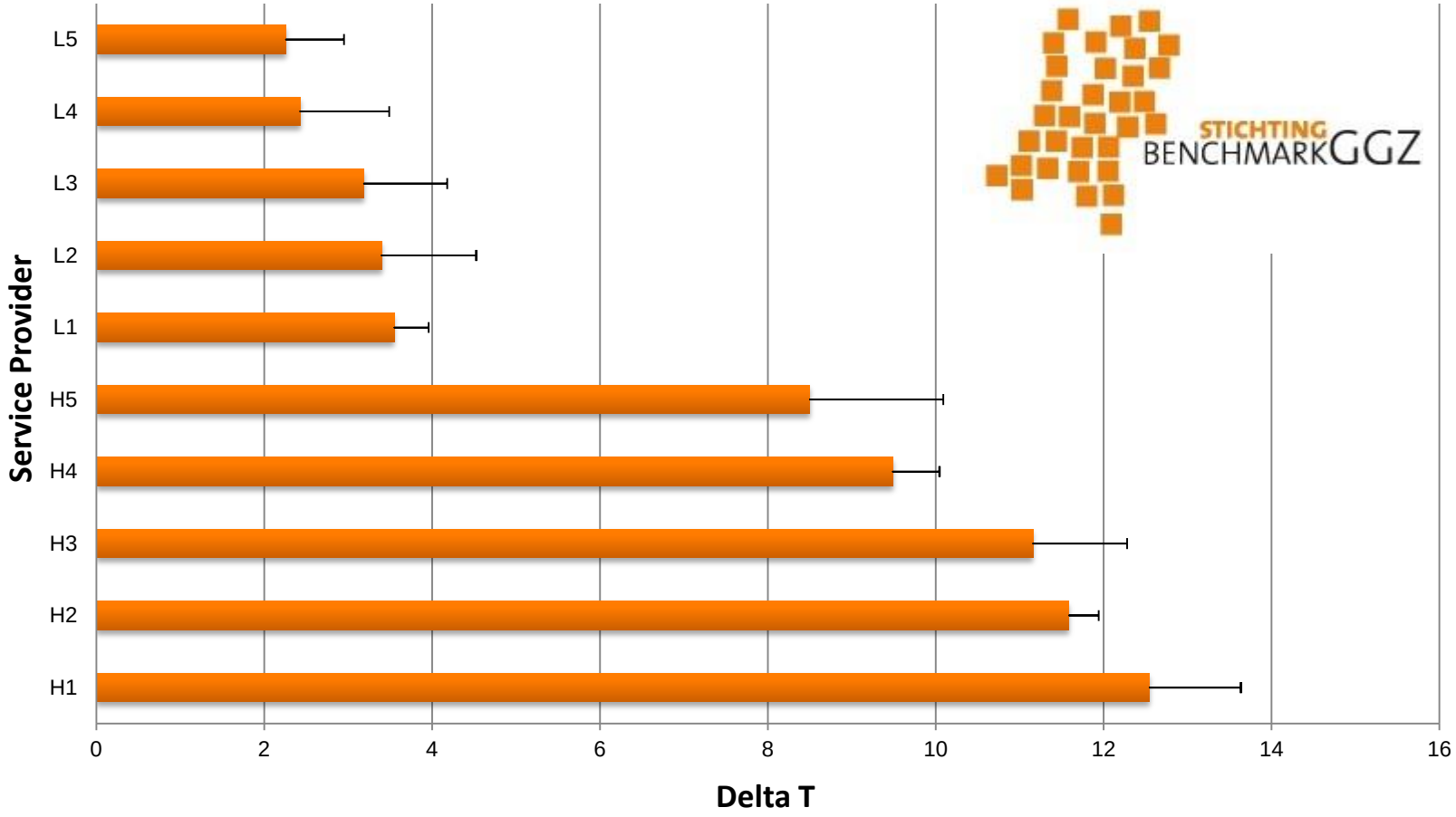
- Board members:
  - national platform of clients in mental health (LPGGZ)
  - health insurers (ZN)
  - service providers (GGZ Nederland; Meer GGZ)
- Scientific council :
  - associations of psychiatrists (NVvP)
  - and psychologists (NIP)

Benchmark, casemix and transparent process: holy trinity of performance assessment



Accumulation of outcome data are an opportunity to discuss performance

Variation between highest and lowest Delta-T in adults with common mental disorders between November 2012 and April 2013



Accumulation of outcome data are an opportunity to discuss performance

Variation in treatment effect (Delta – T) between service providers for completed care pathways in the treatment of adults with common mental disorders

STICHTING BENCHMARKGGZ

	Number	ΔT	(95%)	T-start	T-end
National average	42600	8.69	(8.59 - 8.78)	49.23	40.54
Mental health service provider A	6280	11.57	(11.30 - 11.84)	51.20	39.64
Mental health service provider B	767	10.62	(9.94 - 11.31)	51.60	40.97
Mental health service provider C	558	10.26	(9.37 - 11.16)	52.03	41.76
Mental health service provider D	3489	9.85	(9.55 - 10.15)	47.90	38.05
Mental health service provider E	439	9.80	(8.80 - 10.80)	52.12	42.32
Mental health service provider F	580	9.61	(8.74 - 10.48)	52.60	42.99
Mental health service provider G	741	6.56	(5.92 - 7.19)	48.01	41.46
Mental health service provider H	978	6.47	(5.85 - 7.09)	50.88	44.41
Mental health service provider I	594	6.42	(5.70 - 7.14)	49.93	43.52
Mental health service provider K	1196	6.41	(5.88 - 6.95)	49.33	42.92
Mental health service provider P	89	3.93	(1.72 - 6.14)	48.92	44.99

Accumulation of outcome data are an opportunity to discuss performance

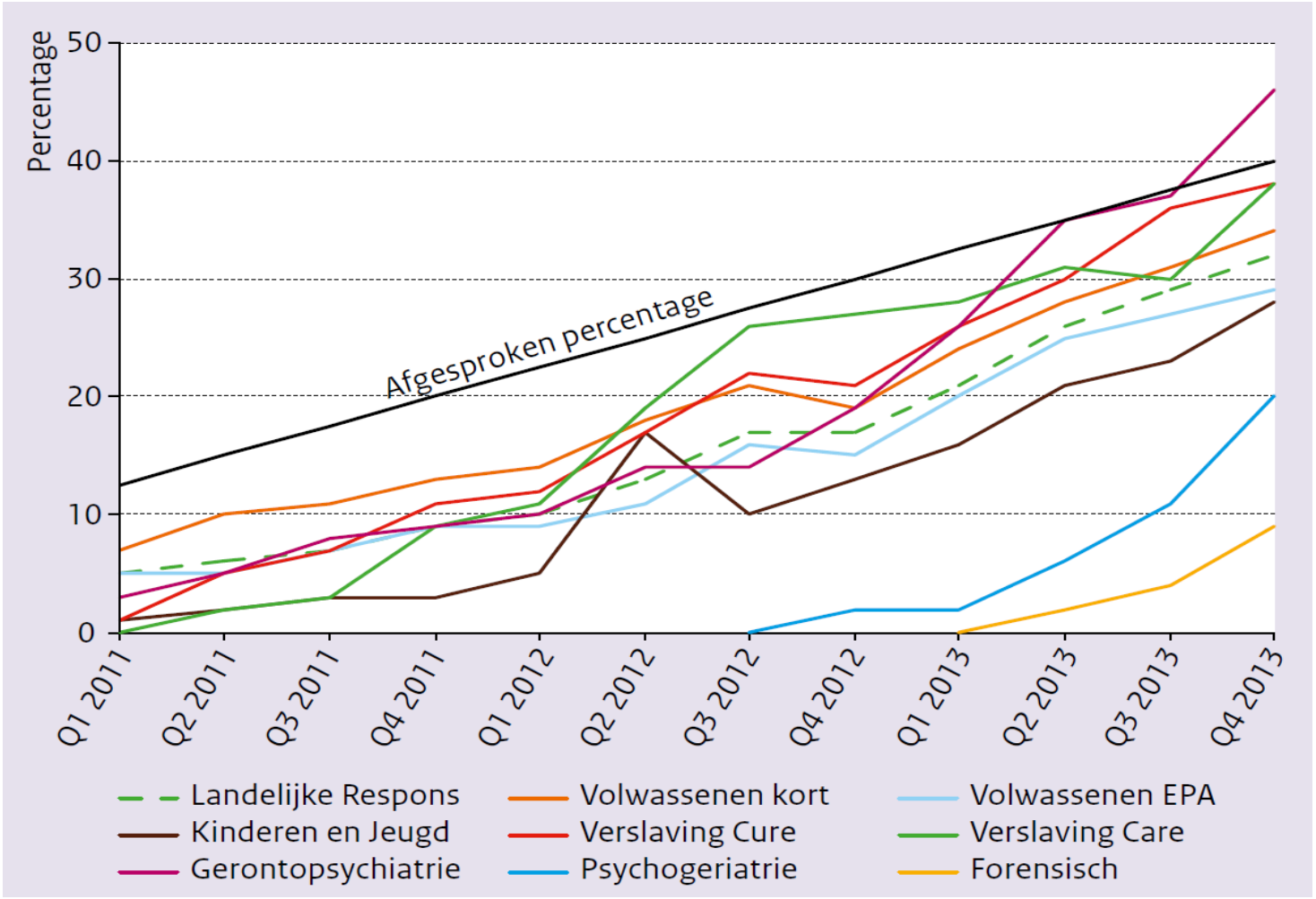
Variation in time in treatment effect within service providers for the treatment of adults with common mental disorders

STICHTING BENCHMARKGGZ

2012	Aantal	Behandeleffect ΔT	(95%)	T-begin	T-eind
Landelijk gemiddelde	**9781**	**7.20**	**(7.01 - 7.39)**	**52.03**	**44.83**
ן	262	3.39	(2.32 - 4.45)	51.27	47.89
ן	493	7.80	(6.91 - 8.69)	54.94	47.14
ן	2769	9.84	(9.43 - 10.26)	51.44	41.59
ן	749	6.91	(6.26 - 7.56)	52.50	45.59

2013	Aantal	Behandeleffect ΔT	(95%)	T-begin	T-eind
Landelijk gemiddelde	**67650**	**7.17**	**(7.10 - 7.25)**	**50.62**	**43.45**
ן	1801	4.81	(4.39 - 5.24)	52.56	47.74
ן	1491	6.50	(6.01 - 6.98)	53.70	47.20
ן	7621	10.81	(10.56 - 11.06)	51.73	40.92
ן	3012	5.44	(5.13 - 5.76)	49.97	44.53

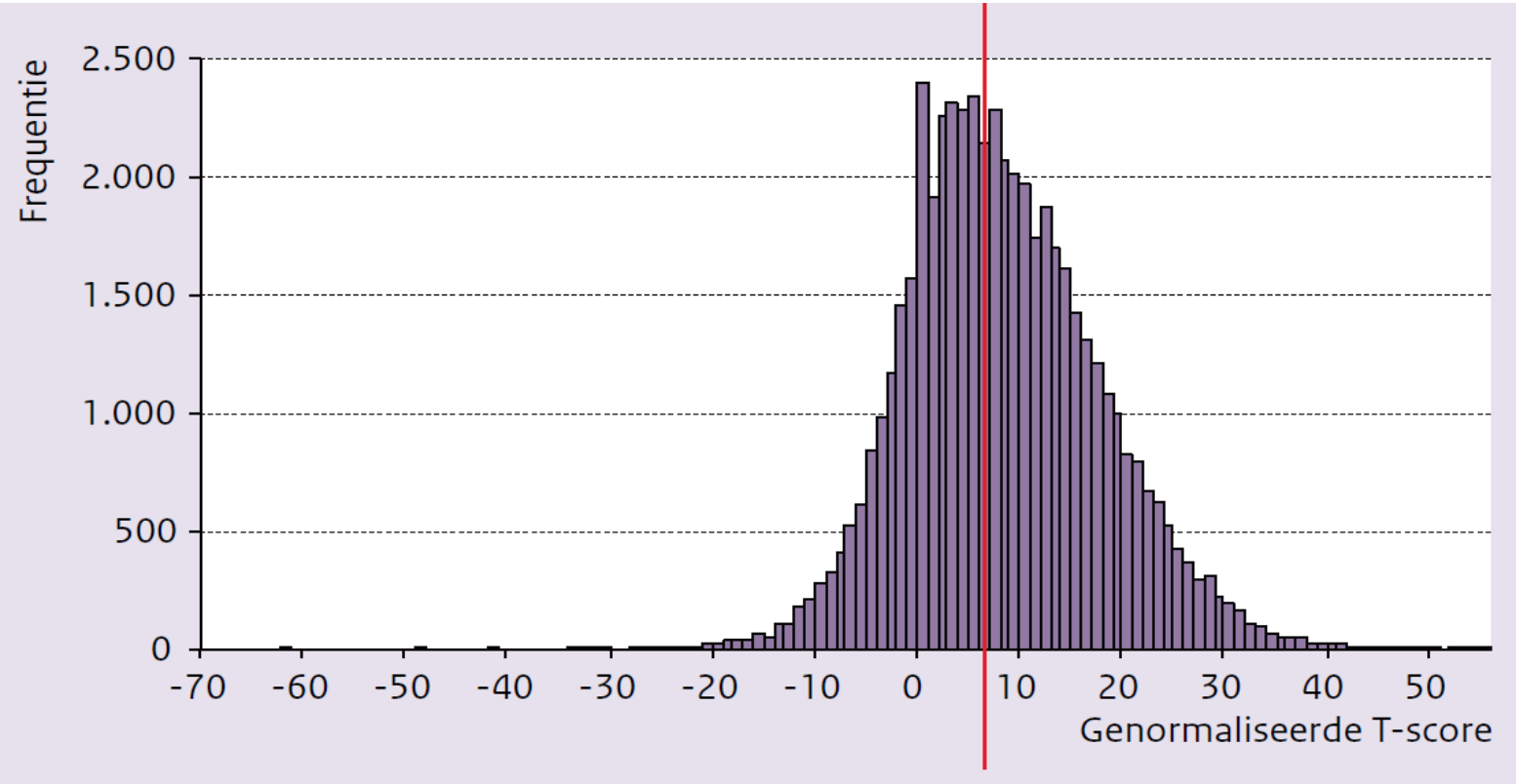
Completed sets outcomes collected by Mental Health Benchmark Institute is 32% in 2013



Source: RIVM (2014), Zorgbalans 2014

For CMD, 78% of patients had positive outcomes with an average improvement of 7.8 (8.0 is very good).

Frequency distribution of treatment effect in closed DRG's for common mental disorders between 1 January 2012 and 30 June 2013, expressed in difference between start and end of treatment (normalised T-score) .



Source: RIVM (2014), Zorgbalans 2014

In research, accumulated outcome data could be very useful. New methodology needed !

RCT test person

Real person

In this randomised controlled trial in addiction care, CBT is obviously more cost effective than MDFT …

Main outcome measure in adolescents according to treatment condition (*n* = 109)

	MDFT Mean (sd)	CBT Mean (sd)
Cannabis use past 90 days (days)		
Baseline	63.1 (22.8)	62.3 (23.6)
Month 3	42.0 (23.7)	45.4 (23.0)
Month 6	40.6 (21.8)	42.9 (20.6)
Month 12	43.0 (33.3)	47.4 (33.3)
Cannabis use past 90 days ('joints')		
Baseline	168.0 (129.6)	155.1 (128.7)
Month 3	108.2 (89.0)	106.8 (82.3)
Month 6	108.8 (134.5)	92.9 (64.6)
Month 12	91.2 (94.2)	96.0 (100.8)
Property/violent crimes past 90 days		
Baseline	6.3 (13.4)	6.6 (18.2)
Month 3	4.2 (3.8)	4.9 (7.6)
Month 6	3.9 (3.8)	3.4 (3.4)
Month 12	1.7 (3.1)	2.1 (4.2)
	MDFT (%)	CBT (%)
Treatment response		
Month 3	51.6%	43.6%
Month 6	58.9%	54.8%
Month 12	41.8%	44.4%
Treatment recovery		
Month 3	9.1%	7.4%
Month 6	5.5%	3.7%
Month 12	14.5%	5.6%

RCT compares MDFT and CBT on outcomes for youths between 13 and 18 years old

There is no significant difference between MDFT and CBT for response or recovery.

However, MDFT costs more time and money than CBT (3-4 times)

Source: Hendriks, V.M., Van der Schee, E, Blanken, P. (2011). Treatment of adolescents with a cannabis use disorder: main findings of a randomised controlled trial comparing multidimensional family therapy and cognitive behavioural therapy in the Netherlands. Drug Alcohol Depend. 119 , 64-71.

… however, post hoc analysis showed a different reality when moderators are taken into account.

Baseline patient characteristics	Change in cannabis use (joints)[b]			
	N	MDFT[c] mean (joints)	*N*	CBT[c] mean (joints)
Age				
13–16	29	−127.8	27	−29.9
17–18	26	−19.9	27	−88.2
Violent and/or property crimes				
No	22	−4.9	29	−51.7
Yes	30	−125.3	24	−71.2

"The RCT showed that MDFT and CBT were equally effective in reducing cannabis use. The post hoc analysis strongly suggests that age, disruptive behaviour and internalizing disorders are important treatment effect moderators. This gives directions for future patient treatment matching"

Source: Hendriks, V., Van der Schee, E, Blanken, P. (2012). Matching adolescents with a cannabis use disorder to multidimensional family therapy or cognitive behavioural therapy: treatment effect moderators in a randomized controlled trial. Drug Alcohol Depend. 125, 119- 126

Present situation and next steps

- Ethical discussion on the national collection of outcome data (counter narrative: every patient is an individual)
- Now more focus on outcomes for treatment and support (breakthrough projects)
- Development outcome measure for “recovery” (I.ROC?)
- Societal outcomes will become more and more important:
  - Keep people at work, get them (back) to work
  - Keep children in school
  - Keep people out of prison
  - Keep people of the street

Already in 1863, Florence Nightingale introduced outcome measurements for hospitals

"It is proposed that one and the same form should be used for each statistical element. Seven elements are required to enable us to tabulate the results of hospital experience:

1. Remaining in hospital on the first day of the year.
2. Admitted during the year.
3. **Recovered or relieved** during the year.
4. **Discharged** incurable, **unrelieved**, for irregularities, or at their own request.
5. **Died during the year**.
6. Remaining in hospital on the last day of the year.
7. Mean duration of cases in days and fractions of a day."

Source: Nightingale F (1863). *Notes on hospitals*, 3rd Edition. London: Longmans (page 161).

GGZNEDERLAND Dutch Association of Mental Health and Addiction Care

GGZ Nederland is the sector organisation of specialist mental health and addiction care providers in the Netherlands. The aim of GGZ Nederland and its members is to ensure the availability of high quality, accessible, affordable and sustainable mental health care.

In 2013, its 113 members employed 89,500 staff who provided specialist mental health care to 815,800 clients. This is a market share of 80.6% in the health insurance market and more than 90% in child and youth care, sheltered housing, addiction care and forensic care.

Seated in Amersfoort, its 66 employees represent the interests of its members in an on-going and constructive dialogue with client organisations, health insurers, national and local governments, professional associations and trade unions.

Website: www.ggznederland.nl/pagina/english
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Source: GGZ Nederland (2013), GGZ in de Zorgverzekeringswet