Patient experience data in practice accreditation—an international comparison

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Accepted for publication 1 January 2010

Abstract

Objectives. Accreditation of medical practices is widely used as a means to assure and improve medical care quality. Patient experience data contribute to a comprehensive quality assessment; some accreditation programmes therefore include patient surveys. Based on a commissioned work for Stiftung Praxissiegel, a provider of practice accreditation in Germany, nine international accreditation programmes were compared. Our study aimed at describing content, method and scope as well as differences, commonalities and unique features regarding the integration of patient experience data into international practice accreditation programmes.

Design. Selective literature review, subsequent systematic analysis of the identified documents.

Setting/Participants. Nine accreditation programmes from Germany, Switzerland, UK, the Netherlands, USA and Australia.

Analysis/Main Outcome Measures. Synthesis of key information on the accreditation programmes, the development of accreditation criteria, the different ways to assess patient experience data and the relevance of patient experience data to the accreditation decision.

Results. Structured patient surveys are mandatory in five accreditation programmes. Two programmes include the specific results of patient surveys in the accreditation decision. Three programmes require the results of patient surveys to be evaluated and, if necessary, to be used for quality improvement activities.

Conclusions. Collecting patient experience data is of great importance for a comprehensive assessment of medical care quality. A practice accreditation programme that includes a structured patient survey can be considered as a high international standard. So far, there are insufficient research results on how and to what extent patient experience data is to be included in the accreditation decision.

Keywords: quality management, external quality assessment, patient satisfaction, ambulatory care, accreditation

Introduction

The accreditation of health-care facilities is currently being tested in many countries as a way to improve health-care quality. It represents an external and independent attestation regarding the functionality and effectiveness of an organization’s quality management (QM) system. Compliance with explicit predetermined standards is verified as part of a peer-based on-site visit. This way the quality of treatment in a facility is to be assured. Furthermore, results of the peer review may also include recommendations for continuous quality improvement [1]. The experience of patients is of particular importance in the assessment of the quality of medical treatment [2–4]. Therefore, several accreditation programmes require a patient survey to be carried out, some of them prescribe a specific instrument.

According to a directive of the Federal Joint Committee, medical practices in Germany are obliged to implement an internal QM system by the end of 2009 and then to continuously develop it further. The directive also includes a requirement for, if possible, validated patient surveys. Random checks of practices are conducted annually to review the implementation of the QM systems [5]. Whilst accreditation is not mandatory, voluntary accreditation represents a suitable means for demonstrating accordance with the federal requirements.

The aim of this study was to present international approaches to giving the experience of patients an integral
Methods

Based on a commissioned work for Stiftung Praxisseigel, who provides accreditation of medical practices themselves, three German and six international programmes for medical practice accreditation were identified and analysed comparatively. These are the following internationally well-known and accessible programmes/providers of accreditations for medical practices, also relevant for Germany:

- EPA (European Practice Assessment) [6, 7]/Stiftung Praxisseigel, Germany [8]
- QEP® (Quality and Development in Practices), Germany [9]
- KTQ® (Cooperation for Transparency and Quality in Health Care), Germany [10]
- EPA (European Practice Assessment) [6, 7]/EQUAM (External Quality Assurance in Medicine), Switzerland [11]
- NPA® (NHG-Practice Accreditation), The Netherlands [12]
- QPA (Quality Practice Award), UK [13]
- AGPAL (Australian General Practices Accreditation Limited), Australia [14]
- JCAHO (Joint Commission on Accreditation of Healthcare Organizations), USA [15]
- NCQA (National Committee for Quality Assurance), USA [16].

All accreditation providers studied are independent, non-profit organizations. Table 1 summarizes key descriptive information on the accreditation programmes.

The subjects of our study were the development of accreditation criteria, contents and method of accreditation as well as contents, method and relevance of the patient survey. This article presents the results regarding the collection and relevance of patient experience data.

For data collection purposes selective literature review and a subsequent systematic analysis of the documents identified were undertaken between October 2008 and March 2009. Initially, the providers’ Internet portals were identified. Relevant information was searched for using the menu navigation or the sites’ search function. Regarding the patient experience data, the form and method of data collection, the surveyed contents and the effect of the results on the accreditation decision were of particular interest. To be included, documents had to be relevant, up-to-date and at the same time freely available. Referrals to cooperating organizations, such as providers of patient questionnaires, were also appraised. For three accreditation programmes, the printed versions of criteria catalogues were used [17–19]. If we failed to extract all the required information this way, a responsible contact person at the organization was consulted on the phone or via e-mail. Nevertheless, for two organizations, NPA® and NCQA, the enquiry remained unanswered. The relevant information was considered individually for each accreditation programme and subsequently consolidated for comparison. Due to the nature of the data, a statistical analysis of the results other than a description was not indicated.

Results

At this point the different approaches to the collection of patient experience data and the relevance of the results to the accreditation of medical practices are presented, followed by a brief comparison of the patient questionnaires applied.

Collection of patient experience data

Within EPA [6, 7, 20]—the QM system Stiftung Praxisseigel accreditation [8] is based on—there are the following surveys: a structured patient survey, a structured staff questionnaire for medical and non-medical staff and a structured cooperation partner’s survey in specialist practices and healthcare centres. All surveys are mandatory parts of the Stiftung Praxisseigel accreditation. The patient survey has to be conducted by means of the EUROPEP questionnaire (European Task Force on Patients Evaluation of General Practice) [21], which allows benchmarking between all participants. Based on the EUROPEP survey, Stiftung Praxisseigel accreditation applies 25 patient experience indicators. For a successful accreditation, at least half of the over 200 indicators have to be complied with. Consequently, the assessment criteria make an accreditation possible without needing to take the 25 indicators from the patient questionnaire into account. However, accreditation requires that the practice team together with the trained surveyor discusses all findings of the accreditation process and, if necessary, uses them for the development and implementation of improvement activities.

Regarding patient experience data, the following is recorded during QEP® accreditation [9]: firstly whether the patients were surveyed, secondly whether the cooperation partners were surveyed and thirdly whether the surveys were evaluated and the results, if necessary, used to implement improvement activities. Neither structured survey instruments nor specified contents are required. Practices only have to meet one of the three criteria [17], it is therefore possible to obtain an accreditation even without a patient survey being performed.

KTQ® accreditation [10] assesses whether patient surveys were carried out, whether data protection and anonymity were assured and whether the results were provided to patients and staff. These documents, however, are not mandatory and therefore not pertinent for an accreditation [18].

The EQUAM accreditation [11] requires a structured patient survey by means of the EUROPEP questionnaire [21]. From the results 26 indicators are assessed, which are included in the accreditation decision in the following manner: EQUAM separates all indicators into five key
Table 1  Overview of the nine accreditation programmes/providers surveyed

<table>
<thead>
<tr>
<th>Organization</th>
<th>Accreditation</th>
</tr>
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| **Germany**  | **Accreditation mainly based on the successful completion of the EPA [6, 7], which was developed in an international study from 2001 to 2004 (20).** Accreditation provided for: |}

- general practices
- specialists’ practices
- dental practices
- ambulatory health-care centres

STPS [8] Established in 2004 Members:
- representatives of SHI, private health insurance, and physicians’ and patients’ organizations
- dentists, physicians, QM experts, scientists

QEP® [9] Established in 2004 Members:
- representatives of the 17 regional and one national associations of SHI physicians (political representation of office-based SHI-affiliated physicians and psychotherapists)

KTQ® [10] Established in 2001 Members:
- representatives of:
  - two German medical associations
  - National confederation of the SHI funds
  - German hospital federation
  - German nursing council

- representatives of three Swiss MCOs

NPA® [12] Developed in 2005


UK

Australia AGPAL [14] Established in 1997 Members:
- representatives of various Australian associations and networks of several medical professions (general practitioners, nurses, rural doctors)
- patient representatives

(continued)
categories. The indicators either are composed of minimum requirements or are rated using a scoring system. An accreditation requires that, besides all minimum requirements being met, within the key category, which includes the patient survey indicators, at least 50% of the maximum possible points are achieved, that is 31 of 62 points. Since 34 points result from the patient survey alone, at least three points have to originate from the patient survey results in order to reach the minimum score and therefore a successful accreditation.

The NPA \[12\] includes 43 indicators regarding the patient experiences. Most of the indicators are determined by means of the EUROPEP survey \[21\]. Furthermore, the NPA\(^\text{®}\) developers have added items to the original questionnaire. At the time of our research, the alternative application of the Consumer Quality Index\(^\text{®}\) (CQ-Index\(^\text{®}\)) instead of the EUROPEP questionnaire was discussed \[22\]. The CQ-Index\(^\text{®}\) \[23\] was developed by the Netherlands Institute for Health Services Research in cooperation with the University of Amsterdam and is based on the US-American CAHPS (Consumer Assessment of Healthcare Providers and Systems) \[24\]. Information regarding the scoring system of the NPA\(^\text{®}\) accreditation and the relevance of patient survey results to the accreditation decision could not be verified.

The QPA accreditation \[13\] requires an annual patient survey by means of one of two survey instruments, both structured by contents and method. Either the General Practice Assessment Questionnaire (GPAQ) \[25\] or the Improving Practice Questionnaire (IPQ) \[26\] is to be used as survey instrument. Not the survey results themselves, but their evaluation and implementation into an improvement plan, where applicable, are pertinent for a QPA accreditation. Additionally, ways to involve and cooperate with the patients are to be developed and established. Since all standards of the QPA accreditation represent minimum requirements, all criteria mentioned have to be met.

As part of the AGPAL accreditation \[14\] patient feedback is required for 16 minimum requirements. Here patient opinions are not only collected, but also evaluated and implemented in improvement activities. To collect patient experience data, six options, including guidelines on how to carry each of them out, are demonstrated. The basic options for collecting data on patient experiences are self-completed surveys, telephone surveys, face-to-face interviews, focus groups, practice advisory groups, or suggestion schemes. It is mandatory to use one of the methods, but using two is recommended. Regarding the self-completed surveys, AGPAL provides a questionnaire for collecting the patient experience data, but its use is not mandatory. It is not possible to get an accreditation without complying with the 16 indicators on patient feedback.

For the JCAHO accreditation \[15\], the collection of patient experience data is mandatory in order to monitor the performance of health-care facilities. Neither the method nor the content of the patient survey are predefined. The results of the patient survey are not explicitly pertinent for the accreditation.

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Continued</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Organization</strong></td>
<td><strong>Accreditation</strong></td>
</tr>
<tr>
<td>USA JCAHO [15] Established in 1951</td>
<td>Accreditation criteria and programme developed by JCAHO. Accreditation provided for:</td>
</tr>
<tr>
<td>Members:</td>
<td>• ambulatory care (medical, dental and surgical health-care facilities)</td>
</tr>
<tr>
<td>• representatives of various American associations and networks of several medical professions (physicians, dentists) and health-care sectors (e.g. hospitals)</td>
<td>• behavioural health-care organizations(^a)</td>
</tr>
<tr>
<td></td>
<td>• (critical access) hospitals(^a)</td>
</tr>
<tr>
<td></td>
<td>• home care(^a)</td>
</tr>
<tr>
<td></td>
<td>• laboratory services(^a)</td>
</tr>
<tr>
<td></td>
<td>• long-term care(^a)</td>
</tr>
<tr>
<td>NCQA [16] Established in 1990</td>
<td>Accreditation criteria and programme developed by NCQA. Accreditation provided for:</td>
</tr>
<tr>
<td>Members:</td>
<td>• commercial health plans</td>
</tr>
<tr>
<td>• representatives of</td>
<td>• health plans for Medicare and Medicaid patients(^a)</td>
</tr>
<tr>
<td>• public and private employers</td>
<td>• MCOs(^a)</td>
</tr>
<tr>
<td>• managers of MCOs</td>
<td>• preferred provider organizations(^a)</td>
</tr>
<tr>
<td>• practitioners</td>
<td>• managed behavioural health-care organizations(^a)</td>
</tr>
<tr>
<td>• consumer associations</td>
<td>• disease management programmes(^a)</td>
</tr>
<tr>
<td>• experts in health-care policy and quality assessment</td>
<td>• wellness and health promotion(^a)</td>
</tr>
</tbody>
</table>

STPS, Stiftung Praxisiegel; MCOs, Managed Care Organizations; \(^a\)not studied.
### Table 2 Synthesis of the utilization of patient experience data for the accreditation of medical practices compared internationally

<table>
<thead>
<tr>
<th></th>
<th>STPS</th>
<th>QEP</th>
<th>KTQ</th>
<th>EQUAM</th>
<th>NPA</th>
<th>QPA</th>
<th>AGPAL</th>
<th>JCAHO</th>
<th>NCQA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mandatory patient survey</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>−a</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Use of structured patient survey</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>Patient survey results relevant to accreditation</td>
<td>Nb</td>
<td>Nb</td>
<td>Nb</td>
<td>ns</td>
<td>Nb</td>
<td>Nb</td>
<td>N</td>
<td>N</td>
<td>Y</td>
</tr>
</tbody>
</table>

STPS, Stiftung Praxisiegel; Y, yes; N, no; ns, not specified. aCollection of patient experience data by at least one of six predetermined methods. bThe evaluation of the survey results and a subsequent implementation of improvement activities, if necessary, are pertinent for the accreditation.

As part of the NCQA accreditation [16], it is required that health plan providers submit the results of a structured patient survey. Certain CAHPS questionnaires (Consumer Assessment of Healthcare Providers and System) [24] are used as instruments. The survey results influence the NCQA accreditation decision [19], but the precise emphasis could not be verified.

Table 2 summarizes the international approaches to collecting patient experience data and the relevance of the results to the accreditation of medical practices.

### Synthesis of the patient questionnaires applied

The EUROPEP questionnaire was developed in an international work group from 1995 to 1998 as part of a research project funded by the European Union [21]. This comprehensively validated instrument contains 23 items. There are different versions of the questionnaire for general practices and specialists, respectively; each version is available in different languages.

The GPAQ [25] was developed in 2003 by the University of Manchester [27], contains 18 questions and is available in different languages.

The IPQ [26] was developed by Client-Focused Evaluation Program UK Surveys, an organization, which specializes in development, implementation and evaluation of patient and health-care staff surveys. It comprises 27 items.

The CAHPS questionnaires [24] were developed in 1995 on the initiative of the Agency for Healthcare Research and Quality in a public–private cooperation. Since then the questionnaires have been revised and further developed, currently the third revision is available. The CAHPS questionnaires represent a collection of survey instruments whose respective application is precisely defined regarding age groups and coverage populations. The corresponding adult version for the NCQA accreditation of health plans comprises 59 items.

The GPAQ, IPQ and EUROPEP surveys are conducted in the practices right after a patients’ consultation; however, for the GPAQ there is also a postal version. The CAHPS survey as part of the NCQA Health Plan accreditation can be conducted in a mail-only methodology (three mailed questionnaires) and a mixed mail-telephone methodology (two mailed questionnaires and a telephone follow-up).

Alternative and enhanced protocols can be used but must be pre-approved by NCQA.

All patient surveys are conducted by an independent external vendor approved by the respective accreditation provider. Usually for the consultation methodology, questionnaires are sent to the practices, the filled questionnaires are collected in a sealed box, returned to the vendor for data analysis purposes, and finally, a comprehensive report of survey results may be sent to the practices. However, for the GPAQ survey practices can also analyse the questionnaires on their own, using Excel®/Access® programmes or SPSS®-syntax freely available and provided by the GPAQ developers.

The structured survey instruments used (EUROPEP, GAPQ, IPQ, CAHPS) show commonalities mainly in content. All questionnaires allow the assessment of patients’ experiences both on individual practitioner level and on practice/Health Plan level. The following subject areas are covered consistently:

- Inter-personal aspects (communication and doctor–patient relationship)
- Information, support and care of patients
- Coordination and continuity of care
- Practice organization including accessibility
- Premises and equipment
- Overall satisfaction.

All survey instruments provide text boxes for other comments, praise or criticism. Additionally, information regarding the health status as well as demographics are requested.

For GPAQ and CAHPS, national benchmarks according to the survey results are set. For the EUROPEP survey, practices can individually choose to receive benchmarks either of practices of equal structure and organization (e.g. single practice) or of practices of their own practice network.

### Discussion

The objective of the present study was the comparative analysis of nine international approaches to the collection and integration of patient experience data into the
accreditation of medical practices. The study revealed that structured patient surveys are not always an immanent part of the accreditation programmes. Furthermore, if patient surveys are conducted, the specific survey results for the most part had no or only very limited impact on the ultimate accreditation decision. Consequently, in the practice accreditation programmes studied, patient experience data have so far little effect on the assessment of ambulatory medical care quality.

Quality of medical care has many dimensions and the different stakeholders involved in the process of delivering medical care preferably prioritize different aspects. Therefore, views of all stakeholders involved have to be considered to comprehensively assess medical care quality. In this regard, there is a broad consensus in international literature on the significance of patient experience data for a comprehensive assessment of medical care quality [2–4, 28].

To date patients are considered to be co-producers of health care, thus their active involvement in health-care delivery may possibly result in better processes and outcomes of care [29]. As a precondition, patients have to be well informed to successfully influence the quality of medical care and participate in medical decision-making [29]. Therefore, the call for transparency about the quality of health-care services has become stronger in recent years [30]. The role of patients in the process of health-care delivery has changed, thus the patients’ perspective on quality of health-care delivery has gained in importance. Furthermore, society demands that health-care providers account for their performance and participate in medical decision-making [29]. Therefore, the call for transparency about the quality of health-care services has become stronger in recent years [30], which may also be a reason for the growing interest in patient experience data.

Assessing patients’ views on the delivery of care as a feedback for potentially improving health-care services was introduced in the 1980s [4]. To date, the application of validated instruments and standardized procedures is frequently demanded [3, 4, 29, 30]. The simple recording of patients’ satisfaction and expectations are considered to be insufficient [3, 4, 31]. Rather, the patients’ experiences [3, 4, 31] and the importance that patients attribute to the different health-care aspects [32] are ascertained.

To date, more and more patient-centred aspects get incorporated into accreditation programmes [33]. It is commonly recommended to use validated instruments right after a patients’ consultation [4] to assess patients’ experiences. Our analyses show that, although patient experience data are incorporated in almost all accreditation programmes studied, only five programmes make use of a structured survey with validated instruments. Three of the four questionnaires applied can be completed right after a patients’ consultation. Only in two accreditation programmes do the survey results have any impact on the final accreditation decision. In three programmes, it is not the specific survey results ascertained but the evaluation thereof and a subsequent implementation of improvement activities, which are pertinent for the accreditation.

All in all, patient experience data is so far only seldom utilized with appropriate instruments and largely with no significant effect on the ultimate accreditation [2]. Possible reasons may be a lack of fully validated instruments [4, 29, 30] and of standardized survey procedures [4, 29]. Additionally, due to the multidimensionality of medical care quality, the results of a patient survey cannot easily be attributed to a single practitioner or practice. Some authors claim, that a quality assessment should not be performed against standards, which are at least partly outside the control of practices themselves and this may also include patient satisfaction and experiences [34]. Furthermore, the integration (or non-integration) of patients’ views may also be driven by political or strategic motivation [29].

It could be beneficial for a wider use of patient experience data as part of the accreditation if the evidence for its methods and effects was improved. To date there is, for example, insufficient data on how to obtain constructive patient feedback and to improve the use thereof [4]. Additionally, no association between the accreditation status of a health-care facility and the results of patient surveys could be verified so far [31, 35]. It is possible that the accreditation does not yet record the quality aspects that are especially important to patients, the main users of the health-care system [31].

The methodology used for this study was restrictive in its generic approach. We only gathered information on general attributes of the collection and integration of patient experience data into practice accreditation. An exhaustive comparison of the applied instruments and collection modalities was not undertaken. The data collection was mainly based on literature freely available online, which did possibly not always include the most detailed and up-to-date information. Furthermore, we did not select the accreditation programmes/providers systematically but focused on internationally well-established programmes that were considered to be relevant for improving the accreditation of medical practices in Germany.

All in all, international comparative studies of content and methods of accreditation programmes for medical practices are rare. In our opinion, it is urgent to tackle, for example, the following issues: Which details concerning the patient experience should be included in the accreditation of medical practices and to what extent? Should the results themselves or the subsequent implementation of improvement activities be taken into account? Would there be differences in healthcare quality if the accreditation considered patient experience data in various ways and to differing extents?

**Conclusions**

The collection of patient experience data appears to be an undisputed requirement for a comprehensive quality assessment of medical services. Therefore, integration into the accreditation of medical practices appears to be strongly indicated. Thereby, an accreditation programme that utilizes a structured patient survey with validated methods can be considered as a higher international standard.

There is a critical need for research regarding the specific content of patient surveys as part of the accreditation of
medical practices, regarding the use of the results, i.e. using the specific results themselves or their evaluation and subsequent improvement activities, as well as regarding their relevance to the accreditation decision.

Acknowledgements

The research presented in this article was based on a commissioned work for Stiftung Praxisiegel, Gütersloh, Germany. We thank S. Hennig (Stiftung Praxisiegel) for her thoughtful comments on this manuscript. We also are grateful to W. de Cruppé and P. Hermeling (both Institute for Health Systems Research, Medical School, University Witten/Herdecke, Germany) for providing insightful and helpful comments on an earlier draft of this manuscript.

Funding

The research was funded by Stiftung Praxisiegel e.V., Gütersloh, Germany. The views expressed here are those of the authors and do not necessarily reflect those of Stiftung Praxisiegel.

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