Author's response to reviews

Title: Measuring client experiences in long-term care in The Netherlands: a pilot study with the Consumer Quality Index Long-term Care

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Author's response to reviews: see over
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Dear Editor,

Hereby we submit the revised manuscript ‘Measuring client experiences in long-term care in The Netherlands – a pilot study with the Consumer Quality Index Long-term Care’.

We are grateful for the many helpful suggestions and comments of the reviewers. The manuscript is adjusted accordingly and below you will find point-by-point our response to their concerns. The format of the manuscript is now in line with style of your journal and we added two additional files (see our response to referee 2, point 2). The name of an ethics committee was not documented in the manuscript, while this is not required and does not apply to this type of study in the Netherlands.

Response to the referees:

Referee 1 (Edeltraut Kröger)

The general comments of this reviewer concerned the validation process and the way in which this index was constructed. The referee indicates that more information is needed about the choice of scales/questions and the results of psychometric testing. Our response to these comments is integrated in the feedback on the specific aspects raised by the reviewer (see point 2 and 9).

Introduction
The introduction (Background section) was made more concise / to the point.

Methods
1) “Somatic care”?
The term “somatic care” was used as a counterpart of “psychogeriatric care”, to distinguish the care provided in somatic and psycho-geriatric wards of nursing homes and residential care homes. This distinction is clarified in the Introduction (page 5) and ‘somatic wards’ is now used instead of ‘somatic care’.

2) Focus group/ other means for consensus regarding the choice of items?
There were no focus groups organized for developing the CQ-index Long-term Care. The national Quality Framework for Long-term Care predefined the issues addressed in the CQ-index Long-term Care (see start of Methods section, page 6) and candidate items were selected from already existing and previously validated instruments on long-term care (see page 7). Initially, the input from focus groups was used for developing these instruments (together with information from literature and experts on long-term care). Furthermore, we used findings from a study on developing quality report cards from the consumer’s perspective by means of focus groups and concept mapping. These sources of input from clients are also described on page 7.
Consensus on the selection of items was reached with members of the national Steering Committee Responsible Care (i.e. stakeholders), as is now mentioned on page 7.
3) Survey vendors?
With ‘survey vendors’ we meant the research organizations or companies that were responsible for data collection. The term was changed accordingly.

4) Why not satisfaction?
An argumentation for not measuring satisfaction was added on page 7.

Analyses
5) More detailed information on psychometric testing
Done (see also point 9).

6) Clarify the aims of the analyses referring to the pilot (i.e. paragraphs 2 and 3)
The analyses described refer to the aims and research questions of the pilot study (see last paragraph of the Background). As outlined, the pilot study was not only used for testing the psychometric properties of the instrument, but also to get a first impression of clients’ experiences and opportunities for quality improvement, and to optimize the instruments for further implementation. The second and third paragraphs of the Analyses sub-section (Methods) refer to the extra aims and the research questions 2 and 3. These aims are now more clearly described in the subsequent paragraphs of the Analyses-section (see pages 11 and 12).

7) Clarify last paragraph (starting with ‘Finally, …’)
The last paragraph of the analyses section indeed refers to a method for optimizing the instrument. Meanwhile, this method is standardized for the development of CQ-index questionnaires and described in a Manual (see reference 4: Sixma & Delnoij (eds.), 2007). This paragraph is revised, and the criteria and cut-off scores are now clarified (see text on page 12).

Results
8) Why exclude the 29% of the somatic ward patients?
Please note that only 10% of all residents of somatic wards (i.e. 35% of the 29% excluded), and not 29%, were excluded because of cognitive impairment such as severe problems with concentration or memory and dementia. (Whenever a client has severe psychogeriatric problems, referral to a psychogeriatric ward is indicated.) Apparently, the first sentence of the subparagraph on ‘Interviews with residents’ was not clear and we reformulated it (see page 13). Also, ‘psychogeriatric disorder or dementia’ is now replaced by ‘cognitive impairment’ (page 13) or ‘severe cognitive problems’ (in the paragraph on exclusion criteria, Methods section, page 9) as these formulations are more suitable to describe this pre-defined exclusion criterion.

Nevertheless, the 10% with cognitive impairments is still a substantial part of the population in somatic wards of nursing or residential care homes. But their exclusion has both practical and methodological reasons. First, the cognitively impaired residents were simply not able to participate in the interviews and thus could not contribute to testing the interview questionnaire and assessing clients’ experiences with ‘somatic care’. Secondly, the exclusion of those clients has to do with the choice for one specific research method (i.e. personal interviews) for this setting and homogeneity of the study samples, which benefits comparative research. These comparisons should encompass similar units of analyses – i.e. organizational units that provide similar types of care -, and homogeneous groups of clients. Hence, we strived to increase homogeneity of the samples by excluding certain groups of clients such as clients with severe cognitive problems that (still) resided at somatic wards. Furthermore, the
number of cognitively impaired residents in each somatic ward is too small - and often far below the minimum sample size - to create a substantial sample of representatives to evaluate the care in somatic wards from their point of view. Our study made a basic distinction between residents with (mainly) somatic or psychogeriatric problems, because of the specific care settings and the units of analyses (somatic or psychogeriatric wards). We already mentioned that the various care settings and types of clients demand tailored research methods (see Methods, second paragraph), and we added some reasons for applying the exclusion criteria on page 9 (Methods). But we believe it is not necessary - given the relatively small numbers of clients with cognitive impairments in somatic wards - to report on all of the above-mentioned reasons for excluding those clients from the study.

9. Results of the psychometric tests are missing
The results of psychometric testing are described more extensively in the Results section ‘Scales of the questionnaires’ (see pages 14-15). More details can be found in the original pilot-report that can be downloaded from the NIVEL-website (see reference 12).

10. More critical details for the results relating to the scales of the questionnaires
We now distinguished the reliable and ‘questionable’ scales (see page 15).

11. Evaluation of the pilot: this part could be more concise and shortened
Done.

Discussion
12. First paragraph: add quantitative results and shorten paragraph
Done (see page 19).

13. 2nd paragraph: clarify & unravel ‘response rate’ and ‘general use’
Done (see page 19).

14. Textbox with recommendations for further surveys?
The discussion on the recommendations is now more concise (also to reduce overlap with the Results section), so no text box was needed (see page 20).

15. Add a paragraph comparing CQ-index to other questionnaires
We now discuss other self-report questionnaires and possibilities for comparative research in ‘comparative and future research’ (see pages 19-20).

Referee 2 (Christopher B Forrest)

Methods
Pilot study
1. Provide information on how institutions were selected and recruited for this project
The institutions were recruited through the Dutch organization for care providers (ActiZ, which represents about 90% of the care entrepreneurs) and they all voluntarily participated in the pilot. This information was added to the sub-section Pilot study (see first paragraph, page 9).

Results
2. Provide appendix with all items (wording, response formats, scores/descriptives)
The response format of experience questions is described in the Methods section (see pages 8-9; for Experience questions either a 4-point frequency scale or dichotomous answers) and the exact wordings and descriptives for all 276 items of the three questionnaires can be found in the original pilot-report [in Dutch] that can be downloaded from the NIVEL-website (see reference 12). Furthermore, additional files are added to show all the items included in the revised questionnaires (see Additional file 1: Appendix 2, part II) and the results of assessments in 2007 and 2008 (see Additional file 2).

Methods
3. Add an elaboration on the conceptual framework (how it was developed and underlying theories) in first sub-section of Methods
As the national Quality Framework Responsible Care provided the conceptual basis for this CQ-index, the Methods section now starts with information on this framework (this paragraph was replaced from the Background to the Methods section), and some additional information is provided (see page 6, first paragraph).

4. What qualitative techniques were used in item development?
See also our response to referee 1, point 2. Items were principally based on already existing and validated instruments on experiences with long-term care that were developed with the input from focus groups (see page 7). Although we did not (again) use focus groups to generate items, consumer representatives were closely involved in the selection of items as they were one of the stakeholder-parties that were responsible for the content of the quality framework as a member of the Steering Committee (see page 7). And although we did not include cognitive testing, the appropriateness and validity of items was extensively evaluated in our pilot study with the item analyses (i.e. item non-response and importance ratings) and the experiences of interviewers. Nevertheless, we do agree with the referee(s) that cognitive testing would still be appropriate. Therefore, we added this as a recommendation for future research in the discussion section (see page 20).

5. Mention ‘classical test theory’
The use of classical test theory is now mentioned both in the Methods section and the Discussion section (see pages 11 and 21).

6. Validity of scales cannot be supported without Differential Item Functioning
The analyses conducted were in line with the Manual for developing and testing of CQ-index questionnaires (see reference 4: Sixma and Delnoij, 2007). In the discussion we added the use of item respons analyses and DIF analyses as an option for further validation of the questionnaires (see ‘comparative and future research’, final paragraph, page 20)

7. Can the scales be used outside the Netherlands? (discuss)
This point is now addressed in the discussion section on ‘comparative and future research’ (see page 20).

8. Justify Cronbach’s alpha >0.60
We used 0.6 as a minimum value for alpha, although in classical test theory a minimum of 0.7 is recommended (Nunnally & Bernstein, 1994). But the lenient cut-off of 0.6 is commonly used in exploratory research and we provisionally accepted scales with an alpha between 0.6 and 0.7. This is now explained in the Methods-section (see page 11) and ‘questionable’ scales
are indicated in table 3. Also, future research to evaluate and further improve the instruments is recommended in the Discussion (see page 20).

9. **Justify the criteria used and cut-points for exclusion or modification**
(See also the reply to referee 1, point 7). The criteria and cut-off scores are clarified (see page 12). The choice of criteria is based on the item-analyses earlier described in the Analyses (first paragraph), in line with the general criteria used for optimizing CQ-index instruments (Sixma and Delnoij, 2007). Although the cut-off scores chosen were somewhat arbitrary, they helped to select the ‘worse’ items in this study.

**Referee 3 (Arja Isola)**

1. **Title:** add “a pilot study” or “testing CQ-index”
The title was changed accordingly.

2. **Many lists (p.4); write those lists in text**
The lists are now integrated in text.

3. **Overlap Text – Tables:** put main results in text; details in tables
Done.

4. **Discussion: too long; add sub-headings?**
We shortened the discussion and added sub-headings.

We feel that the comments of the referees contributed to the quality of our manuscript and we hope that the revised version will be accepted for publication in your journal.

Sincerely yours,
on behalf of all authors,

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