Incentivising patient centred coordinated care: challenges and pitfalls

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Incentivising patient centred coordinated care: challenges and pitfalls

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This paper draws upon recent experience in England to reflect upon the challenge of incentivising the collection and use of patient reported information in pay for performance schemes.

Introduction

The last few decades have seen increasing recognition on patient experience and patient centred care. Whilst still somewhat contested, patient centred care incorporates aspects of the patient experience including communication, shared decision making, access to services and integration of care.¹ The NHS in England now conceptualises quality of care as a triumvirate of clinical effectiveness, patient experience and safety.² This has resulted in calls for quality measurement and incentive schemes to be realigned to place a greater focus upon patient reported information.

Specific criticism has been aimed at the GP pay for performance scheme, the Quality and Outcomes Framework (QOF), for its failure to explicitly incorporate measures of patient experience, its focus upon the clinical management of specific conditions, increasing medicalisation and deterioration in the patient experience since the introduction of the new contract in 2004.³⁵

Development of potential new QOF indicators is the responsibility of the National Institute for Health and Care Excellence, through their Indicator Advisory Committee.⁶ This group has accepted the challenge of developing indicators which incorporate patient reported information, but doing this is not without challenges.⁷ This paper will define what is meant by patient reported information and will then explore the measurement and incentive challenges associated with capturing this.

What is patient reported information?
At its simplest, patient reported information (PRI) is that which is gathered directly from patients or their families and carers, either as a narrative or through survey questions. Schlesinger et al. suggest that these data can be organised into four sub-types: patient reported outcome measures, patient experience measures, patient narratives and patient complaints (Figure 1). Whilst not mutually exclusive, this typology will be used to inform the debate as to how these can play a greater role in quality measurement. These different forms of patient feedback present different challenges when seeking to incorporate them into an incentive structure, for using them to differentiate between high and low performers and when determining the changes necessary to improve the patient experience. Feedback which can be quantified probably lends itself most easily to inclusion in an incentive structure.

**Measurement issues**

Utilising patient reported information in financial incentive structures requires a fundamental shift in the importance placed upon such information. Since 2004, the QOF has variously incentivised the collection of patient experience measures, the collection of patient reported outcome measures (PROMs) in people with depression and the outcomes of patient experience measures, although none currently survive. Critical reflection upon the strengths and weaknesses of these indicators is required in order to inform future indicator development.

**Firstly**, consideration needs to be given to defining what is being incentivised: the act of collecting the PRI (process) or achieving a given response (outcome)? Both approaches have been used in QOF in the past and they have their strengths and weaknesses. Incentivising data collection and local survey use was incentivised between 2004-2010 and led to concerns about workload and implementation differences between practices. In 2006, a national GP patient survey was
introduced with the incentive payment being linked to patient responses to two questions about access (Table 1). This led to concerns about fairness on the part of the profession, linked specifically to sample size, indicator reliability and incentive structure. It also revealed professional discomfort with payment being explicitly linked to PRI, which was viewed as outside of the practice control.

Secondly, there are questions of sample size, sampling frame, response rates and ultimately reliability. Reliability is critical for performance measurement as it quantifies the reproducibility of the result and ensures that any observed differences in practice level scores are attributable to real performance differences rather than random error. Indicator reliability receives relatively little discussion in relation to clinical indicators where scores are drawn from the medical record of all eligible patients, but was a critical issue for the profession when survey responses were linked to payment. Analysis at the time suggests that these concerns were largely overstated with less than 3% and 0.5% of practices having fewer than the number of responses required for 90% and 70% reliability. However, the design of the incentive needs to consider how to proceed if minimum sample sizes are not achieved.

Whilst analysis of the GP patient survey identified that in most cases minimum sample sizes were achieved, the overall response rate was low at 38.2%. Similar response rates have been reported in studies seeking to evaluate the feasibility of collecting patient reported outcomes in primary care. Professional concerns about response rates and the representativeness of responders negatively affect the credence they ascribe to the results. They are also suspicious of patient motivations for providing this feedback. The recent proliferation of opportunities for giving feedback in all areas of life also risks inducing ‘survey fatigue’ in potential respondents. When providing solicited feedback, respondents are freely giving of their time and mental energy, resources which patients
(especially those with multi-morbidity) may have in short supply. Therefore, surveys should only address issues which the organisation is willing or able to address.

Thirdly, which measurement instrument should be used and how can the data be collected? There are a plethora of measurement instruments which capture different aspects of PRI ranging from generic PROMs such as EQ-5D to disease specific quality of life measures, PREMs which measure discrete aspects of a consultation such as shared decision making, a more holistic assessment of the experience of care such as the GP Patient Survey or aimed at people with specific conditions.\textsuperscript{16} Therefore the first step is to determine the concept of interest. Patients should be actively engaged in this process to ensure that the focus is upon issues of importance to them and their experience. Available measures addressing these aspects of care can then be reviewed to ensure that they demonstrate appropriate psychometric properties.

Consideration also needs to be given to the impact of multi-morbidity. With an estimated 23\% of the population reporting co-morbidities,\textsuperscript{17} the utility of single disease orientated PROMs and PREMs may be limited in capturing the experiences of these patients, whilst the more generic quality of life measures may not discriminate between practices.\textsuperscript{12} It is questionable whether replacing a disease orientated focus upon clinical management with a disease orientated focus upon outcomes and experiences will yield positive results. New PROMs aimed specifically at those with multi-morbidity are currently in development.\textsuperscript{18}

Fourthly, there are issues of interpretation. These are particularly acute in relation to PROMs and when seeking to incentivise the outcome rather than the data collection process. Within England, PROMs data has been collected pre and post-operatively on patients undergoing hip or knee
replacements, inguinal hernia repair and varicose vein surgery since April 2009. The aim is to demonstrate the health gain accrued to patients as a result of these procedures. However, changes in health status in the context of long-term conditions may be more difficult to interpret at the practice, rather than the individual patient, level.

Incentive issues

Once the constructs of interest and the optimal method for data collection have been determined then it is necessary to consider the size and structure of any incentive. It has been suggested that relative value of any incentives for PRI should be large in relation to incentives for clinical care quality. Studies have reported significant changes in reported patient experience when the incentive has been structured in this way. However, the question of how much larger the incentive needs to be requires further investigation.

Further information is also required as to whether the value of the incentive can outweigh clinician misgivings about the credibility of using PRI for payment purposes. Between 2006 and 2013 GP practices were incentivised to complete an assessment of severity in patients with a new diagnosis of depression, with the intention of this being used to inform discussions with the patient about treatment options. This was valued at 17 points: a valuation shared with blood pressure control in patients with coronary heart disease, cholesterol control in patients with coronary heart disease and achieving an HbA1c ≤59mmol/mol in patients with diabetes. Described at the time as ‘controversial’, the implementation of this indicator was challenging with it being perceived by clinicians as having limited utility, threatening their clinical judgement, distorting of the consultation and prone to gaming. Given the strength of feeling expressed and the admission of recourse to gaming
behaviours it is uncertain as to whether merely increasing the value of the incentive would have resolved or exacerbated acceptability.

New indicators developed by NICE are also subject to a cost-effectiveness evaluation.\textsuperscript{6} This calculation can act as a cap upon the total value of the incentive, due to the fixed nature of incentive funding available. Cost effectiveness is measured using net benefit analysis whereby:

\[
\text{Net benefit} = (\text{monetised health benefit} - \text{delivery cost}) - \text{incentive payment}
\]

Theoretically, the level of the incentive available could be anything up to the point at which there ceases to be a net benefit, but in reality the amount is capped by the need to provide incentives for clinical outcome across a range of different disease domains. It may also be difficult to establish a monetised measure of benefit for PRI to carry out cost effectiveness analysis.

The application, as well as the value, of the incentive affects measure acceptability. Changes to the incentive applied to the results of the GP patient survey between 2008 and 2009 resulted in a loss of revenue for some practices in the absence of any change in performance.\textsuperscript{20} This was viewed as unfair by the profession and contributed to the measure being abandoned in 2011.\textsuperscript{24}

**Making quality improvements**

Ultimately, the collection of any data related to quality should be to pinpoint areas for improvement. Previous research has identified a number of motivators to acting upon patient
experience data including an organisational emphasis upon improving overall performance and the 
patient experience in particular, dedicated resources to support quality improvement, a belief that 
patient experience is integral to high quality care, it being part of pay for performance, public 
reporting and to help retain patients. Barriers include time to focus upon this area of care, costs, 
limited supporting resources and physician resistance to the data.\textsuperscript{25,26} The presentation of the PRI is also important with the following aspects of reporting being identified as helpful: inclusion of 
narrative comments, recommendation of actionable results, ease of interpretation, inclusion of 
benchmarking data and results being reported at the individual clinician level.\textsuperscript{26} Evidence from the 
English GP patient survey suggests that individual clinician variability in reports of patient-doctor 
communication is more likely to be observed in lower performing practices.\textsuperscript{27}

GP patient survey data in England is publically available and comparative data is produced at a 
Clinical Commissioning Group level (https://gp-patient.co.uk/slidepacks/July2016) enabling 
benchmarking and peer comparison. However, this does not include recommendations for change to 
facilitate improvement.

As of April 2015, all GP practices in England are required to have a patient participation group.\textsuperscript{28} 
There is an expectation that these groups will actively participate in the collection of patient 
feedback. These groups offer a potentially untapped resource to help practices understand the lived 
experience behind the quantitative results, thereby aiding quality improvement efforts. Further 
research is required to understand the support these groups need to play an active role in the 
practice and any unintended consequences which may arise from this.

Conclusions
Previous attempts to introduce measures of PRI into the QOF have been controversial and have ultimately failed to garner professional support. Whilst the reason for this is multi-factorial it has been driven by professional concern about the reliability, validity and/or utility of the selected measure, concerns about sampling and sample size, intrusion into the consultation and perceived threats to clinical judgement. Further research is required to understand how to address clinician’s scepticism about PRI measures and the optimal size, structure and value for money of any incentive. Critically though, clinicians and health care organisations need to be provided with feedback in a way which enables them to take action to improve their patients’ experience of care.

**Key Messages:**

The UK has a history of attempting to incentivise the collection and use of patient reported information in general practice with limited success.

Challenges to doing this successfully include how best to structure the incentive, how to address professional concerns about data collection and credibility.

Further research is required to understand how best to present patient reported information to clinicians and patient participation groups so that it can be used to drive improvements in care.

**Contributors and sources:** This article was developed from a paper presented by the authors to the NICE Indicator Advisory Committee in April 2016. RFT, NH and PG have expertise in the development and evaluation of quality indicators for general practice. AC is an experienced Patient and Public Involvement representative in relation to both research programmes and service development. RFT wrote the first draft and all authors contributed to its revision and approved the final version. PG is the guarantor.
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References


Figure 1: Types of patient reported information (PRI)

- Patient reported outcome measures (PROMs)
  e.g. quantified reports of health and functional status. May be generic or disease specific.
- Patient reported experience measures (PREMs)
  e.g. quantified feedback about interactions with clinicians and the health care system
- Patient narratives
  e.g. patients descriptions of their experiences. May be collected opportunistically or systematically.
- Patient complaints
  e.g. formal and informal feedback of problematic outcomes or experiences.
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<th>Time in use</th>
<th>Indicator</th>
<th>Incentive framework</th>
<th>Points value</th>
<th>Payment thresholds</th>
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<td>2006-2008</td>
<td>The percentage who report being able to get an appointment within 48 hours.</td>
<td>Enhanced service</td>
<td>Not applicable</td>
<td>50-90% (50-100% of the incentive payment)</td>
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<td>2006-2008</td>
<td>The percentage of patients who indicated that they were able to advance book an appointment.</td>
<td>Enhanced service</td>
<td>Not applicable</td>
<td>40-90% (40-100% of incentive payment)</td>
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<td>2008-2011</td>
<td>The percentage of patients who, in the appropriate national survey, indicate that they were able to obtain a consultation with a GP (in England) or appropriate health care professional (in Scotland, Wales and NI) within 2 working days (in Wales this will be within 24 hours).</td>
<td>QOF</td>
<td>23.5</td>
<td>70-90% (0-100% of incentive payment)</td>
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<td>2008-2011</td>
<td>The percentage of patients who, in the appropriate national survey, indicate that they were able to book an appointment with a GP more than 2 days ahead.</td>
<td>QOF</td>
<td>35</td>
<td>60-90% (0-100% of incentive payment)</td>
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