The Quality and Outcomes Framework: transparent, transferable, tenable?

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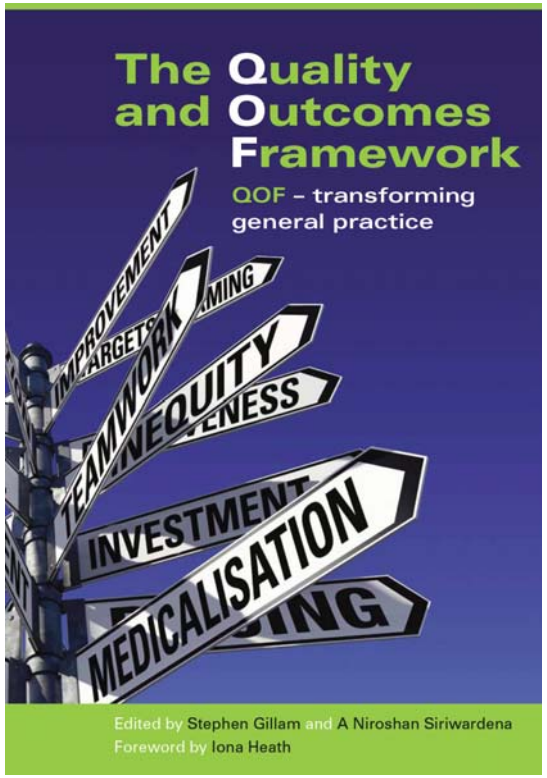
european forum for primary care

Aims

- To provide information to and share information between the members
- Advocacy for Primary Care towards policymakers and politicians
- Support to the development of research and establishment of a research agenda

Overview

- Transparent
- Transferable
- Tenable



Gillam S, Siriwardena AN (eds) *The Quality and Outcomes Framework*, Radcliffe, Oxford 2010

Kings Fund. Improving the quality of care in general practice. 2011. www.kingsfund.org.uk/publications//gp_inquiry_report.html

Background

- Introduced in 2004 in the UK
- >£1billion per annum
- 22% GP income
- Domains: clinical, organisational, patient experience, additional services
- Largest natural experiment in pay for performance (P4P) in the world

QOF domains

- Clinical
  - Secondary prevention of coronary heart disease
  - Cardiovascular disease: primary prevention
  - Heart failure
  - Stroke & TIA
  - Hypertension
  - Diabetes mellitus
  - COPD
  - Epilepsy
  - Hypothyroid
  - Cancer
  - Palliative care
  - Mental health
  - Asthma
  - Dementia
  - Depression
  - Chronic kidney disease
  - Atrial fibrillation
  - Obesity
  - Learning disabilities
  - Smoking

- Organisational
  - Records and information
  - Information for patients
  - Education and training
  - Practice management
  - Medicines management

- Patient experience
  - Length of consultations
  - Patient survey (access)

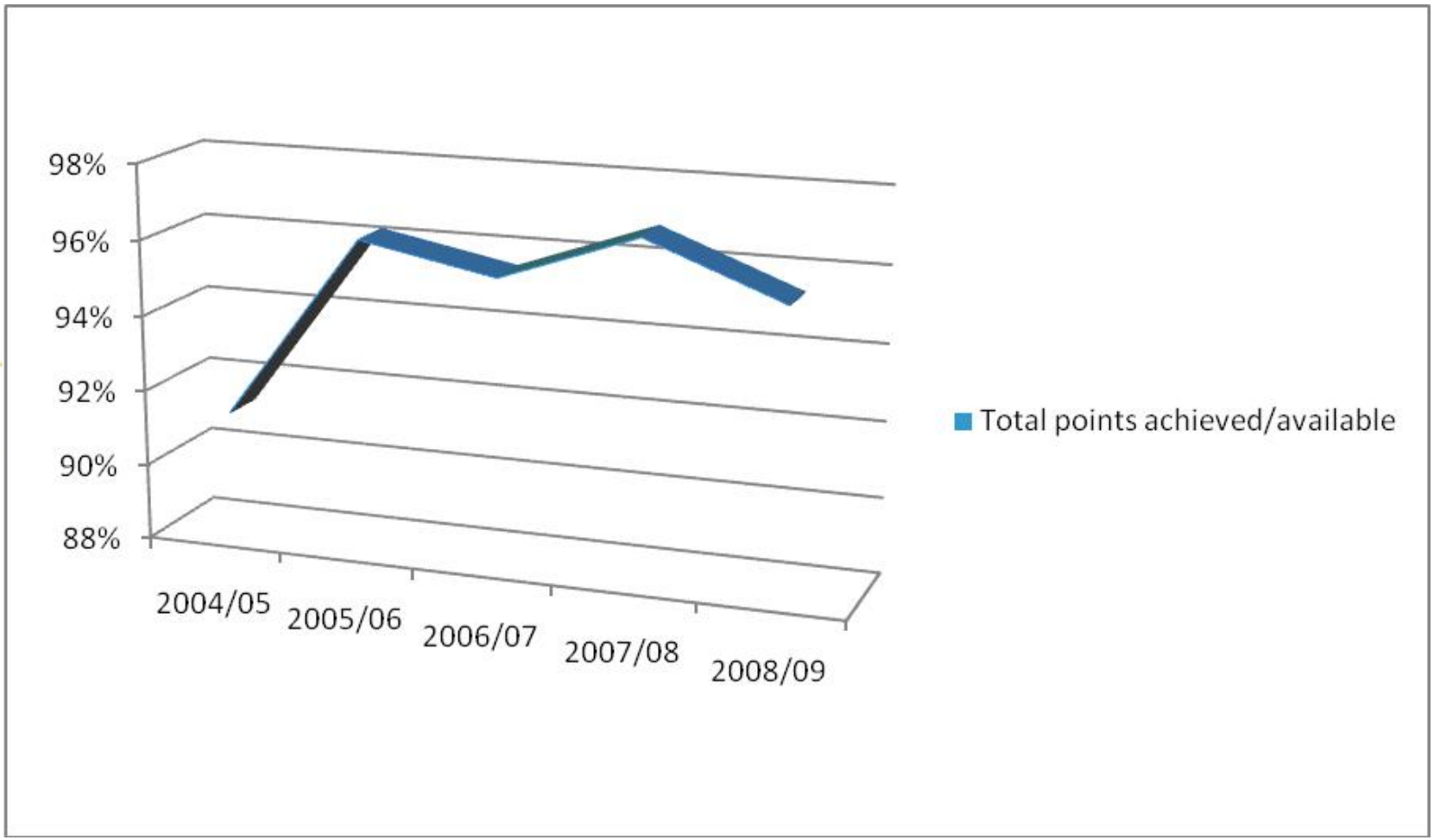
- Additional services
  - Cervical screening
  - Child health surveillance
  - Maternity services
  - Contraception

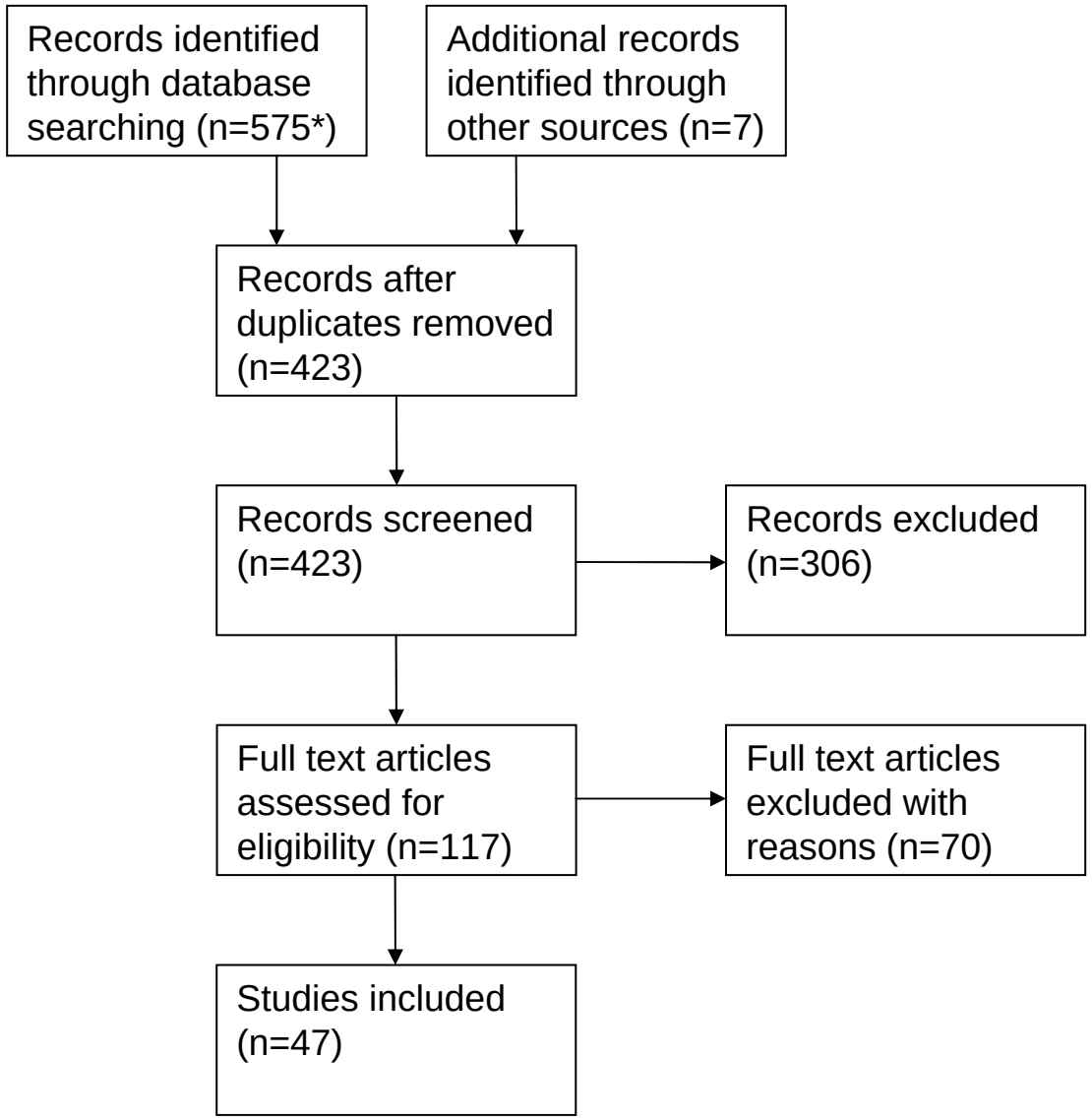
Indicators

Hypertension

Indicator	Points	Payment stages
Records		
BP1. The practice can produce a register of patients with established hypertension	6	
Ongoing management		
BP4. The percentage of patients with hypertension in whom there is a record of the blood pressure in the preceding 9 months	16	40–90%
BP5. The percentage of patients with hypertension in whom the last blood pressure (measured in the preceding 9 months) is 150/90 or less	57	40–70%

QOF scores

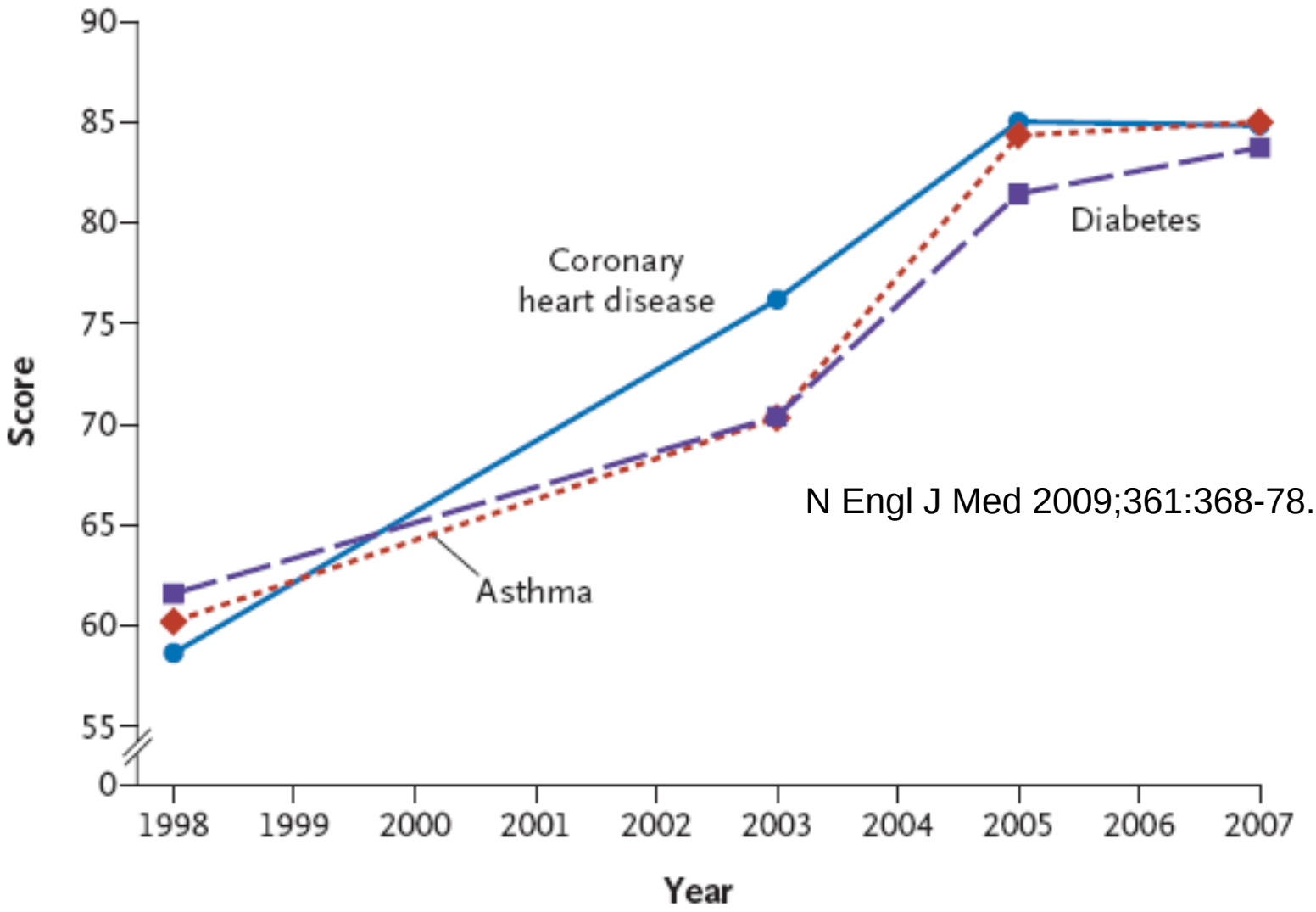

98%
96%
94%
92%
90%
88%
2004/05
2005/06
2006/07
2007/08
2008/09
Total points achieved/available


Records identified through database searching (n=575*)
Additional records identified through other sources (n=7)
Records after duplicates removed (n=423)
Records screened (n=423)
Records excluded (n=306)
Full text articles assessed for eligibility (n=117)
Full text articles excluded with reasons (n=70)
Studies included (n=47)

The contribution of the QOF

- Health care gains
- Population health and equity
- Costs and cost effectiveness
- Providers, teams and organisations
- Patients' experiences and views

Health gains?



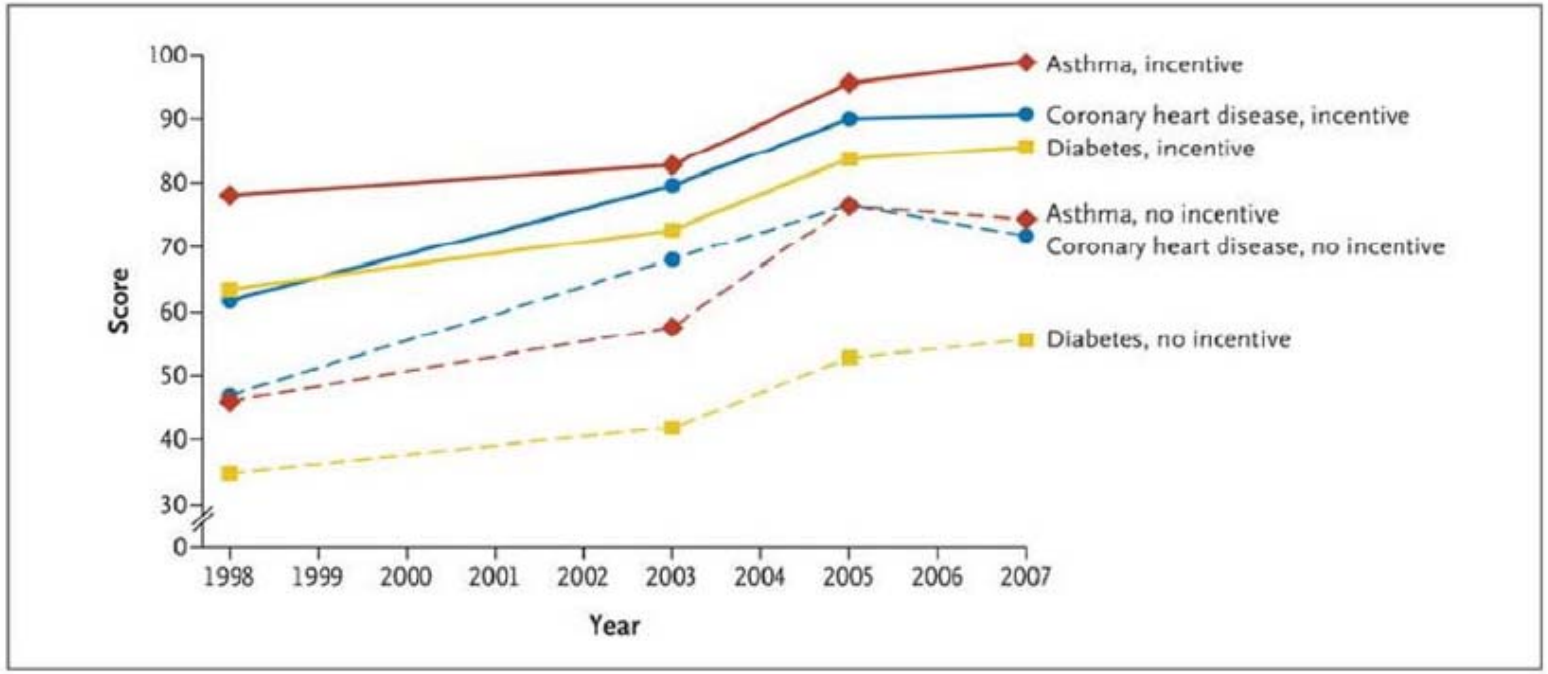
N Engl J Med 2009;361:368-78.

Campbell S. N Engl J Med 2009;361:368-78.

"no significant difference in the rate of improvement between clinical indicators for which financial incentives were provided and those for which they were not provided suggests that the pay-for-performance program may not necessarily have been responsible for the acceleration in improvement"

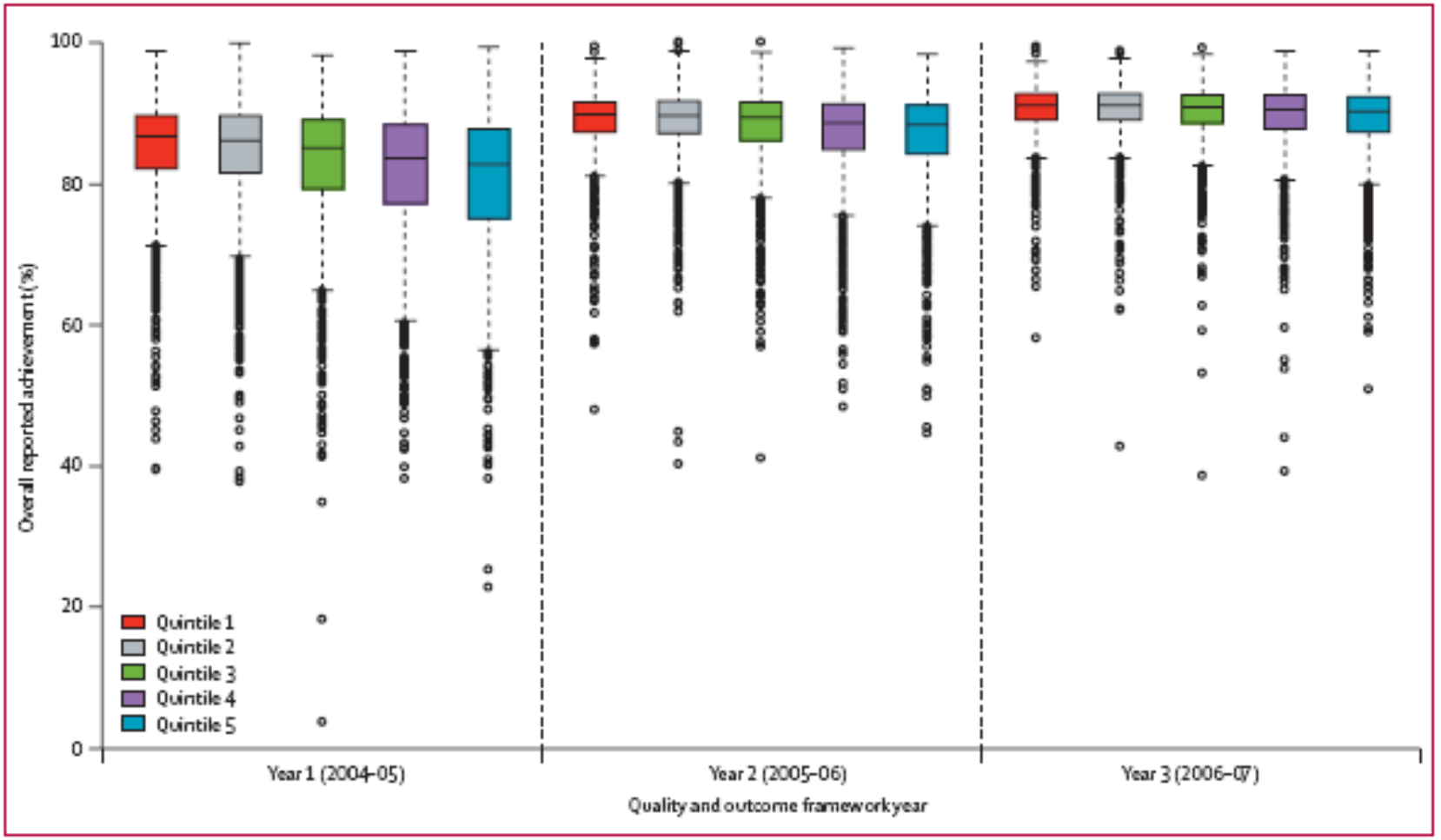
Campbell Quality of Primary Care in England with the Introduction of Pay for Performance NEJM 2007

Incentives vs. no incentives



Campbell S. N Engl J Med 2009;361:368-78.

Population health and equity



Doran Lancet 2008; 372: 728–36

Dixon, Khachatryan & Boyce. The public health impact, In Gillam & Siriwardena (eds) *The Quality and Outcomes Framework*, Radcliffe, Oxford 2010.

Gaming

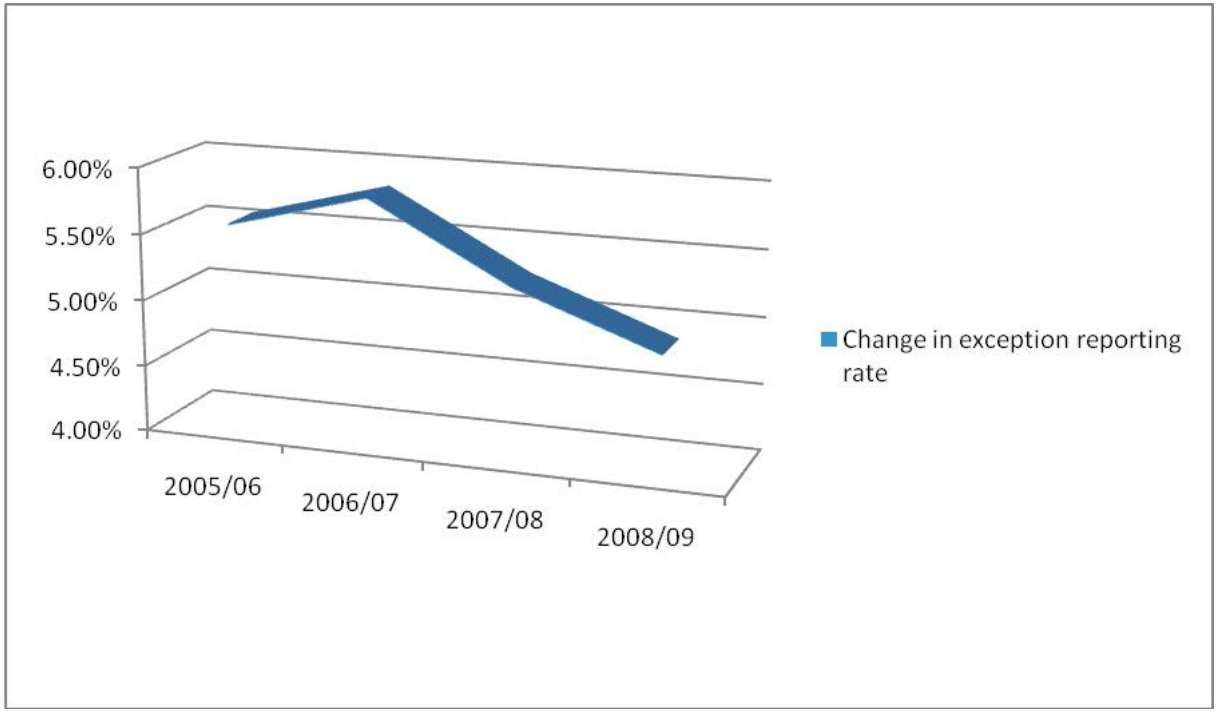
- Threshold effect
- Ratchet effect
- Output distortion

Kordowicz M and Ashworth M Smoke and mirrors? Informatics opportunities and challenges in Gillam S, Siriwardena AN (eds) *The Quality and Outcomes Framework*, Radcliffe, Oxford 2010

Exception reporting

‘We try and stick to the rules, I think occasionally people get exception reported for reasons that, perhaps, they shouldn’t be, but we have very low rates of exception reporting.’

Campbell S: *Br J Gen Pract* 2011, **61:** 183-189.



Kordowicz M and Ashworth M Smoke and mirrors? Informatics opportunities and challenges in Gillam S, Siriwardena AN (eds) *The Quality and Outcomes Framework*, Radcliffe, Oxford 2010

Cost effectiveness

- No relationship between pay and health gain
- Cost effectiveness evidence for 12 indicators in the 2006 revised contract with direct therapeutic effect
- 3 most cost-effective indicators were:
  - ACEI/ARB for CKD
  - Anticoagulants for AF and
  - Beta-blockers for CHD

Fleetcroft R*Br J Gen Pract* 2010, 60: e345-e352.

Practice and organisation

Some patients will come to you and they'll plead with you, 'Please don't give me any tablets, I'll bring my blood pressure down, I'll do everything. I'll bring it down', and again they're not horrendously high, they're like say 140/90 or whatever ... but we're saying to them 'well, look we've checked it three times now and it remains raised, you're clinically classed as hypertensive, we follow these guidelines and this is what we should be doing with you'. (Nurse practitioner)

Every day I come in I check (performance) ... I'm a chaser ... if you're a chaser you have to chase yourself though. 'Cos you've no credibility if you don't deliver.' (GP partner).

Checkland & Harrison. In Gillam & Siriwardena (eds) *The Quality and Outcomes Framework*, Radcliffe, Oxford 2010. Checkland K, *Qual Prim Care* 2010, **18:** 139-146.

Clinical behaviour

‘And there have been 1 or 2 occasions where I went through the cholesterol, the depression, the CHD, and everything else, and “Oh, that’s wonderful, I’m finished now,” and the patient said “Well, what about my foot then?” “What foot”?’ [GP]

I feel actually I’m looking at the patient less than I used to, which is a shame…. I have to say to them, “I’m sorry, I’ve got to look at the computer as well and type in while you’re talking to me” (PN).

Campbell SM. *Ann Fam Med* 2008, **6:** 228-234.

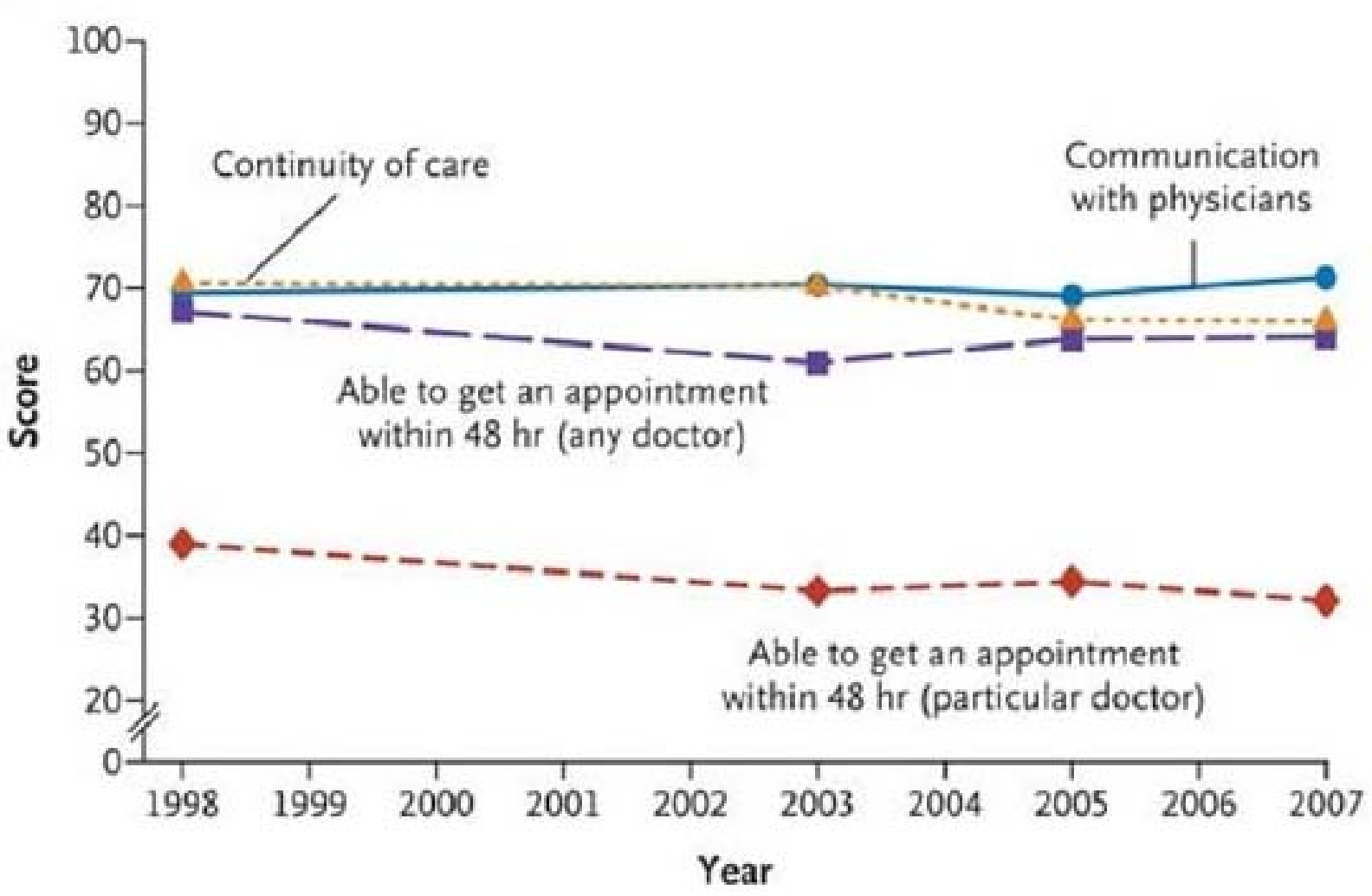
Patient experience

"A slim, active 69-year-old patient attending for influenza vaccine was faced with questions about diet, smoking, exercise and alcohol consumption. There was no explanation for why these questions were asked; they seemed irrelevant to having a 'flu vaccine.'

Blood pressure and weight had to be recorded and a cholesterol test organised. A short appointment lasted almost 15 minutes without the patient having the opportunity to ask a question about any aspect of 'flu vaccine."

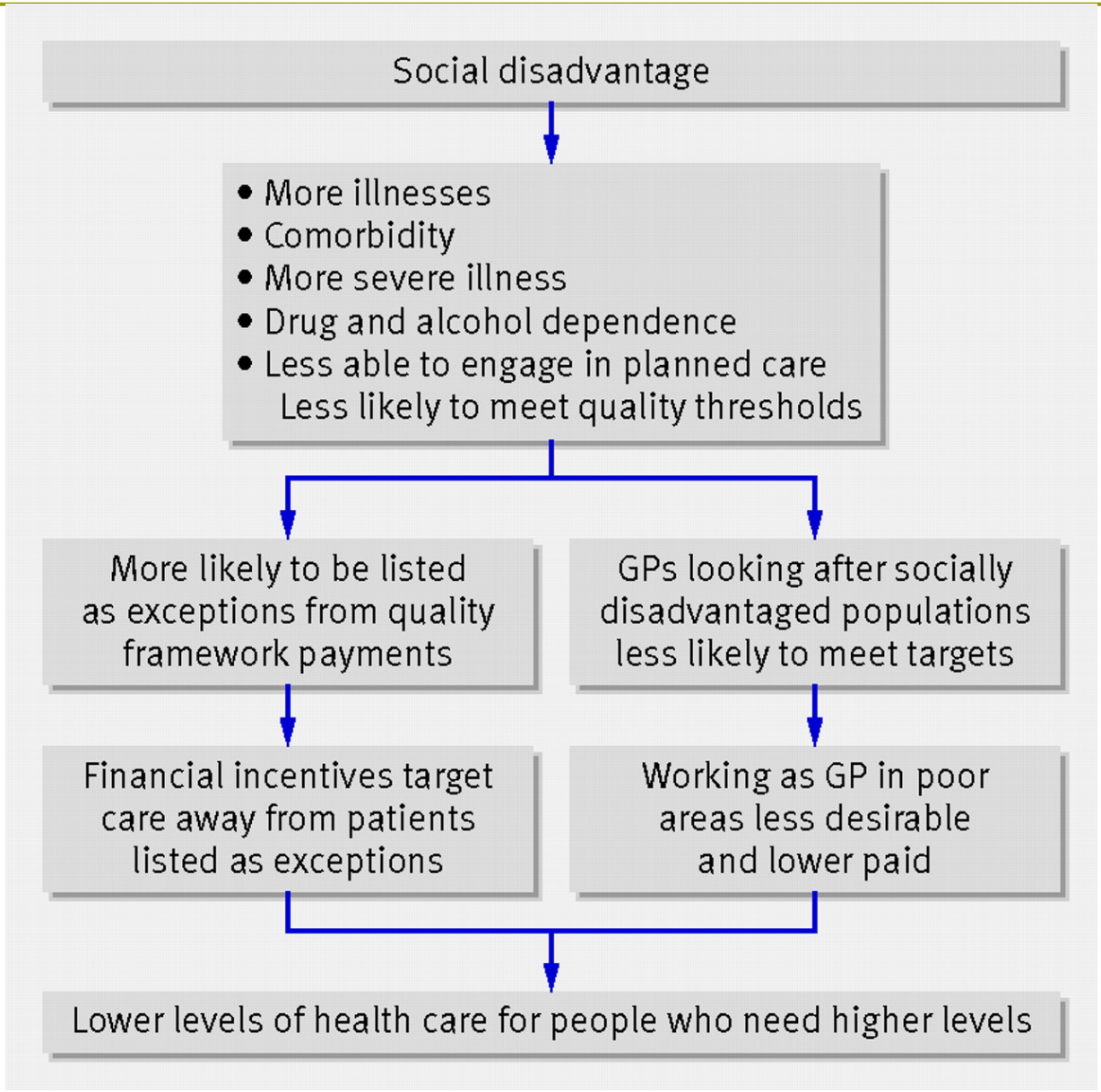
Wilkie. Does the patient always benefit? In Gillam & Siriwardena (eds) *The Quality and Outcomes Framework*, Radcliffe, Oxford 2010

Continuity



Campbell S. N Engl J Med 2009;361:368-78.

Inverse care law



Heath, I. et al. BMJ 2007;335:1075-1076

"That any sane nation, having observed that you could provide for the supply of bread by giving bakers a pecuniary interest in baking for you, should go on to give a surgeon a pecuniary interest in cutting off your leg, is enough to make one despair ..." George Bernard Shaw

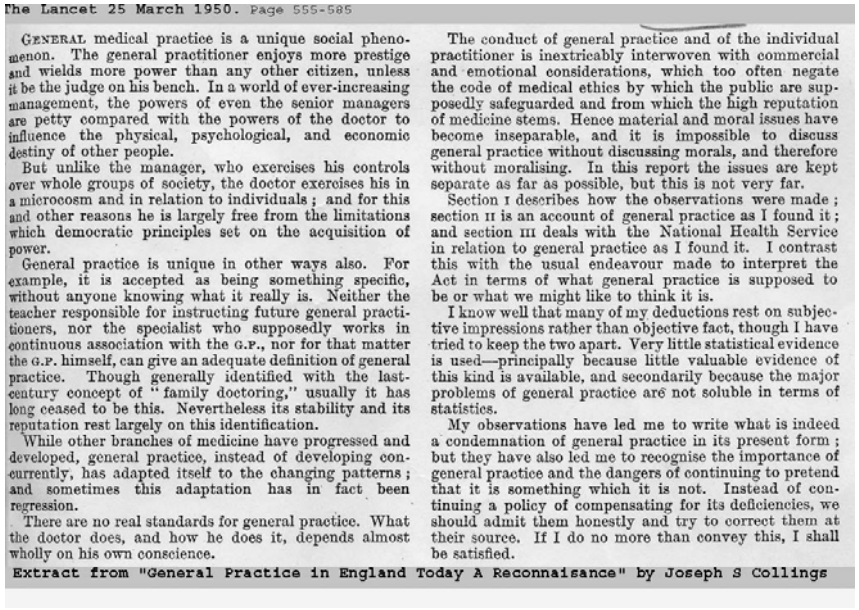
Successes and failures

- Improved processes, data and analysis
- Initial health benefits for individuals and populations
- Some narrowing of inequalities in processes of health care
- Opportunity costs contested
- Unintended consequences
- Negative effect on care

Starfield & Mangin. An international perspective on the basis of P4P. In Gillam & Siriwardena (eds) *The Quality and Outcomes Framework*, Radcliffe, Oxford 2010

Quality then…

- "The overall state of general practice is bad and still deteriorating“
- "The development of other medical services … has resulted … in wide departure from both the idea and the ideal of family doctoring“
- "Some [working conditions] are bad enough to require condemnation in the public interest"



The Lancet 25 March 1950. Page 555-585

GENERAL medical practice is a unique social phenomenon. The general practitioner enjoys more prestige and wields more power than any other citizen, unless it be the judge on his bench. In a world of ever-increasing management, the powers of even the senior managers are petty compared with the powers of the doctor to influence the physical, psychological, and economic destiny of other people.

But unlike the manager, who exercises his controls over whole groups of society, the doctor exercises his in a microcosm and in relation to individuals; and for this and other reasons he is largely free from the limitations which democratic principles set on the acquisition of power.

General practice is unique in other ways also. For example, it is accepted as being something specific, without anyone knowing what it really is. Neither the teacher responsible for instructing future general practitioners, nor the specialist who supposedly works in continuous association with the G.P., nor for that matter the G.P. himself, can give an adequate definition of general practice. Though generally identified with the last-century concept of "family doctoring," usually it has long ceased to be this. Nevertheless its stability and its reputation rest largely on this identification.

While other branches of medicine have progressed and developed, general practice, instead of developing concurrently, has adapted itself to the changing patterns; and sometimes this adaptation has in fact been regression.

There are no real standards for general practice. What the doctor does, and how he does it, depends almost wholly on his own conscience.

The conduct of general practice and of the individual practitioner is inextricably interwoven with commercial and emotional considerations, which too often negate the code of medical ethics by which the public are supposedly safeguarded and from which the high reputation of medicine stems. Hence material and moral issues have become inseparable, and it is impossible to discuss general practice without discussing morals, and therefore without moralising. In this report the issues are kept separate as far as possible, but this is not very far.

Section I describes how the observations were made; section II is an account of general practice as I found it; and section III deals with the National Health Service in relation to general practice as I found it. I contrast this with the usual endeavour made to interpret the Act in terms of what general practice is supposed to be or what we might like to think it is.

I know well that many of my deductions rest on subjective impressions rather than objective fact, though I have tried to keep the two apart. Very little statistical evidence is used—principally because little valuable evidence of this kind is available, and secondarily because the major problems of general practice are not soluble in terms of statistics.

My observations have led me to write what is indeed a condemnation of general practice in its present form; but they have also led me to recognise the importance of general practice and the dangers of continuing to pretend that it is something which it is not. Instead of continuing a policy of compensating for its deficiencies, we should admit them honestly and try to correct them at their source. If I do no more than convey this, I shall be satisfied.

Extract from "General Practice in England Today A Reconnaisance" by Joseph S Collings

Now…

- Quality of most care in general practice is good
- Wide variations in performance and gaps in the quality of care both within and between practices
- Many working in general practice are not aware of variations, gaps and the significant opportunities for general practice to improve the quality of care it provides.

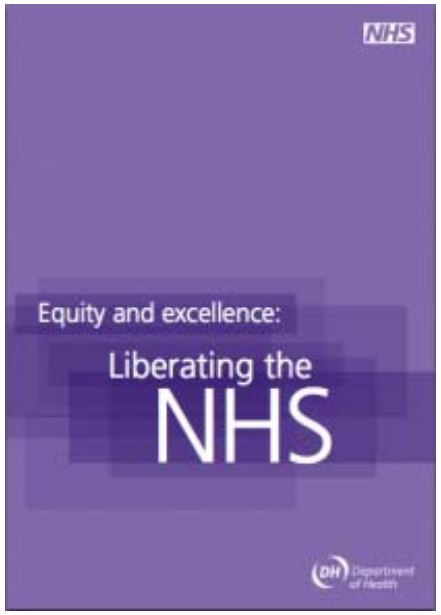
Kings Fund. Improving the quality of care in general practice. 2011.
www.kingsfund.org.uk/publications//gp_inquiry_report.html

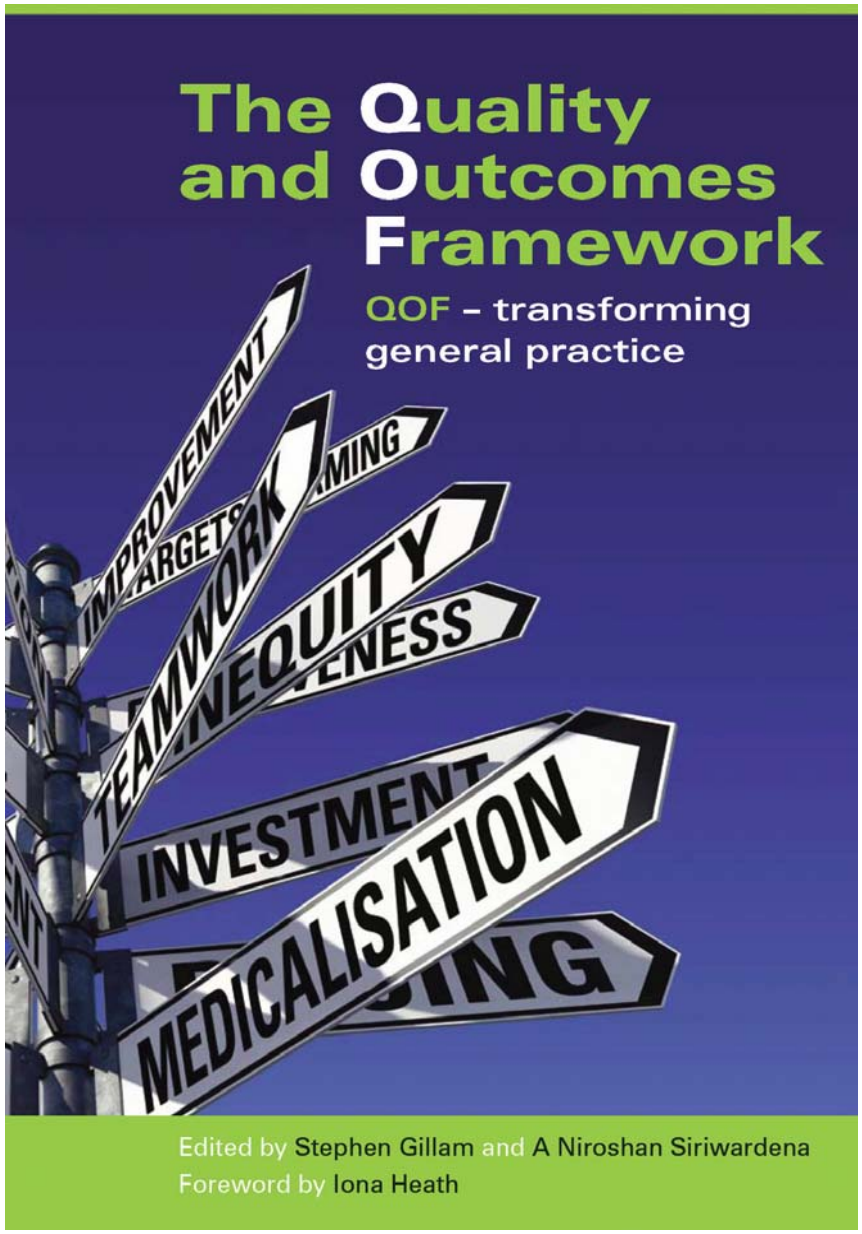
'What do "targets" accomplish? Nothing.
Wrong: their accomplishment is negative.‘

'Management by numerical goal is an attempt to manage without knowledge of what to do'.

W Edwards Deming 1900-1993

Conclusions and ways forward





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