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Incentivising patient centred coordinated care: learning from experience

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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 of 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 With the conceptualisation of quality of care as a triumvirate of clinical effectiveness, patient experience and safety² there have been calls internationally for measurement and incentive structures to be realigned to place a greater focus upon patient reported information. Existing pay for performance schemes such as the Quality and Outcomes Framework (QOF) in England, have been criticised for their overt focus upon clinical management and associated with a deterioration in the patient experience.³⁻⁵ However, whilst the shortcomings of current incentives may be easily identified, incorporating measures utilising patient reported information is not without challenges.⁶

Here we define what is meant by patient reported information and will then explore the measurement and incentive challenges associated with capturing this through pay for performance (P4P) schemes.

What is patient reported information?

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.⁷ suggest that PRI can be organised into four sub-types: patient reported outcome measures (PROMs) which measure the

outcome or effects or care, patient experience measures (PREMs) which measure processes or experience of care, patient narratives and patient complaints (Figure 1). Whilst these sub-types are not mutually exclusive, this typology will be used to inform the debate as to how PRI can play a greater role in quality measurement. These differing forms of patient feedback present different challenges when seeking to incorporate them into an incentive structure, to differentiate between high and low performers or to inform quality improvement efforts. Feedback which can be quantified lends itself most easily to inclusion in an incentive structure as responses are standardised, enable direct comparison between providers and can be given a financial value; although, it may offer a limited understanding of the patient experience.⁸

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 PREMs, the collection of 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. Data collection and local survey use was incentivised between 2004-2010 leading to concerns about workload and implementation differences between practices.⁹ In 2006, a national GP patient survey was introduced with the incentive payment linked to 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.¹⁰ 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.¹¹ Indicator reliability receives relatively little discussion in relation to measures of clinical care in the UK, 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.¹⁰ However, the combination of low (38.2%) and variable response rates (<20% for some practices) negatively affected health care professional confidence in the results. Healthcare professionals are also suspicious of patient motivations for providing this feedback.^{12,13} Maintaining adequate response rates may also be challenging in the face of 'survey fatigue' in potential respondents, which is exacerbated through the use of poorly constructed and implemented measures, such as the Friends and Family Test^{14,15} and incentive design needs to consider how to proceed if minimum samples are not achieved.

Thirdly, which measurement instrument should be used and how can data be collected? The first step is to determine the concept of interest and review the psychometric properties of available measures. Patients should be actively engaged in this process to ensure that the focus is upon issues of importance to them and their experience. Despite the plethora of available instruments to capture PRI these have not always been developed or extensively tested with patients,¹⁶ and as a

result potentially fail to address issues of importance. Valid and reliable measures of some critical concepts, such as coordination, remain elusive despite international research efforts.¹⁷

Consideration also needs to be given to the impact of multi-morbidity. With an estimated 23% of the population reporting co-morbidities,¹⁸ 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 providers.¹⁹ 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.²⁰

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 2009.²¹ The aim is to demonstrate the health gain accrued as a result of these procedures. However, interpreting changes in health status in the context of long-term conditions and crucially, attributing these changes to primary care providers is more difficult, with the net result being that these scores cannot be used to make meaningful comparisons of quality or outcomes of care between practices.²² This conclusion may change if PROMs are incorporated into routine practice in primary care and used to guide clinical decision-making.²³

Incentive issues

Once measurement issues have been addressed then it is necessary to consider the size and structure of any incentive. It has been suggested that the relative value of any incentives for PRI should be large in relation to incentives for clinical care quality.⁷ Studies have reported significant changes in reported patient experience when the incentive has been structured in this way.^{24,25} However, the question of how much larger the incentive needs to be requires further investigation.

Experience from the UK challenges the implicit assumption within this suggestion that professional reticence about the use of PRI for payment purposes can be 'bought out'. Between 2006 and 2013 GP practices in the UK were incentivised to complete assessments of severity in patients with a new diagnosis of depression, with the intention of the result informing discussions about treatment options.²⁶ This care was incentivised at approximately £2,118GBP for an average sized practice: a valuation shared with key clinical intermediate outcome indicators such as blood pressure control in patients with coronary heart disease, and glycaemic control (HbA1c \leq 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.²⁷ Given the strength of feeling expressed, and the admission of gaming behaviours, it is uncertain as to whether merely increasing the value of the incentive would have resolved or exacerbated acceptability.

Commitments to cost-effectiveness as seen in England not only cap the total value of the incentive,²⁸ but also require methods of monetising the benefit of PRI. Cost effectiveness is measured using net benefit analysis whereby:

Net benefit = (monetised health benefit – delivery cost) – 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 desire to provide incentives across a range of disease domains.

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.¹⁰ This was viewed as unfair by the profession and contributed to the measure being removed from the incentive framework in 2011.²²

However, whilst the technical aspects of incentive design and implementation are obviously complex, concentration on these can mask the more important question of whether care should be incentivised at all. Whilst full consideration of this is beyond the scope of this paper, evidence suggests that the impact of incentives on clinical care is modest with an associated uncertain but sometimes negative impact upon clinician behaviours and motivation.²⁹⁻³¹ Patients themselves are unconvinced of the utility of incentives.^{32,33}

Making quality improvements

Ultimately, the collection of PRI should be to pinpoint areas for improvement. Financial incentives risk creating a 'high stakes' environment in which debate becomes focused upon the performance of selected metrics, rather than how patient feedback, both survey results and patient narratives, can be used to improve care.

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.^{34,35} Barriers include time to focus upon this area of care, costs, limited supporting resources and physician resistance to the data.^{34,35} 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 reported at the individual clinician level; where individual variability may be masked by the organisational score.^{35,36}

In England, legislation and guidance seeks to strengthen the patient voice.³⁷ The current contractual requirement for all GP practices to have a patient participation group (PPG) forms part of this organisational culture change. Whilst this is the latest attempt to encourage practices to engage patients in discussions about their experiences, and previous attempts have ultimately been of limited impact,³⁸ a critical difference is that this is now a prerequisite of service rather than an optional extra.

Whilst mandating PPGs makes a policy statement, further support is required to ensure their effectiveness. Quality improvement relies heavily upon feedback, learning from the best and working in collaboration.³⁹ New care models being explored in England, such as Multi-Speciality Community Providers (MCPs), offer the potential to embed a shared approach to quality improvement in healthcare through a supportive culture, based upon a shared aim to improve care which exploits intrinsic professional motivation, supported by confidential sharing of clinical data

and patient feedback accompanied by recommendations for change. Projects such as the Robert Wood Johnson Foundation Aligning Forces for Quality study could offer useful lessons in how this could be achieved.⁴⁰

Conclusions

Previous attempts to introduce measures of PRI into P4P in the UK 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. The UK experience offers lessons for international colleagues considering such incentives. Critically though, the quest for optimal incentive design should not distract policy makers, clinicians and health care organisations from their moral imperative to deliver patient focused quality improvements.

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 of results.

Using patient reported information requires organisational commitment and practical support: without this, the impact of incentives is likely to be disappointing.

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