Exempting dissenting patients from pay for performance schemes
retrospective analysis of exception reporting in the UK Quality and Outcomes Framework

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Kontopantelis, Reeves Exception reporting under QOF
Glasgow, 3 Oct 2012

Outline

1 Background
2 Methods
3 Results
4 Summary
A P4P program kicked off in April 2004 with the introduction of a new GP contract
- General practices are rewarded for achieving a set of quality targets for patients with chronic conditions
- The aim was to increase overall quality of care and to reduce variation in quality between practices
- The incentive scheme for payment of GPs was named Quality and Outcomes Framework (QOF)
- Initial investment estimated at £1.8 bn for 3 years (increasing GP income by up to 25%)
- QOF is reviewed at least every two years

Domains and indicators in year 1 (year 5):
- Clinical care for 10 (19) chronic diseases, with 76 (80) indicators
- Organisation of care, with 56 (36) indicators
- Additional services, with 10 (8) indicators
- Patient experience, with 4 (5) indicators

Implemented simultaneously in all practices (a control group was out of the question)
Practices are allowed to exclude patients from the indicators and the payment calculations
Into the 9th year now (01Mar12/31Apr13); cost for the first 8 years was well above the estimate at ≈£8 bn
Some of the indicators for diabetic patients
Percentage of diabetics...

- with a record of HbA1c in previous 15 months (3p)
- in whom last HbA1c is ≤7.4 in previous 15m (16p)
- who have a record of BP in the past 15m (3p)
- in whom the last BP is ≤145/85 (17p)
- with a rec of serum creatinine testing in previous 15m (3p)
- who have a record of total cholesterol in previous 15m (3p)
- whose last measured total cholesterol in previous 15m is ≤5mmol/l (6p)
- who have had influenza immunisation in the preceding 1Sep-31Mar (3p)

Exception reporting

- For each indicator practices are permitted to remove inappropriate patients from achievement calculations
- The process is known as ‘exception reporting’ (ER) and reasons are:
  - logistical
  - clinical - contraindication or intolerance
  - clinical - patient unsuitable
  - informed dissent
- In place to protect patients from coercion or refusal of care
- Principal drawback is that it allows practices to receive maximum remuneration without necessarily providing the required care for all eligible patients
Exception reporting reasons

- **Logistical**
  - Patient has recently received a diagnosis or recently registered with the practice
  - A specified investigative service is unavailable to the practice

- **Clinical - contraindication or intolerance**
  - Patient has had an allergic or other adverse reaction to a specified drug or has another contraindication to the drug
  - Patient has not tolerated the drug
  - Patient is taking the maximal tolerated dose of a drug, but the levels remain suboptimal

- **Clinical - patient unsuitable**
  - The indicator is judged inappropriate for the patient because of particular circumstances, such as terminal illness or extreme frailty
  - Patient has a supervening condition that makes the specified treatment clinically inappropriate
  - Patient has received at least three invitations for a review during the preceding 12 months but has not attended

- **Informed dissent**
  - Patient refuses to be reviewed
  - Patient does not agree to a specific investigation or treatment

- **Not all reasons are available for every indicator e.g. no contraindication option for measurement indicators**
To examine the reasons why practices exempt patients from the UK Quality and Outcomes Framework

To identify the characteristics of general practices associated with informed dissent

In 2008/9 (year 5), 62 clinical activity indicators across 15 clinical areas, for which exceptions applied

Data from the QMAS system on 8,229 English practices

Data on practice and patient characteristics from the ONS and the GMS database

Informed dissent could be accurately measured only for 37 of the 62 indicators (measurement and outcome only)
For each practice and clinical indicator we calculated the rate of exception reporting:

\[ ER_i = \frac{E_i}{(E_i + D_i)} \]

- \( E_i \), number of patients exception reported for that indicator
- \( D_i \), number of patients meeting the criteria for the indicator and not excepted by the practice

- Calculated overall rates and separately for each of the main reasons
- Focused on overall scores and informed dissent
- Multilevel multiple linear regression used to identify practice & population predictors of exception reporting
- Estimated average financial gain from exception reporting

In 2008/9 the median exception reporting rate across all 62 clinical indicators was 4.5% (IQR: 3.4-5.8%)

- Median rates for individual indicators ranged from 0.0% (for seven indicators) to 24.4% (CHD 10: \( \beta \) blocker therapy for patients with coronary heart disease)
- Median rates were generally lower for measurement indicators (2.4%) than for treatment (10.0%) and intermediate outcomes indicators (5.7%)
- For the 37 indicators for which reasons of ER were ascribable, median overall exception rate was 2.7% (IQR: 1.9-3.9%)
Rates of informed dissent exception reporting
37 indicators

- Median rate was 0.44% (IQR: 0.14-1.1%)
- 10% of practices excepted over 2.2% of patients for informed dissent and 1% of practices excepted over 5.7%
- Median rates for individual indicators ranged from 0.0% (25 ind) to 1.2% (DM20, HbA1C control ≤ 7.5%)

<table>
<thead>
<tr>
<th>Reason for exception report</th>
<th>Measurement</th>
<th>Intermediate outcome</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unknown*</td>
<td>3.5</td>
<td>2.2</td>
<td>2.9</td>
</tr>
<tr>
<td>Logistical</td>
<td>35.9</td>
<td>45.9</td>
<td>40.6</td>
</tr>
<tr>
<td>Clinical—contraindication</td>
<td>0.0</td>
<td>16.2</td>
<td>7.6</td>
</tr>
<tr>
<td>Clinical—patient unsuitable</td>
<td>23.1</td>
<td>13.8</td>
<td>18.7</td>
</tr>
<tr>
<td>Informed dissent</td>
<td>37.4</td>
<td>21.9</td>
<td>30.1</td>
</tr>
<tr>
<td>Total No of exceptions</td>
<td>1 158 735</td>
<td>1 026 076</td>
<td>2 184 811</td>
</tr>
</tbody>
</table>

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Exception reporting under QOF

Rates of informed dissent exception reporting
37 indicators

CONCLUSIONS:

[Add text here.]

For additional information please contact:

[Institution or organization]

[Department]

[Name]
Factors associated with exception reporting

<table>
<thead>
<tr>
<th>Variable</th>
<th>All exceptions</th>
<th>Informed dissent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coefficient</td>
<td>P value</td>
<td>95% CI</td>
</tr>
<tr>
<td>Indicator characteristics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Upper payment threshold (per 1% increases)</td>
<td>-0.09</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Indicator type (intermediate outcome)</td>
<td>-0.05</td>
<td>0.321</td>
</tr>
<tr>
<td>Maximum points/remuneration available</td>
<td>0.11</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>No of eligible patients (per 100 increase in disease register size)</td>
<td>-0.03</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Practice characteristics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum points scored in previous year (2007/08)</td>
<td>-2.20</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>% of doctors aged (≥55)</td>
<td>-0.01</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>% of women doctors</td>
<td>0.00</td>
<td>0.244</td>
</tr>
<tr>
<td>Personal/Medical Services contract</td>
<td>0.17</td>
<td>0.004</td>
</tr>
<tr>
<td>No of patients (per 1000 increase in list size)</td>
<td>0.28</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Patient and area characteristics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of patients aged (≥65)</td>
<td>0.03</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>% of female patients</td>
<td>0.00</td>
<td>0.967</td>
</tr>
<tr>
<td>% of patients from ethnic minority group</td>
<td>-0.00</td>
<td>0.197</td>
</tr>
<tr>
<td>Population density in locality</td>
<td>0.00</td>
<td>0.176</td>
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<tr>
<td>Material deprivation in locality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1st fourth (most affluent)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2nd fourth</td>
<td>0.13</td>
<td>0.002</td>
</tr>
<tr>
<td>3rd fourth</td>
<td>0.44</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>4th fourth (most deprived)</td>
<td>0.69</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

Most influential factor was previous performance on the scheme

Factors associated with higher levels of informed dissent exceptions were broadly comparable with those for overall exceptions.
Overall, 5.4% of clinical points scored by practices were attributable to exception reporting
- This equates to about £30,844,500 for all English practices
  - £3,834 for the average practice (£3,586-£4,093)
  - £0.58 per patient
- Cost varied widely by indicator, from £1,630 for DM11 (BP recording for DM) to £4.5m for DEP2 (assessing depression severity)
- DEP2 and MH9 (reviewing physical & social care for people with psychotic illness), accounted for £8.4m; over a quarter of the total cost associated with exception reporting

4.9% of remuneration received was attributable to overall exception reporting
- This equates to about £19,188,917 for all English practices
  - £2,386 for the average practice
  - £0.36 per patient
- The gain attributable to informed dissent exceptions was £2,406,500 nationally
  - £300 for the average practice (£244-£351)
  - £0.05 per patient
- Cost of informed dissent exceptions was relatively low since most applied to measurement indicators, which attract less remuneration
Conclusions

- Respecting a patient's decision to refuse an investigation or treatment, even if considered wrong or irrational by the attending clinician, is central to medical professionalism.
- We found that rates of informed dissent in QOF are low, with little variation across the spectrum of deprivation.
- This suggests that activities incentivised in the scheme are broadly acceptable to patients.
- Thousands of patients expressed their wish not to receive interventions under the framework.
- At relatively low cost, the provision to exception report enables patients’ voices to be heard and counters some of the critiques of the scheme.


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