Pay-off for patients of person-specific data

A Public Health Perspective

Adrian Phillips

A Public Health Perspective

- Improving the health of the population
- Reducing inequalities in health within a population
- Improving quality and governance
- Maximising benefits – direct and indirect

Cochrane (1)

I once asked a worker at a crematorium, who had a curiously contented look on his face, what he found so satisfying about his job. He replied that what fascinated him was the way in which so much went in and so little came out. I thought of advising him to get a job in the NHS, it might have increased his job satisfaction, but decided against it. He probably got his kicks from a visual demonstration of the gap between input and output.

Cochrane (2)

An investigation into the working of the clinical sector of the NHS strongly suggests that the simplest explanation of the findings is that this sector is subject to a severe inflation with the output rising much less slowly than would be expected from the input.

New Opportunities

- Explosion in evidence-base for many conditions
- IM&T developments
- Participation by people in their own health
- Shift to disease management
- GMS 2 contract – QOF (and others)
- "New genetics"

QUALITY & OUTCOMES FRAMEWORK

"A bold initiative to improve quality of care"

"With one mighty leap, the NHS vaults over anything being attempted in the United States, the previous leader in quality improvement initiatives"

- *Paul Shekelle, Professor of Medicine, University of California, Los Angeles*

Quality Outcomes Framework

- Focus on quality and outcomes
- Payment by results
- Back to clinical basics
- Standardised processes, systematic recording
- Areas of real health gain
- Engagement of patients

QOF - Balance of 1000 points

Clinical	550
Organisational	184
Additional Services	36
Patient Experience	100
Holistic Care	100
Quality Practice Payment	30

Points = Prizes

eparatory Payments – 03/04, 04/05

- £9000, £3250 per average practice

LUS

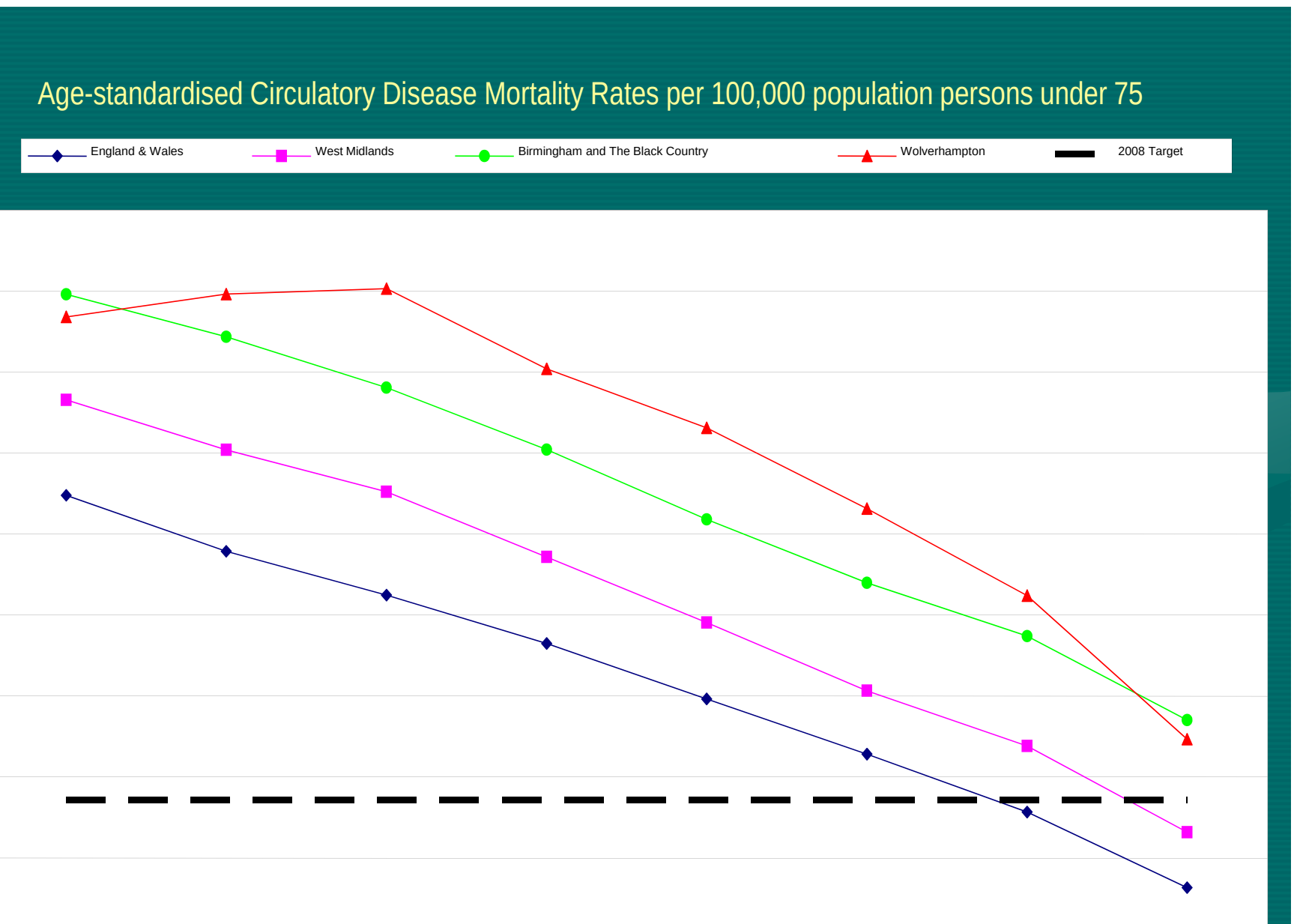
04-5 1 Point = £75

05-6 1 Point = £120 (max. £126,000)

Clinical Areas

CHD and LVD	121
Hypertension	105
Diabetes Mellitus	99
Asthma	72
COPD	45
Mental health	41
Stroke or TIA	31
Epilepsy	16
Cancer	12
Hypothyroidism	8

Age-standardised Circulatory Disease Mortality Rates per 100,000 population persons under 75



QUALITY INDICATORS
CORONARY HEART DISEASE (1)

icator	Points	Min-Max Threshold
Practice produce a register of patients with CHD	6	
% of patients with newly diagnosed angina agnosed after 01/04/03) who are referred for rcise testing and/or specialist assessment	7	25-90%
% of patients with CHD whose notes record oking status in the past 15 months, except those o have never smoked where smoking status need recorded only once	7	25-90%
% of patients with CHD who smoke, whose notes tain a record that smoking cessation advice has en offered within the last 15 months	4	25-90%
% of patients with CHD whose notes have a	7	25-90%

QUALITY INDICATORS CORONARY HEART DISEASE (2)

7. % of patients with CHD whose notes have a record of total cholesterol in the previous 15 months	7	25-90%
8. % of patients with CHD whose last measured total cholesterol (measured in the last 15 months) is ≤5 mmol/l or less	16	25-60%
9. % of patients with CHD with a record in the last 15 months that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken	7	25-90%
10. % of patients with CHD who are currently treated with a beta blocker	7	25-50%
11. % of patients with a history of MI (diagnosed after 1 April 2003) who are currently treated with an ACEI	7	25-70%

QUALITY INDICATORS

CORONARY HEART DISEASE (3)

ubset – Left Ventricular Dysfunction		
. Practice can produce a register of patients with CHD nd LVD	4	
. % of patients with a diagnosis of CHD and LVD liagnosed after 01/04/03) which has been confirmed by cho	6	25-90%
. % of patients with a diagnosis of CHD and LVD who re currently treated with ACEIs (or A2As)	10	25-70%

HYPERTENSION

icator	Points	Min-Max
cords		
Practice can produce a register of patients n established hypertension	9	
gnosis and initial management		
% of patients with hypertension whose notes ord smoking status at least once	10	25-90%
% patients with hypertension who smoke, who e been offered smoking cessation	10	25-90%
going Management		
% of patients with hypertension in which there record of the BP in the past 9/12	20	25-90%

Pay-off

Patients

- Identifying clinical issues
- Treating issues – linking RCT data to individuals
- Focus on common conditions

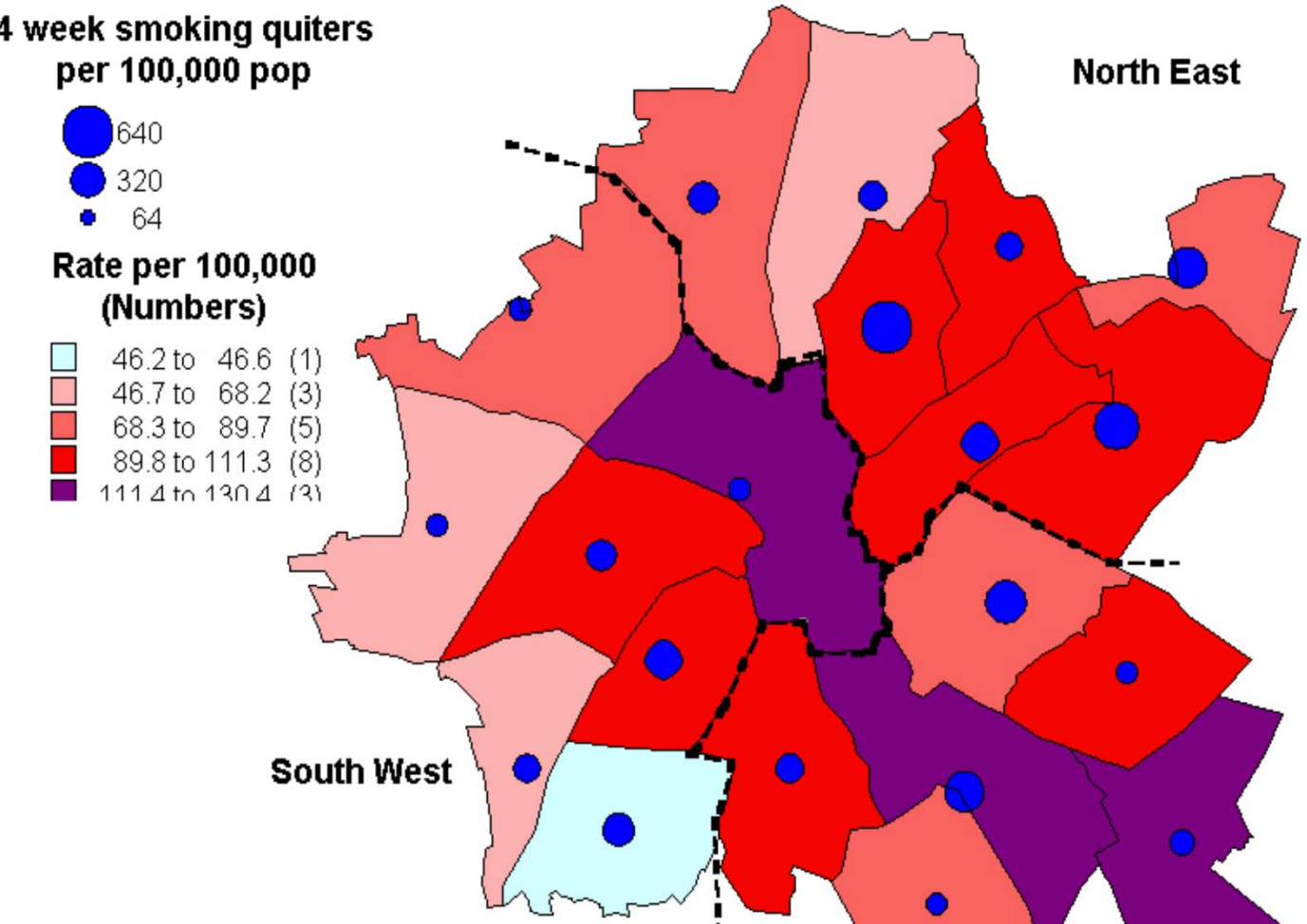
Primary Care Professionals

- Focus on common clinical conditions
- Evidence base reasonable
- Link to financial reward

Public Health

- Common conditions
- Reasonable “buy”
- Governance through IT

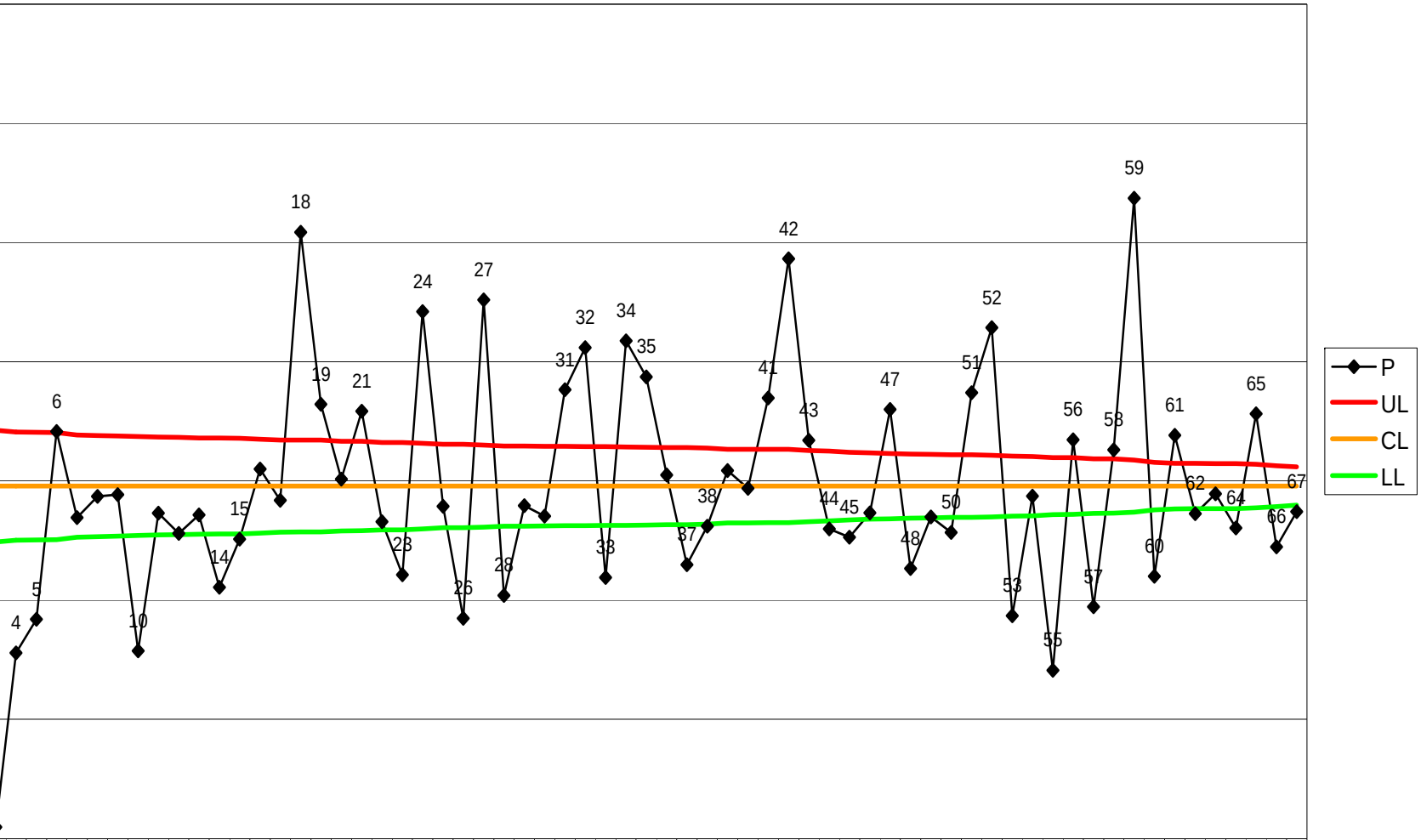
Age-standardised mortality rate from CHD amongst people aged under 75 in Wolverhampton (1998-2002)



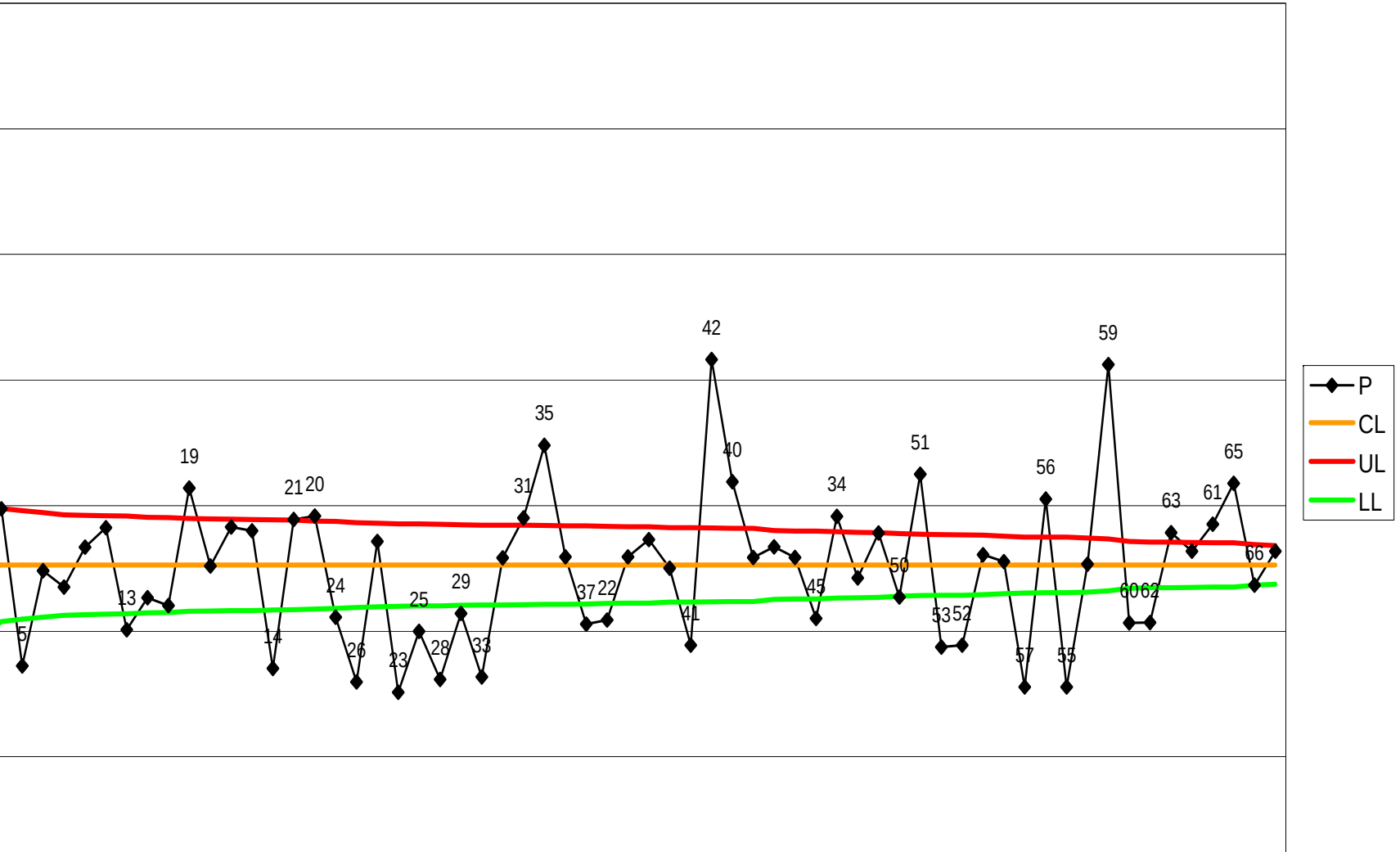
Some Concerns

- Uncertain of focus on some health proxies (effectiveness)
  - Peoples' health vs. Bio-data
- Uncertain if clinical decisions "variation proofed" – common process
- Uncertain if pay-off maximal or consistent – emphasis on high cost areas with variation in evidence
- Effect of compliance – especially on asymptomatic proxies
- Most at risk either
  - more likely to be non-compliant
  - more likely to be in the missing 10%
- Data validation – self validation
- IT and access to information

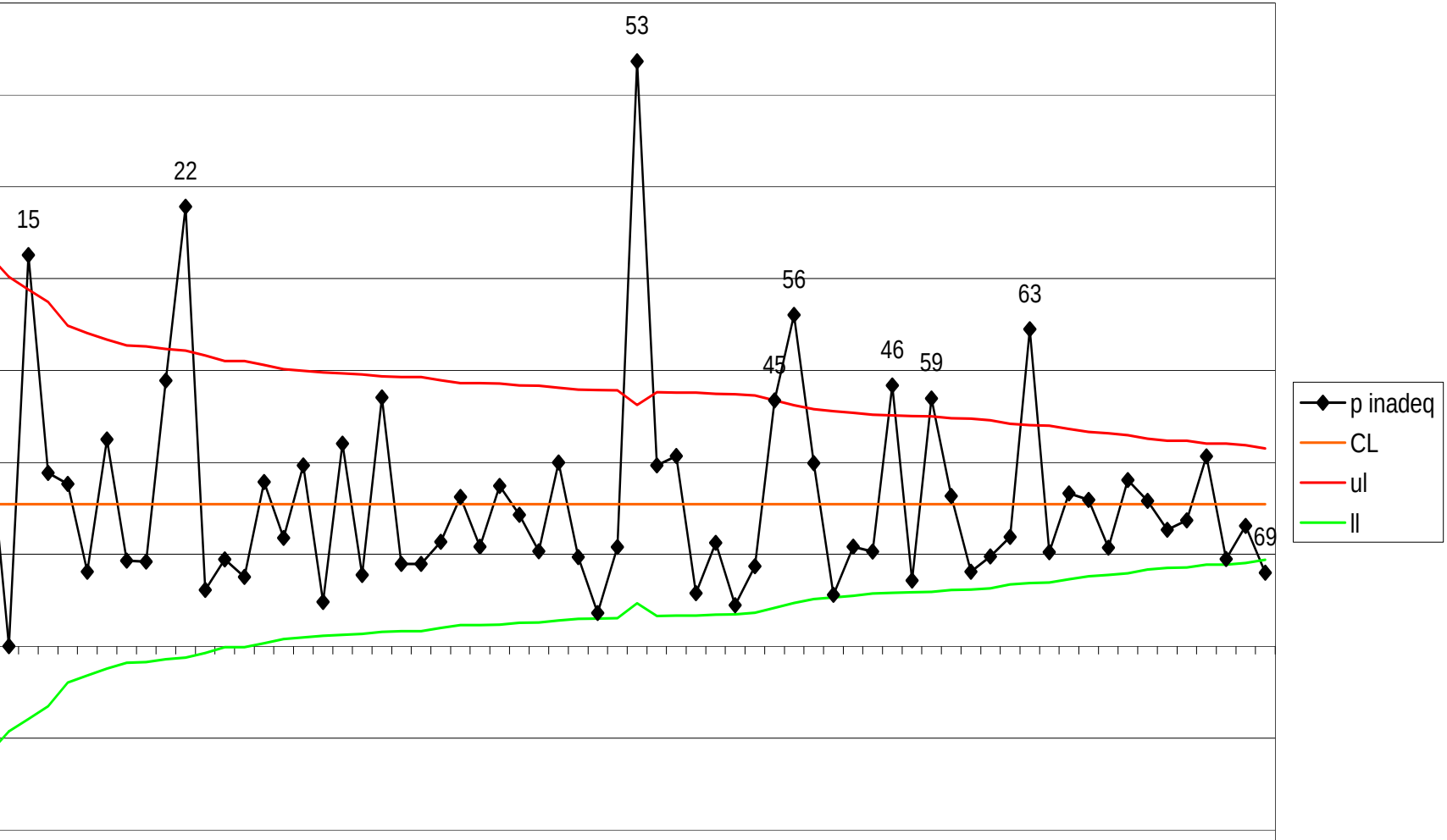
Control Chart Anti-Bacterial Prescribing Quarter 1 2003-2004 (Apr-Jun)



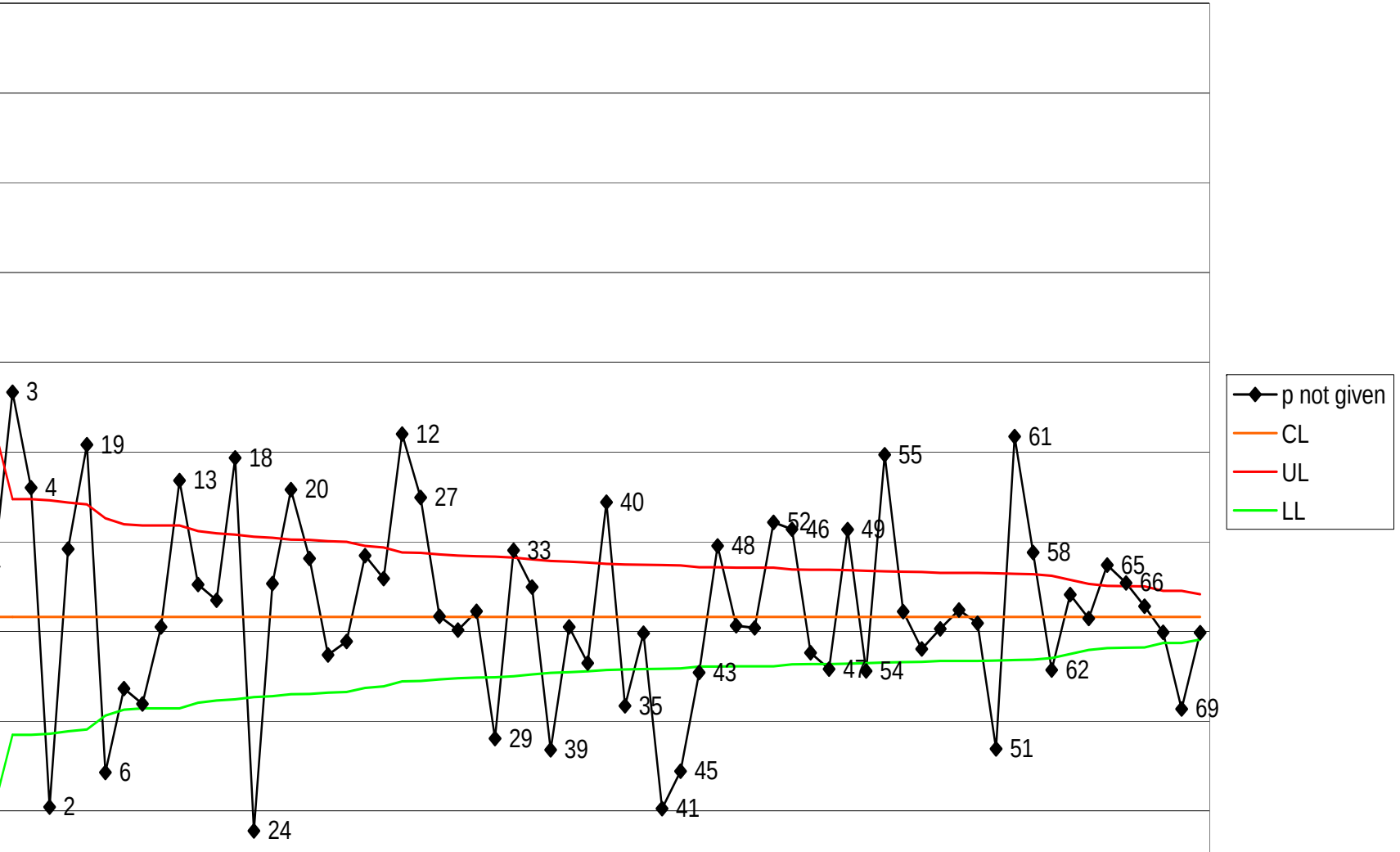
Control Chart Anti-Bacterial Prescribing Quarter 1 2004-2005 (AprJun)



Control chart of inadequate Cervical Smears rates per 100 in Wolverhampton GP practices April 2002 to March 2003



Flu immunisation uptake by GP 2003-04 Limits using p-chart



Some Possible Effects

- More data – not necessarily more intelligence
- Efficiency
  - Funding care in relatively low pay-off areas
  - Uncertain effects on high NHS resource areas
- Will require more information to investigate special cause variation
- May place responsibilities on individuals who are not skilled to meet them
- May increase health inequalities
- May lose holistic approach to health and well-being – the trade off between clinical and social well-being

Early Findings

- Large rise in tests
- Increase in practice-based specialised clinics
- Evidence of shift in prescribing
- Increased (appropriate) referral of difficult patients
- Validation is time consuming
- Can be linked to appraisal
- Uncertain if greater patient engagement
- Issues regarding data access

Pay-off?

- Real opportunity to see real increase in health output or gain (effectiveness)
- Potential to maximise current resource and develop standard procedures (efficiency)
- Possibility to use new, person-relevant data, for health surveillance and planning
- Focus for professionals
- Opportunity for better governance
- Can invest locally to address specific issues