Outcomes from a patient perspective: National PROMs update

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Consultant Level Outcomes Meeting
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Outline: 8 questions

• Why consider patients’ views?
• What are PROMs?
• What is the National PROMs Programme?
• How is it going?
• Do providers’ outcomes vary?
• Does choice of metric matter when comparing providers?
• What are the challenges?
• What about use at consultant level?
Why consider patients’ views?

• Patients welcome being asked/involved
• Patients’ response rates invariably better than clinicians
• Avoidance of observer bias
• Increases public accountability of health services and health care professionals
• Appropriate for most health care as patients seeking:
  – reduction in symptoms
  – reduction in disability
  – improvement in quality of life
What are PROMs?

- Misnomer: instruments (sets of questions) measuring health status
  - By comparing measures before and after intervention can derive impact or benefit

- Generic (eg EQ-5D, SF36)
  - Measures patients general or overall health
  - Allows comparison between conditions & interventions
  - Can generate data for cost-utility assessment (‘cost per QALY’)

- Disease-specific (hundreds!)
  - Measures specific health concerns
  - More sensitive/responsive

- And single transitional items
  - Post-intervention assessment of benefit/result
What is the National PROMs Programme?

• Mandated for all providers of NHS-funded patients from April 2009
  – Primary hip replacement
  – Primary knee replacement
  – Inguinal hernia repair
  – Varicose vein surgery

• Pre-operative questionnaire
  – At pre-op assessment clinic (67%) or on admission (33%)

• Post-operative questionnaire
  – Mailed at 3 months (VVs and hernia) or 6 months (joint replacement)

• Approximately 250 000 eligible patients per annum
Socio-demographic factors
Duration of problem
Revision surgery
Co-morbidity
Disease-specific PROM
(Oxford Hip Score; Oxford Knee Score; Aberdeen VV Questionnaire)
Generic PROM (EQ-5D and EQ-VAS)
+
Post-op complications
Overall result of operation
(single transitional items)
How is it going?

Provider participation: 100% (mandatory)

<table>
<thead>
<tr>
<th>Service</th>
<th>Recruitment rate</th>
<th>Response rate</th>
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</thead>
<tbody>
<tr>
<td>Hip replacement</td>
<td>69%</td>
<td>85%</td>
</tr>
<tr>
<td>Knee replacement</td>
<td>67%</td>
<td>85%</td>
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<tr>
<td>Hernia repair</td>
<td>46%</td>
<td>75%</td>
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<tr>
<td>VV surgery</td>
<td>41%</td>
<td>65%</td>
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Does it matter?
Do providers’ outcomes vary?

• Disease-specific and generic PROMs
  – Mean post operative score/mean change in score
  – Proportion of patients achieving ‘good’ hip function (threshold score)
  – Proportion of patients achieving a Minimally Important Difference (‘a little better’)

• Single transitional items
  – Health problem treated (much worse – much better)
  – Satisfaction with result (poor – excellent)

• Adverse outcomes
  – Complications
  – Readmission
  – Further surgery
Do providers’ outcomes vary?

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Proportion hip patients achieving a MID (EQ-5D)
Proportion hip patients reporting ‘improved’

- Much better than average
- Better than average
- Average
- Worse than average
- Much worse than average
Proportion hip patients reporting post-op problem
Does choice of metric matter when comparing providers?

• Proportion of providers rated as ‘outliers’ differed between metrics (e.g. hip replacement)
  – Mean post-op OHS: 25.1%
  – Mean post-op EQ-5D: 16.0%
  – % achieving OHS MID: 11.9%
  – % ‘improved’: 11.9%

• Agreement reasonable
What are the challenges?

• Minimising the time and cost of collection, analysis, and presentation of data
• Achieving high rates of patient participation
• Combining with other dimensions of quality: safety and experience
• Providing appropriate output to different audiences
• Avoiding misuse of PROMs
• Expanding to other areas: long term conditions, emergency conditions, mental health
What about use at consultant level?

• Research underway to look at this
• Key challenges
  – Sample sizes (need to combine several years)
  – Will be restricted to NHS-funded cases
  – Attribution of outcome ( Assumes it is associated with surgeon rather than surgical team/department)