

# Do financial incentives improve the treatment of diabetes in Swiss primary care?

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<b>Registration date</b> 20/03/2018	<b>Overall study status</b> Completed	<input type="checkbox"/> Statistical analysis plan <input checked="" type="checkbox"/> Results
<b>Last Edited</b> 19/05/2023	<b>Condition category</b> Nutritional, Metabolic, Endocrine	<input type="checkbox"/> Individual participant data

## Plain English summary of protocol

### Background and study aims

Evidence regarding pay-for-performance (P4P) programs is inconclusive. However, P4P interventions might be an interesting approach to improve adherence to guidelines and improve quality of care in primary care. In a gatekeeping healthcare system such as the National Health System (NHS) of the United Kingdom, the Quality and Outcomes Framework (QOF) introduced financial incentives for evidence based quality indicators (QI) in primary care resulting in an increase of QI achievements. Since the QOF was a nationwide pre-/post-trial without a control group, it remains controversial to which extent the P4P program and to which extent increasing guideline adherence over time was responsible for this improvement. Evidence from P4P programs in a different healthcare setting such as the USA was shown to be conflicting. Current evidence suggests that QI achievements targeting process indicators (e.g. the number of HbA1c measurements) have shown greater effects than financial incentives targeting clinical indicators (e.g. blood pressure values). In Switzerland no data on the P4P approach exists and the role of QIs, especially in primary care has been marginal. The main reason might be that - in contrast to the UK for example - documentation in primary care is still mainly paper-based instead of based on electronic medical records (EMR). The Institute of Primary Care of the University and University Hospital of Zurich founded the research network FIRE (Family medicine ICPC Research using Electronic medical records) with currently 290 primary care physicians (PCPs), voluntarily documenting their consultations based on EMRs. The study team previously demonstrated that the FIRE database offers a valuable database for the calculation of QIs according to the QOF in patients with diabetes. This study aims to test a P4P approach in Swiss primary care using clinical routine data from EMRs. It is thought that financial incentives increase physicians' achievements regarding QIs in diabetes patients more effectively than evidence-based educational feedback reports. Furthermore, differences of P4P on process QIs and clinical QIs will be investigated and the sustainability as well as the effect of a P4P intervention on non-incentivized QIs will be assessed.

### Who can participate?

Patients with diabetes of 290 GPs from 14 German-speaking cantons of Switzerland

### What does the study involve?

The participating GP practices are randomly allocated into the intervention group or the control

group.

PCPs already receive a bimonthly feedback report on their data. The intervention and control groups receive additional intensified feedback reports on the characteristics of their current diabetic patients. Moreover, the recommendations of the current diabetes treatment guidelines and target thresholds of QI are provided. PCPs in the intervention group are also informed that they will receive a financial incentive 12 months after initial feedback provision for increasing achievements regarding the following two QI: percentage of diabetic patients with blood pressure below 140/85 mmHg (clinical QI), and percentage of patients where HbA1c was measured within the last 12 months (process QI). At the start of the study, the percentage of patients meeting the criteria of each QI is measured. After 1 year, the percentage of patients meeting the QI is again measured. For each improved percentage point, PCPs in the intervention group are entitled to a single payment of 75 Swiss francs (CHF). PCPs in the control group do not receive a financial incentive and are not informed about the provision of incentives in the intervention group. The intervention stops after 12 months, and bimonthly intensified feedback reports continue for another 12 months. After 24 months, performance is measured again in order to estimate the long-term effects of the incentive.

What are the possible benefits and risks of participating?

Participants will only be exposed to the usual care of their medical provider which is generally expected to be best practice even in a non-study setting. Participants taking part might notice a benefit from an improved quality of care as the participating PCPs are motivated to reach higher achievements regarding the QI. No risks are expected.

Where is the study run from?

University of Zurich (Switzerland)

When is the study starting and how long is it expected to run for?

January 2018 to June 2021

Who is funding the study?

Swiss National Science Foundation (Switzerland)

Who is the main contact?

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## **Additional identifiers**

**Protocol serial number**  
407440\_167204

## **Study information**

**Scientific Title**  
Impact of financial incentives to improve quality indicators in diabetes patients

**Study objectives**  
The study aims to test a pay-for-performance (P4P) approach in Swiss primary care using clinical routine data from electronic medical records (EMRs). We hypothesize that financial incentives increase physicians' achievements regarding quality indicators (QIs) in diabetes patients more effectively than evidence-based educational feedback reports. Furthermore differences of P4P on process QIs and clinical QIs will be investigated and the sustainability as well as the effect of a P4P intervention on non-incentivized QIs will be assessed.

**Ethics approval required**  
Old ethics approval format

**Ethics approval(s)**

According to the local ethics committee of the canton of Zurich, the project does not fall under the scope of the law on human research and therefore no ethical consent is necessary (BASEC-Nr. Req-2017-00797).

## **Study design**

Cluster randomised controlled trial

## **Primary study design**

Interventional

## **Study type(s)**

Treatment

## **Health condition(s) or problem(s) studied**

Diabetes mellitus

## **Interventions**

The level of randomization will be at the practice level. The participating practices will be divided into an intervention and control group. Randomization will be stratified by current performance status (clinical QI blood pressure), number of primary care physicians (PCPs) per practice, network participation of the practice and number of diabetic patients.

PCPs contributing to the FIRE database already receive a bimonthly feedback report on their data. Intervention and control group will receive additional intensified feedback reports on the characteristics of their current diabetic patients, including last data of blood pressure and HbA1c measurements. Moreover, recommendations of the current diabetes treatment guidelines and target thresholds of QI will be provided.

After randomization, PCPs in the intervention group will additionally be informed that they will receive a financial incentive 12 months after initial feedback provision for increasing achievements regarding the following two QI:

1. Percentage of diabetic patients with blood pressure < 140/85 mmHg (clinical QI)
2. Percentage of patients where HbA1c was measured within the last 12 months (process QI)

At baseline, the percentage of patients meeting criteria of each QI will be measured. After one year, the percentage of patients meeting the QI will again be measured. For each improved percentage point, PCPs in the intervention group will be entitled to a singular payment of 75 Swiss francs (CHF). PCPs in the control group will not receive a financial incentive and will not be informed about the provision of incentives in the intervention group. The intervention stops 12 months after baseline, bimonthly intensified feedback reports will continue for another 12 months. 24 months after baseline, performance will be measured again in order to estimate long-term effects of the incentive.

## **Intervention Type**

Other

## **Primary outcome(s)**

Obtained from the FIRE database at baseline, 12 and 24 months:

1. Proportion of diabetic patients with last blood pressure measurement < 140/85 mmHg (clinical QI)

2. Proportion of diabetic patients with at least one measurement of HbA1c in the preceding 12 months (process QI)

### **Key secondary outcome(s)**

Obtained from the FIRE database at baseline, 12 and 24 months:

1. Proportion of diabetic patients with at least one blood pressure measurement in the preceding 12 months (process QI)
2. Proportion of diabetic patients with HbA1c levels < 7.5% (clinical QI)
3. Proportion of diabetic patients with at least one cholesterol measurement in the preceding 12 months (process QI)
4. Proportion of diabetic patients with total cholesterol < 5 mmol/l (clinical QI)

### **Completion date**

30/06/2021

## **Eligibility**

### **Key inclusion criteria**

Up to December 2017, 290 GPs from 14 German speaking cantons of Switzerland participated in the FIRE project. In December 2017, the database contained data of 3,372,343 encounters of 345,811 patients. The FIRE database, consisting of administrative data, vital signs (blood pressure), lab values (Hba1c), diagnostic codes (ICPC-2), and medication data (ATC codes) provides the database for the project. Structural data on participating GP practices (physicians' age and training, practice type (single-handed, double or group practice) and location, laboratory connection) are collected at individual FIRE project entry.

PCPs are eligible for the current study based on the FIRE database, if the dataset of 2017 is complete and a minimum threshold of 0.1 is achieved for the process indicators HbA1c and blood pressure, to rule out technical problems.

Of the eligible PCPs, primary care patients with diabetes mellitus will be identified from the FIRE database according to the following criteria:

1. Patient with ICPC-2 codes T89 (insulin dependent diabetes mellitus) and T90 (insulin independent diabetes mellitus)
2. Patients with antidiabetic medication (oral antidiabetics and/or insulin) according to the pharmaceutical cost group (PCG) (A10A/A10B)

### **Participant type(s)**

Health professional

### **Healthy volunteers allowed**

No

### **Age group**

Not Specified

### **Sex**

All

### **Total final enrolment**

**Key exclusion criteria**

Incomplete data set of 2017 and/or a minimum threshold of 0.1 is not achieved for the process indicators HbA1c and blood pressure

**Date of first enrolment**

15/05/2018

**Date of final enrolment**

15/12/2018

**Locations**

**Countries of recruitment**

Switzerland

**Study participating centre**

Institute of Primary Care, University of Zurich

Switzerland

8001

**Sponsor information**

**Organisation**

Institute of Primary Care

**ROR**

<https://ror.org/029ma5383>

**Funder(s)**

**Funder type**

Government

**Funder Name**

Schweizerischer Nationalfonds zur Förderung der Wissenschaftlichen Forschung

**Alternative Name(s)**

Schweizerischer Nationalfonds, Swiss National Science Foundation, Fonds National Suisse de la Recherche Scientifique, Fondo Nazionale Svizzero per la Ricerca Scientifica, Fonds National Suisse, Fondo Nazionale Svizzero, Schweizerische Nationalfonds, The Swiss National Science Foundation (SNSF), SNF, SNSF, FNS

### Funding Body Type

Private sector organisation

### Funding Body Subtype

Trusts, charities, foundations (both public and private)

### Location

Switzerland

## Results and Publications

### Individual participant data (IPD) sharing plan

The FIRE database of the Institute of Primary Care, University of Zurich will provide the database for this study.

It consists of following data components:

1. Administrative data (year of birth, gender, dates of each consultation, unique de-identified patient-identification-number)
2. Vital signs: systolic and blood pressure, pulse, height, weight, waist circumference
3. International Classification of Primary Care 2 (ICPC-2): between one to seven codes for reason for encounter and diagnoses per contact date as assessed by the GP
4. Laboratory values: hemoglobin, leukocytes, C-reactive protein (CRP), erythrocyte sedimentation rate, creatinine, total cholesterol, HDL- and LDL-cholesterol, triglycerides, GOT (ASAT), GPT (ALAT), GGT, fasting glucose, HbA1c, prostate-specific antigen; all values including their reference range and date of analysis
5. Medication data: Anatomical Therapeutic Chemical Classification (ATC), medication doses, intake time (morning, noon, evening, night-time), cessation date and comments

Structural data on participating GP practices (physicians' age and training, practice type (single-handed, double or group practice) and location, laboratory connection) are collected at individual project entry. The data retrieved from the different practices is fully anonymized. Therefore the project does not fall under the scope of the law on human research and therefore no ethical consent is necessary. No persistent weblink is available to the public. The data can be accessed at any time by the scientific team member of the institute. For foreign bodies access has to be requested from the head of the institute.

### IPD sharing plan summary

#### Study outputs

Output type	Details	Date created	Date added	Peer reviewed?	Patient-facing?
<a href="#">Results article</a>		01/04/2021	28/04/2021	Yes	No
<a href="#">Results article</a>	Follow up analysis	26/10/2021	19/05/2023	Yes	No
<a href="#">Protocol article</a>	protocol	30/06/2018		Yes	No
<a href="#">Study website</a>	Study website	11/11/2025	11/11/2025	No	Yes

