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Maximising your QOF: Coronary heart disease

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- Indicators: 5
- Points: 35
- Prevalence (2017-18): 3.1%
- £/patient on the register (est): £26

Coronary heart disease (CHD) has been a part of the QOF since the very beginning and, encouragingly, the prevalence has steadily dropped over that time. While it has been a large area in the past, there are now just five indicators, which are generally straightforward to achieve.

Indicator 1: Maintain patient register (4 points)

The first indicator is for maintaining the register and it is important that patients have a disease code for heart disease entered into their record.

Patients who have had a heart attack or other acute event tend to be well coded. Patients who could be missed are those with less acute symptoms, who may be diagnosed following an angiogram or other investigation.

Searching for patients with a missed code could include all patients with a prescription for glyceryl trinitrate or other nitrates. Other drugs that could be searched for include aspirin and diltiazem, although these medicines can also be used for other conditions.

Indicator 2: Blood pressure 140/90 mmHg in patients under 80 years old (12 points);

Indicator 3: Blood pressure 150/90 mmHg in patients over 80 years old (5 points)

These are new indicators for the 2019/20 contract. They replace the previous single indicator (with a blood pressure target of 150/90 mmHg for all patients) with two new indicators stratified by age and including a tighter treatment blood pressure target for younger patients. This brings the QOF CHD area in line with other disease areas where there are more relaxed target levels in patients over 80 years old.

Nearly half of the points are available for these two indicators.

Only the final blood pressure reading within the QOF year is used for the calculation, so it can be useful to avoid re-measurement once the target has been reached. This can still be a difficult indicator and it is likely that some exception reporting will be required.

There is a code for patients who refuse a blood pressure measurement, although in practice this will be rarely used. There are also the usual codes to except patients from the CHD area on the grounds of unsuitability or patient's dissent.

The final code that can be used is to record 'maximal blood pressure therapy'. There is no hard definition of this and it certainly is not necessary for patients to have tried every antihypertensive in the BNF. The maximum level for each patient will be specific to them, based on their preferences and reactions to treatment.

As these indicators are based on the outcome of treatment, patients diagnosed or registered with the practice after July in the previous year will be automatically excepted.

Indicator 4: Aspirin, clopidogrel or anticoagulant treatment (7 points)

There are seven points available where patients have received aspirin, clopidogrel or oral anticoagulation over the previous year. This is a little different from other prescribing indicators, as it looks at prescriptions and codes for the whole of the QOF year.

It will also look for non-prescription codes where the patient is buying over-the-counter aspirin therapy or is receiving anticoagulation from another provider. These codes can easily be selected in either Read or SNOMED. To get all of the points requires that 96% of patients have a record of prescription, which is pretty high. It is worthwhile – clinically and QOF-wise – checking with patients with CHD who attend and don't have aspirin or similar on their repeat template, that they are taking aspirin bought over the counter.

Exception reporting can be a little complicated. Excepting from the whole CHD area is straightforward for patient dissent or unsuitability. Specifically excepting a patient from this indicator, however, will require three codes: one each for aspirin, clopidogrel and oral anticoagulation. As usual, codes recoding allergies or adverse reactions will last from year to year, while codes describing the drugs as not indicated will have to be repeated annually.

This is a process indicator, so automatic exceptions will apply if the patient registers or is diagnosed in the last three months of the QOF year.

Indicator 5: Influenza vaccination (7 points)

The final seven points are for giving a flu vaccination to over 96% of patients on the CHD register. The codes will be the same as those used in the DES and the rest of the flu campaign.

Reminders can be in person, by letter, telephone or SMS message. Patients are excepted if they decline to have the vaccination and this can be done opportunistically in person or by message. There are codes for sending reminders that you can use to keep track of things, but patients will need an informed dissent code where they have not responded to three direct reminders. Allergies and codes for where the vaccination would be unsuitable are also available.

For reference:

Indicator 1: The contractor establishes and maintains a register of patients with coronary heart disease (CHD001)

Indicator 2: The percentage of patients aged 79 years or under with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (CHD008). Payment threshold: 40-77%

Indicator 3: The percentage of patients aged 80 years or over with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less (CHD009). Payment threshold: 46-86%

Indicator 4: The percentage of patients with coronary heart disease with a record in the preceding 12 months that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken (CHD005). Payment threshold: 56-96%

Guide URL:
http://preview.pulse-intelligence.co.uk/guide/how-to-increase-your-qof-payments-coronary-heart-disease/

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