GPIAG
GENERAL PRACTICE AIRWAYS GROUP
OPTIMAL RESPIRATORY HEALTH

Opinion

GPIAG Opinion No 6

A Guide to the Quality and Outcomes Framework for respiratory disease

Asthma and Chronic Obstructive Pulmonary disease (COPD) are major causes of morbidity in the UK. COPD is the 5th greatest cause of mortality world wide and expected to reach third place by 2020. The inclusion of asthma and COPD in the quality and outcomes framework of the 2004 GMS contract recognises the importance of these conditions and the value of appropriate monitoring. In this opinion sheet we explain the changes to the respiratory elements of the QOF for 2006[1], advise clinicians on how to achieve these objectives, and attempt to suggest what further changes should come over the next few years.

The GPIAG does not wholeheartedly endorse the current respiratory QOF but does recognise that it is a step in the right direction. The following sections outline the major issues in Asthma and COPD.

Asthma

Asthma 1. The asthma register.
The concept of the 'active asthma' register is maintained in the 2006 QOF. Practices do not need to worry about how to code patients with asthma which is currently inactive. The QMAS search facility will automatically exclude patients who have not received any asthma-related drugs and those patients remaining will form the asthma register for QOF purposes. The advantage of this active register is that patients whose asthma is quiescent will not need to be pursued for review. The disadvantage is that a patient may develop symptoms and request an inhaler in the last few days of the QOF timescale and automatically appear on the register even if they have not presented with symptoms in the preceding year. It is therefore vital to ensure that the practice is well above the upper threshold for payment so as to avoid a couple of last minute prescriptions from spoiling the performance.

The number of points for the asthma register has been reduced from 7 to 4. The rationale is that it is much less work to maintain the register than it was to set it up in the beginning.

Asthma 8. The initial diagnosis.
There is no real change in the criteria for initial diagnosis but the 2006 indicator clarifies what was meant in the original QOF. It was always intended that variability or reversibility would be the diagnostic criterion and this has now been specified in the new version of the QOF. The 2006 QOF specifies that a >15% reversibility in FEV_1 or a >20% variability in peak flow readings is required for a firm diagnosis to be made. This criterion applies to patients diagnosed from 1st April 2006. The QOF guidance acknowledges that many patients will not exhibit variability or reversibility at any given time. They recommend consideration of more specialist assessment in cases of persisting doubt. Fifteen QOF points are available for this indicator. It appears from the wording of the 2006 QOF that a patient may qualify for points if variability or reversibility has been measured but is not diagnostic of asthma.

Two additional significant changes should be noted:

- The payment stages now range from 40-80%, considerably higher than the 25-70% in the original QOF
- It is now recognised that patients can have both COPD and asthma. Patients who show adequate variation or reversibility can be coded as asthma, while if they remain below 80% of predicted FEV_1 they can also be coded as COPD.

Asthma 6. Annual review.
There is no major change in the recommended annual review. The essential features of the annual review are set out as:

- Assess symptoms - using the RCP three questions
  - Sleeping difficulties
  - Day time symptoms
  - Interference with normal activities
- Measurement of peak flow
- Assessment of inhaler technique
- Consider personalised asthma plan
  - It should be noted that there is no requirement for personal action plans. This is based on the limited evidence for the efficacy of personal action plans outside of secondary care. However the GPIAG recommends that all asthma patients should be offered a personal action plan.

It should be noted that, using these criteria, telephone reviews would not be possible since assessing inhaler technique is part of the review as recommended by SIGN/BTS[2]. It has been suggested that the nature of the asthma review should be left to the discretion of the clinician involved, although the QOF does appear to set out a summary which contains all of the above assessments without any indication that any of these are discretionary. This issue is likely to come up at post-payment verification visits and the outcome will clearly depend on how the Primary Care Organisation interprets the QOF guidance.

As in other indicators the minimum payment threshold has been raised from 25-70% to 40-70%.

Asthma 3. Smoking
Asthma is unique in that smoking is retained within the asthma indicator set for patients between the ages of 14 and 19. In all other areas smoking has been removed and transferred to a generic smoking category. The minimum and maximum payment ranges are 40-80%. This could be potentially a difficult target to reach in this age group.

A major change in the asthma criteria set has been the removal of influenza immunisation from the indicators.

Chronic Obstructive Pulmonary Disease

The main changes in COPD are an increased frequency of spirometry measurements.

COPD 1. The COPD register
The main change in COPD 1 is the reduction from 5 points to 3. This is matched by a reduction in points for all registers and reflects the relatively lower workload of maintaining a register as opposed to instituting one.

COPD 9. Confirmation of diagnosis by spirometry.
The main change in this indicator is that it now applies to all patients as opposed to those recently diagnosed. The minimum payment threshold has gone up from 25 to 40%. In recognition that the criterion now applies to all patients the upper threshold has been reduced to 80%.

A major area of contention in the first iteration of the QOF was that the definition for inclusion in the QOF was an FEV_1 of less than 70% as opposed to the BTS[3] and GOLD[4] diagnostic definition of less than 80%. This distinction remains in the 2006 QOF. The rationale for this remains that patients with FEV_1s between 70 and 80% predicted normal will be asymptomatic and require no intervention other than smoking cessation advice. The major difficulty for practices will be the coding of patients with FEV_1 between 70 and 80% predicted. The simple solution would be for QMAS to automatically exclude patients in this group. It is not clear at the time of writing if this will be possible.

COPD 10. FEV_1 measured within the past 15 months.
The main change is an increase in the frequency of FEV_1 measurement to annually with an audit standard of 15 months. This is in response to the NICE clinical guideline 12[5] which recommends FEV_1 measurements annually for patients with mild to moderate COPD. The rationale is that by using annual FEV_1 measurement, practices will be able to identify patients in need of treatment modification. This will clearly mean a doubling of spirometry workload for practices. In recognition of this the points tally has been raised from 6 to 7! It should be noted that cheap electronic machines are available for measuring FEV_1 quickly; these would be unsatisfactory for diagnostic spirometry but would very quickly measure the annual FEV_1. The minimum payment threshold has been raised from 25% to 40%.

COPD 8. Influenza immunisation.
This remains unchanged in the 2006 QOF but the lower payment threshold has been raised to 40% from 25%.

Smoking

The smoking indicators remain largely unchanged but have been removed from individual disease areas into a generic chronic disease category. Practices can continue to record smoking in asthma and COPD in the usual way.

The purpose of this change is to reduce the element of double counting. In the previous QOF, if a patient with COPD, asthma and ischaemic heart disease was advised to stop smoking the practice would receive three payments. This will be now reduced to one. The only areas where practices will continue to be paid twice will be for asthma patients aged between 14 and 19.

Palliative Care

This is a new indicator set for 2006 QOF. Three points are available for having a register of patients in need of palliative care and a further three points for having quarterly multidisciplinary team meetings where all patients on the register are discussed. Clearly, patients with COPD will be eligible for inclusion in this register.

The Future

The GPIAG welcomes the continued inclusion of asthma and COPD in the QOF. The organisation looks forward to further developments which will hopefully place more emphasis on treatment and outcomes rather than the current process measures which make up the bulk of QOF criteria.

References:

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