



Ischaemic cardiovascular disease

What are the PHO performance programme indicators and how are they best achieved?

Supporting the PHO Performance Programme

The PHO Performance Programme

The PHO Performance Programme was established to reduce disparities and improve health outcomes for all people using primary healthcare services in New Zealand. A number of priority health areas have been identified and performance indicators created which can be measured against ideal targets. Incentives, in the form of financial payment to the PHO, encourage performance. For most of the indicators, the closer the PHO is to achieving the target, the greater the proportion of the payment is made. Performance indicators may change from year to year and some indicators are provided for information only and do not qualify for a payment. Table 1 lists the indicators that are currently funded.

PHO performance indicator for ischaemic cardiovascular disease

Indicator definition

The PHO performance indicator and target for ischaemic cardiovascular disease is: **For 90% of enrolled patients aged between 30 and 79 years with ischaemic cardiovascular disease, to have been identified and coded within their patient notes.**

The denominator for this indicator (i.e. what the results are compared against) is the estimated prevalence

Table 1: Funded PHO Performance Indicators for the period commencing 1 January, 2011

Chronic conditions	Cervical cancer screening
	Breast cancer screening
	Ischaemic cardiovascular disease detection
	Cardiovascular disease risk assessment
	Diabetes detection
	Diabetes follow-up after detection
Infectious disease	Smoking status
	Influenza vaccine in people aged over 65 years
	Age appropriate vaccinations for children aged two years
Financial	GP referred laboratory expenditure
	GP referred pharmaceutical expenditure

of ischaemic cardiovascular disease within the PHO population. This is calculated by adjusting the national prevalence of ischaemic cardiovascular disease to the age, gender and ethnicity variables of the PHO population.

This indicator makes up a total of 9% of a PHO's performance payment (3% for achieving the target in the total population and 6% for achieving the target in the high needs population).*

* High needs is defined as Māori and Pacific peoples and people living in New Zealand Deprivation Decile 9 or 10 socioeconomic areas (most deprived)

What is defined as ischaemic cardiovascular disease?

For the purpose of the indicator, ischaemic cardiovascular disease is defined as a medical diagnosis, either current or in the past, of one or more of the following conditions:

- **Ischaemic heart disease** – acute coronary syndrome, angina, percutaneous coronary intervention (PCI), coronary arterial bypass graft (CABG), myocardial infarction
- **Peripheral vascular disease** – atherosclerosis, aortic aneurysm
- **Cerebrovascular disease** – stroke and transient ischaemic attack (TIA)

N.B. Cardiac failure is not included as an indicator due to variable access to diagnostic testing. In addition, not all cardiac failure is caused by ischaemic heart disease.

How should a diagnosis of ischaemic cardiovascular disease be recorded?

The diagnosis of ischaemic cardiovascular disease needs to be recorded in a way that is retrievable. This means that an appropriate read code should be entered on the electronic patient record in the practice management system (PMS).

A G3 Read code detects all coded current and past cases of ischaemic heart disease. A computerised search using G3 automatically captures all lower codes such as G30 for myocardial infarction and G33 for angina. Cardiac procedures such as bypass surgery or angioplasty are listed under Read code 79 (although the patient should also have an existing G3 root code for the condition that required them to undergo the procedure).

A G6 Read code detects all coded current and past cases of cerebrovascular disease, but does not differentiate between atherosclerotic disease and cerebral haemorrhage. A G70-73 Read code detects all coded current and past cases of peripheral vascular disease. In these two cases, specified Read codes are excluded from counting towards the PHO Performance Programme target (Table 2).

The use of the code G70 relates to the Read term atherosclerosis, which in itself provides little clinical context. To record the presence of peripheral vascular disease we suggest the use of the G73z code. This covers the performance programme definition and provides better clinical context for clinicians.

 For a list of all Read codes that are identified for the PHO Performance Programme see “Code Mappings for data transfer specification and clinical performance indicator data format standard document.” pages 17-27, available from: www.dhbnz.org.nz/Site/SIG/pho/Technical-Documents.aspx

Any qualifying Read code matched to a qualifying patient will be counted, regardless of when it was recorded. Previously, some PMS' had an arbitrary ten-year look-back cut-off built into their queries but this limit has now been removed. The PMS error will have adversely affected the levels reported by the PHO Performance Programme prior to April 2011 when the patch was released.

Table 2: Read codes for ischaemic cardiovascular disease for the PHO Performance Programme

Description	Root Read code	Excluded codes
Ischaemic heart disease	G3...	
Heart failure	G58..	
Heart disease (not otherwise specified)	G5y..	
Cerebrovascular disease:	G6...	G60.. G61.. G62.. G669. G6731 G674.
Cerebral arterial occlusion	G64..	G675. G676.
Transient cerebral ischaemia	G65..	
Atherosclerosis	G70..	
Aortic aneurysm	G71..	G717.
Other aneurysm	G72..	
Other peripheral vascular disease	G73..	G730. G731. G73y2 G73y4 G73y5 G73y6 G73y7 G73y8 G73yZ
Cardiac procedures	792..	
Endarterectomy carotid artery	7A204	

Ways to optimise coding for ischaemic CVD coding within the practice

To decide which approach to ischaemic cardiovascular disease coding is best for your practice, first consider who within the practice might have the skills and time available to review the various sources where information concerning ischaemic CVD can be retrieved.

Sources include:

1. Letters from secondary care, e.g. outpatient clinics, surgical operation notes, inpatient admission letters.
2. Previous medical records (usually in the form of paper-based patient notes), especially from patients that are newly registered with the practice.
3. Audits on medicines that suggest a diagnosis of ischaemic cardiovascular disease such as: anti-anginals (glyceryl trinitrate, isosorbide, nicorandil and perhexiline), dipyridamole and clopidogrel. N.B.

Some medicines such as warfarin, aspirin or statins would not be appropriate for this audit as they may be used for conditions others than ischaemic cardiovascular disease, e.g. primary prevention of cardiovascular disease, atrial fibrillation.

Read codes can be added to patient notes within the PMS, at the time of the consultation. When relevant letters from secondary care arrive at the practice, Read codes can be entered directly by the GP reviewing the letter, or by highlighting or underlining any keywords on the letter for another staff member to enter the code.

Check Read codes whenever doing a repeat prescription, and if the code is not there, add it to the list of classifications. When adding a classification it is useful to tick both “long-term” and “add to patient history” on the classifications template in the PMS (if available). This will assist when writing referral letters in the future.

Establish policies within the practice to ensure consistency, accuracy and completeness of disease classification recording and clinical event coding.

Missing medical history?

Some patients have little or no recorded medical history, e.g. they may have immigrated to New Zealand or spent some time out of New Zealand, or their old notes (or parts of their record) may have become “lost” when transferring from one practice to another. When asking these patients about their previous medical history, it may be useful to enquire specifically about whether they have ever had a heart attack, stroke, “mini-stroke” or any heart surgery as these are terms that most people are familiar with.

Also consider opportunistically asking this same question of any patients aged over 50 years, to potentially identify ischaemic cardiovascular disease that is not recorded on the medical record held in primary care.

What are the benefits of coding ischaemic cardiovascular disease?

The main benefit of identifying and coding patients with ischaemic cardiovascular disease is in creating the best opportunity for secondary prevention.

Another important benefit is patient safety – it is easy for other doctors in the practice and locums to know what health problems the patient has when their primary doctor is absent. Accurate coding also ensures that any referral includes this information, which is particularly important if referring the patient for a surgical intervention.

General Practice disease registers – CVD

Consistent coding across general practice enables the development of disease registers. Disease registers group together long-term medical conditions with similar precursor risk factors and secondary preventative measures. Registers can be used to help to plan and organise preventative programmes and appropriate care, monitor the health of the practice population, facilitate audit and review clinical practice.

It is important to understand the difference between disease codes and health event codes. For example, a patient with an inferolateral myocardial infarct could have the following codes:

Ischaemic heart disease	G3.00	Disease classification Code
Acute inferolateral infarction	G302.00	Health event code

The G3 code should be linked to consultations where this specific disease area has been covered. This ensures that the overriding disease class code remains at the top of the classification list in the PMS.

Resource:

DHBNZ. PHO Performance programme. Indicator definitions. Version 5. Available from: www.dhbnz.org.nz/Site/SIG/pho/Operational-Documents.aspx