GPSC
General Practice Services Committee

COPD Management in BC

A System Approach

BRITISH COLUMBIA

doctors of bc
British Columbia Medical Association

Overview

- Background
- Guidelines and Protocols Advisory Committee (GPAC)
- Provincial Supports
- GP Services Committee (GPSC)
- Practice Support Program
- Questions

BC Background

- Administrative health services data from the BC Ministry of Health reports 107,325 individuals in British Columbia with COPD in 2010/11. In 2011, the enumerated total population of British Columbia was 4,400,057.
- The Burden of Obstructive Lung Disease study (BOLD) measured moderate to severe airflow obstruction indicative of COPD in 8.2% of the population of Vancouver aged 40 and over.
- A chronic disease and self-management approach directed by health professionals can significantly improve health status and reduce hospital admissions for exacerbations.

Guidelines and Protocols Advisory Committee (GPAC)

- Advisory Committee to the Medical Services Commission
- Joint Doctors of BC/Ministry of Health Committee
- Mandated to support both the effective utilization of medical services and high quality, appropriate patient care. This mandate is achieved through the development, publication and promotion of clinical practice guidelines and protocols.

GPAC COPD Guideline - 2011

- Based on Canadian Thoracic Society and other international strategies for the management of COPD, and adapted for Family Physicians in British Columbia using the chronic care management approach.
- Provides strategies for the improved diagnosis and management of adults with chronic bronchitis and emphysema (chronic obstructive pulmonary disease, COPD).
- Includes Patient resources/handouts

http://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/bc-guidelines/copd

Provincial Supports

- In 2011, the B.C. government introduced the BC Smoking Cessation Program intended to help eligible B.C residents stop smoking or stop using other tobacco products by assisting them with the cost of smoking cessation aids.
- The program covers two types of smoking cessation aids. Each calendar year eligible B.C residents will be able to get up to 12 continuous weeks (84 continuous days) of coverage for either:
  - **Prescription smoking cessation drugs**
    - bupropion (brand name Zyban®)
    - varenicline (brand name Champix®)

  OR

  - **Non-prescription nicotine replacement therapy NRT gum or patches**
    - Thrive™ nicotine chewing gum (in two strengths)
    - Habitrol® nicotine patches (in three strengths)

GP Services Committee (GPSC)

- The GP Services Committee is a joint Doctors of BC, Society of General Practice and the Ministry of Health committee developed in 2003 as part of the Physician Master Agreement.
- Vehicle to work together on matters affecting the provision of services by General Practitioners in British Columbia, including ways of providing incentives for General Practitioners to provide full services family practice and benefit patients.
- $208.5 M Annual funding, > 75% of which is invested in compensation incentives for Full Service Family Physicians

GPSC Incentives & COPD

- **Complex Care**
- **Chronic Disease Management**
- **Non-face-to-face Follow-up Management**
- **Conferencing with Allied Care Providers**

Billable by the family physician most responsible for the majority of the patient's longitudinal general practice care

Complex Care Incentive

- There are 2 different Complex Care fees depending on patient eligibility (original dual diagnosis; frailty). Both are annual billed at time of planning visit. Only one, not both per patient per year.
- Minimum 30 min complex care planning process that:
  - ✓ Reviews the Complex Conditions and current treatment. Development of the care plan (including Advance Care Planning) is done jointly with the patient &/or the patient representative as appropriate. (see next slide)
  - ✓ The patient & or their representative/family should leave the planning process knowing there is a plan for their care and what that plan is.
- Bill Complex Care fee plus office visit for that initial process on the day of the planning visit.
- Value of fee covers planning visit and prepayment for time, intensity and complexity of care provided face to face over the following year or so in addition to fees billed under MSP visit fees. Not required to be on the anniversary of previous year.

Complex Care Plan

A complex care plan requires documentation of the following elements in the patient's chart:

- There has been a ***detailed review of the case/chart and of current therapies***.
- Specifies a **clinical plan for the care** of that patient's **chronic condition(s)**.
- Incorporates the **patient's values and personal health goals** in the care plan with respect to the chronic condition(s).
- Outlines expected outcomes as a result of this plan, ***including any advance care planning for end-of-life issues when clinically appropriate***.
- Outlines **linkages with other health care professionals** that would be involved in the care, their expected roles.
- Identifies an appropriate **time frame for re-evaluation** of the plan.
- Confirms that **the care plan has been communicated verbally or in writing to the patient and/or the patient's medical representative**, and to other involved health professionals as indicated.

Chronic Disease Management Fee COPD (G14053)

- CDM payments recognize the additional work, beyond the office visit, required to provide guideline-based care to patients with chronic diseases.
- The CDM fee is a management incentive billable yearly on the anniversary of the initial billing date for care provided over the previous 12 months.
- Billing for office visits continues as usual through FFS. Must have at least 2 visits per 12 months
- Encourages patient self-management supports.
- Encourages the use of tool such as flow sheets for tracking and supporting guideline-informed care.

Non-face-to-face Patient Follow-up

- **Currently there are 2 GPSC non-face-to-face patient follow-up fees:**
  - Both are intended to avert need for a visit – either for acute or planned follow-up.
  - Require clinical discussion. NOT for notification of appointments, referrals or prescription renewals.
- Original GP Telephone/E-mail Follow-up Management fee
  - Must have at least one of portal fees including complex care or COPD CDM successfully billed in previous 18 months.
  - 5 phone/e-mail follow up fees (requires 2 way communication) per patient per calendar year.
- Attachment Telephone Management Fee
  - Only available for FPs who are participating in Attachment (~ 90% of FSFPs)
  - 1500 per physician per calendar year limit (including locums)
  - Expanded patient eligibility

Conferencing with Allied Care Providers

- Patient Conference fees developed to compensate the GP when conferencing with other health care professionals for the creation of a coordinated clinical action plan for the care of patients
- Allied Care Providers includes trained professionals with a scope of practice that allows the provision of medical and medically related services to patients. Examples include but are not limited to: Specialist Physicians; GPs with Specialty Training; Nurses; Nurse Practitioners; Mental Health Workers; Psychologists; Clinical Counsellors; School Counsellors; Social Workers; Registered Dieticians; Physiotherapists; Occupational Therapists; and Pharmacists etc.
- Billable in addition to any patient visit as long as not done simultaneously
- Payable in units of 15 minutes or greater portion.

Practice Support Program (PSP)

Shared System of Care for COPD/HF Module

- Aim is to create a system of care that improves the quality of care and experience for patients at risk for and living with COPD by:
  - Identifying patients earlier who have COPD and/or HF using a case-finding approach
  - Developing relationships and care plans amongst family physicians, specialists, patients, and community services
  - Implementing more standardized referral and consult letters, and improving relationships, hand offs, and communication between GPs and specialists
  - Improving the management of COPD and HF by putting the GPAC guidelines into practice
  - Supporting patients to quit smoking
  - Enhancing patient self-management skills for patients to manage their condition

Evaluation – COPD CDM

- Hollander Analytic provided evaluation reports of all GPSC CDMs including COPD
- When adjusting for the impacts of age, gender and RUB distributions, the costs were:
  - $6,678 for patients on whom the COPD CDM incentive was billed.
  - $7,536 for patients on whom the COPD CDM incentive was not billed.
- This resulted in a net cost avoidance (over and above the costs of the incentives themselves), based on adjusted data, of $10.9 million for fiscal 2010/11.
- In terms of hospital utilization, patients who received incentive based care had fewer days in hospital per 1,000 patients both across time and care levels.

Evaluation – PSP Shared Care COPD/Heart Failure

- Hollander Analytic also evaluated the PSP Shared Care Module.
- With regard to the specific module goals and learning objectives, over 93% of the GPs agreed or strongly agreed that:
  - They felt comfortable with helping their COPD/HF patients (97.8%);
  - They were partners with their patients in their patients' health care (95.7%); and
  - Attending the module had enhanced their ability to identify patients with COPD/HF (93.5%), support patients in quitting smoking (97.8%) and support their patients' self-management (95.7%), and
  - skills in developing an action plan for their COPD/HF patients (97.8%).

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Questions?

Thank you

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