GP SERVICES COMMITTEE
Prevention INCENTIVES

Revised
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General Practice Services Committee

doctors of bc

BRITISH COLUMBIA

SGP
Society of General Practitioners of BC

Prevention

The following incentive payments are available to B.C.'s eligible family physicians. The purpose of the incentive payments is to improve patient care. GPSC retains the right to modify or change fees.

Eligibility:

Physicians are eligible to participate in the GPSC incentive programs if they are:

1. A general practitioner who has a valid BC MSP practitioner number;
2. Currently in general practice in BC as a full service family physician;
3. The most responsible general practitioner for the majority of the patient's longitudinal general practice care; and
4. Practitioners who have billed any specialty consultation fee in the previous 12 months are not eligible.

GPSC defines a "Full Service Family Physician" (FSFP) as the FP who provides continuous comprehensive care to his/her patients and takes responsibility for the coordination of care needs for these patients. It is not about any specific set of services being provided by a specific individual; however, if the FP does not provide a particular service needed at any given time (e.g. Obstetrics) the FSFP will coordinate the referral to a colleague who is able to provide that service in a shared care arrangement with the FSFP until such time as that particular service is no longer required.

GPSC Personal Health Risk Assessment Initiative

The Family Physician (FP) is uniquely placed to fit the available health promotion and disease prevention possibilities to the individual patient, based on the FP's knowledge of each patient's personal medical condition, family history, and social, lifestyle and work circumstances. It is also considered that personal customized health plans for patients will be taken a great deal more seriously if they are recommended by a familiar and trusted FP.

Not all actions that may come from an assessment of an individual's risk factors need to be addressed directly by the Family Physician. Many activities that will modify an individual's risk factors can be undertaken with the access of other health care providers. Patient self-management has been targeted through the PSP process for chronic diseases, and in fact is necessary for any life style modification to be successful. Support from other providers such as dieticians, advanced practice nurses, nurse practitioners, physician assistants and personal coaches (professional and possible lay coaches as part of behaviour modification processes) can be very beneficial to patients provided the overall coordinator of care is the Family Physician.

In December 2009, the BC the Clinical Prevention Policy Review Committee 2009 report "*A Lifetime of Prevention"* commented that while there has been improvement since the BC Screening report in 2006, there continues to be no comprehensive provincial process that systematically supports the benefit of a number of clinical preventive actions, these ideally being tailored to patients according to age, sex, lifestyle factors, motivation, etc. The BCMA paper *Partners in Prevention: Implementing a Lifetime Prevention Plan* recommended that "the provincial government should fund the lifetime prevention plan primarily through the GP Services Committee, the Specialist Services Committee, and the Shared Care Committee where appropriate." The BCMA paper also recommended that "the Ministry of Health Services should recognize the GP as the primary clinician responsible for the delivery of clinical prevention services offered under the lifetime prevention plan where appropriate" and that "the Ministry of Health Services should recognize the GP as the coordinator of the lifetime prevention plan."

In April 2016, the updated BC Lifetime Prevention Schedule was released. The document "Establishing Priorities among Effective Clinical Prevention Services in British Columbia: 2016 Update" can be found on the Minisitry of Health website at:

http://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/lps-report_2016.pdf

In addition to the full report, a "Lifetime Prevention Schedule Tool" was developed to allow identification of the recommended interventions at a glance. When viewed online, there are embedded links to more details for each specific recommendation. This can be found at:

http://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/lps-graphic-tool.pdf

To support the Lifetime Prevention Schedule, the GPSC developed the Personal Health Risk Assessment Incentive that is available to patient populations with the one or more of following risk factors:

* Smoking
* Unhealthy eating
* Physical inactivity
* Medical Obesity

Under this initiative, Family Physicians would initiate Personal Health Risk Assessment visits with these "at risk" patient populations as part of proactive care, or in response to patient request for preventive care from the patient in one of these target populations. ***The FP is expected to recommend age- and sex-specific targeted clinical preventive actions of proven benefit, consistent with the Revised Lifetime Prevention Schedule (see chart outlining recommended actions) and includes but is not limited to recommendations found in the revised GPAC Obesity Guideline (when available) and Cardiovascular Disease – Primary Prevention Guideline.*** These lifestyle modification services should be provided in partnership with other community services such as access to appropriate nutritional and exercise programs, counselling or support. The use of patient self-management tools in addition to supportive lifestyle modification services would likely increase the success rate for sustained behavioural change.

G14066 Personal Health Risk Assessment incentive remains outside the "G14070/71 Portal and is available to any Full Service Family Physician (FSFP) to support the provision of prevention services to their patients.

G14066 Personal Health Risk Assessment $50.00

This fee is payable to the general practitioner who undertakes a Personal Health Risk Assessment with a patient in one of the designated target populations (obese, smoker, physically inactive, unhealthy eating). The GP is expected to develop a plan that recommends age and sex specific targeted clinical preventative actions of proven benefit, consistent with the Lifetime Prevention Schedule and GPAC Obesity and Cardiovascular Disease – Primary Prevention Guidelines. The Personal Health Risk Assessment requires a face to face visit with the patient or patient's medical representative and the G14066 must be billed in addition to the age appropriate visit fee.

Eligibility:

- Eligible patients must be living at home or in assisted living. Patients in acute and long term care facilities are not eligible.

Notes:

i) Payable only for patients with one or more of the following risk factors: Smoking, unhealthy eating, physical inactivity, medical obesity.
ii) Diagnostic code submitted with 14066 must be one of the following: Smoking (786), Unhealthy Eating (783), physical inactivity (785), Medical Obesity (783).
iii) The discussion with the patient and the resulting preventive plan of action must be documented in the patient's chart.
iv) Visit (office or home) or CPx fee to indicate face-to-face interaction with patient or patient's representative same day must be billed for same date of service.

v) *G14016 or G14077 payable on same day for same patient if all criteria met.*
vi) *G14015, G14017, G14033, G14043, G14063, G14076 and G14078 not payable on the same day for the same patient.*
vii) *Payable to a maximum of 100 patients per calendar year, per physician.*
viii) *Payable once per calendar year per patient.*
ix) *Not payable once G14063 has been billed and paid as patient has been changed from active management of chronic disease to palliative management.*
x) *Not payable to physicians who are employed by or who are under contract to a facility and whose duties would otherwise include provision of this care;*
xi) *Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care.*

The Ministry of Health website contains:

The current Lifetime Prevention Schedule "Establishing Priorities among Effective Clinical Prevention Services in British Columbia: 2016 Update":

http://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/lps-report_2016.pdf

A "Lifetime Prevention Schedule Tool" which allows identification of the recommended interventions at a glance. (When viewed online, there are embedded links to more details for each specific recommendation.):

http://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/lps-graphic-tool.pdf

BC Prevention Guidelines:

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

FREQUENTLY ASKED QUESTIONS REGARDING THE PERSONAL HEALTH RISK ASSESSMENT FEE G14066

1. **Why was the initial focused prevention fee (cardiovascular risk assessment fee) replaced by the Personal Health Risk Assessment fee?**
   In reviewing the various prevention papers that have been released over time, the GPSC felt it needed to broaden the prevention target population. In addition to the 2009 Lifetime Prevention Schedule, there are numerous other prevention guidelines that are applicable across the target population. (See Appendix B for links to background documents and resources)
2. **Are there any age restrictions for this new incentive?**
   No, it was felt that due to the broad nature of the target patient population, it would be appropriate to be inclusive of children and adolescents in addition to the adult population, with age appropriate prevention recommendations (eg. Immunization review; chronic illness & cancer screening; diet; exercise; and smoking discussions).
3. **Am I eligible to bill for an office visit, procedure, or conference fee on the same day?**
   Yes. In fact, the incentive must be performed in a face-to-face individual visit with the patient or the patient's medical representative, and as such the age appropriate 00100 must be billed in addition to the G14066.

4. **Is this fee billable in a group medical visit setting?**
   No. The Personal Health Risk Evaluation fee requires a one-on-one personal evaluation of health risks with the patient or the patient's medical representative. It requires the development of a personalized plan of action to address any risks identified. However, medically necessary follow-up of the plan of action may be undertaken in a group medical visit setting.

5. **Why is this fee payable only to the "General Practitioner that accepts the role of being most responsible for the longitudinal coordinated care of the patient for that calendar year"?**
   The value of the risk evaluation as well as what is done with that evaluation over the course of time is derived from having an ongoing relationship with the patient over time. While the GPSC acknowledges that individual Family Physicians may practice in many different settings, including group practices, the key attributes of primary care indicate that having an individual family Physician who is the main coordinator of care provides the most efficient and effective form of primary health care. It has been shown that it is the Family Physician who is MRP that has the most impact on a patient's willingness to undertake changes in their lifestyle choices and is key to the success and sustainability of those changes.

6. **Can I provide a follow-up by telephone to the patient to review the progress of their personal prevention plan?**
   If you have submitted G14070 (or G14071 for locums) earlier in the calendar year, then the provision of follow-up by telephone can be billed using the G14076 GP Patient Telephone fee.

7. **Is this billable by a locum in my office?**
   Yes. In your absence the locum is providing part of the continuity of care. Locums also have access to 100 prevention incentives per year. This means they must track how many have been billed, so that the total over the year does not exceed 100. The incentives billed by the locum do not count toward the host FP limit, but the host FP must have a conversation with the locum about the circumstances they should be billing this for and what the expectations are from this prevention planning process.

8. **Am I able to bill this on the same patient every year or is there a recommended frequency?**
   In high risk patients a review every year may be appropriate and so this may be billed on the same patient every year. If in your clinical judgment, risk assessments every two or three years would be appropriate, this would free up additional Personal Health Risk Evaluation fees over the 2 – 3 year time period.

9. **If I find a patient at higher risk is willing to make changes, is there any information on where I can refer them for further support?**
   Patients may be referred to a number of support groups and programs that are available within local communities. For more details, please go to the Ministry BC Smoking Cessation Program website:

   http://www2.gov.bc.ca/gov/content/health/health-drug-coverage/pharmacare-for-bc-residents/what-we-cover/drug-coverage/bc-smoking-cessation-program

10. **Why does this initiative exclude "physicians who are employed by or who are under contract to a facility and whose duties would otherwise include provision of this care"?**
    This incentive has been designed to remove the disincentive that exists, under current fee for service payments, to provide more time-consuming complex care to a patient in lieu of seeing more patients of a simpler clinical condition. The physician's time is considered to be already compensated if he/she is under a contract "whose duties would otherwise include provision of this care", or is being compensated by a salary, service, or sessional arrangement.

11. **Is there any plan to expand this in the future to other patient populations and areas of prevention?**
    The Clinical Prevention Policy Review Committee 2009 report "*A Lifetime of Prevention"* was updated in 2016. As such, the specific prevention recommendations will change over time, and GPSC has the flexibility to accommodate these changes as additional funding becomes available. While the target

population for G14066 is focused on those with one or more of the specified conditions, the GPSC will continue to monitor the effectiveness of the initiative, and as additional funding becomes available, consideration of expansion into other populations will be discussed at the GP Services Committee.

12. **When undertaking a personal health risk assessment, am I to restrict my discussions with the patient to the specific risk factors that made them eligible for the incentive?**
    No, *the intention of the new personal health risk assessment initiative is to review the prevention interventions recommended in the Lifetime Prevention Schedule as age and sex appropriate for patients in these 4 risk groups*. While the issues that put them into these risk groups are part of the schedule, the incentive is intended to compensate the Family Physician for taking the time to review all appropriate recommendations for that particular patient (eg. Stool testing for Occult Blood, Immunization status, etc) see the table above outlining specific recommended actions from the BC Lifetime Prevention Schedule.

13. **Must I use a flow sheet or paper Risk Scoring Sheet?**
    While there is no specific flow sheet or risk scoring sheet that is required for the personal health risk assessment, there are a number of tools available to use as a template when providing this service. See Appendix B for links to these resources.

14. **Are the payments eligible for the rural premiums?**
    Yes

Prevention Incentive Fee

G14066	**Personal Health Risk Assessment Fee**	**$50**

Appendix A – Resources for Additional Patient Support

1. BC Lifetime Prevention Schedule Tool
http://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/lps-graphic-tool.pdf

2. Hypertension Guideline Lifestyle Change recommendations
www.gacguidelines.ca/site/GAC_Guidelines/assets/pdf/HYPE05-Lifestyle_Changes.pdf

3. Quit Now
quitnow.ca/
or
bc.lung.ca/smoking_and_tobacco/quit_now.html

4. BC Healthy Living Guide for patients
www2.gov.bc.ca/gov/topic.page?id=E74B9B9D2C634C7EBAAA6F4A3F54E3A2

5. Healthy Families BC including:
- **i. Food & Nutrition**
- **ii. Activity & Lifestyle**
- **iii. Pregnancy & Parenting**

www.healthyfamiliesbc.ca

6. Dietician Services at HealthLink (formerly Dial-a-dietician)
healthlinkbc.ca/dietitian/

7. BC Recreation and Parks Association Walking programs (in partnership with ActNow)
http://www.bcrpa.bc.ca/recreation_parks/walking-program

8. Walk BC
walkbc.ca/activities-programs

9. BC Heart and Stroke Foundation – Health Living
heartandstroke.bc.ca/site/c.kpIPKXOyFmG/b.3644425/k.94E9/Healthy_Living.htm

10. Screening Mammography Program
www.screeningbc.ca/Breast/default.htm

Appendix B – Background Documents and Resources

1. Lifetime Prevention Schedule (Revised 2016)

http://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/lps-report_2016.pdf

2. BCMA "Partners in Prevention: Implementing a Lifetime Prevention Plan"

www.doctorsofbc.ca/sites/default/files/prevention_jun2010.pdf

3. GPAC Guidelines

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

i. **Cardiovascular Disease Primary Prevention**
ii. **Preventative Health**
iii. **Overweight and Obese Adults – diagnosis and Management**
iv. **Colorectal Screening for Cancer prevention in Asymptomatic Patients**
v. **Breast Disease and Cancer: Diagnosis**

4. Revised WHO Child Growth Standards (2010)

dietitians.ca/growthcharts

5. College of Family Physicians of Canada Preventive Care including:

i. **Greig Health Record (ages 6 – 17)**
ii. **Pan-Canadian physical activity strategy**
iii. **Preventive Care Checklist Forms**
iv. **Preventive Medicine**
v. **Rourke Baby Record**

http://www.cfpc.ca/HealthProfessionalResources/?filter=139

6. SGP Chronic Disease Prevention Flow Sheet (SGP Members sign in to access)

http://www.sgp.bc.ca/billing.php

7. BC Childhood Immunization Schedule

i. SGP Immunizations patients 18 and younger billing information (SGP Members sign in to access)

http://www.sgp.bc.ca/billing.php

ii. MOH/HealthLink BC

www.healthlinkbc.ca/toolsvideos/immunization

8. Self-management Supports

http://www.selfmanagementbc.ca/

http://www.swselfmanagement.ca/smtoolkit/

Appendix C

Billing Scenarios

Case 1. Miss K is a 16 year old patient who has come in to see you due to severe dysmenorrhea. Her periods are very regular at 28 – 30 days. She has not tried any over the counter medications but is thinking she might want to start the birth control pill as her best friend went on it for this reason and has had a great decrease in the cramps. She is 5 ft 3 inches with a weight of 180 lbs which calculates to a BMI of. She does not smoke. She does not participate in any formal exercise program but does like to swim and has in fact passed her bronze cross in swimming. Miss K has no past medical history of illnesses or surgery. There is a family history of diabetes in her mother and maternal grandmother but no other significant family history. In asking further questions, you find she does not have a boyfriend and has not yet been sexually active. She did not have the HPV vaccine in school as her mom was not sure of this. Her other immunizations are up to date. You review the pro's and con's of HPV and give her some information to take home for her parents to read and encourage them to come in to discuss this further if they feel it is appropriate for her to be immunized.

On examination, her BP is 115/70. You discuss the pro's and con's of oral contraceptives for dysmenorrhea. You also discuss with her the concern of further weight gain from the pill and she admits she wants to try and lose some weight that has accumulated since puberty. After reviewing her options, she agrees to try naproxen 220 mg for the dysmenorrheal and to start swimming three times per week. Since her friend also likes to swim, she will see if they can do this together. You advise her to return after the next two menstrual cycles to see if the naproxen is working and to weigh her again.

When seen 2 ½ months later with her mother, she finds that the naprosyn has worked very well for her cramps. She has been swimming 3 – 4 times per week at the local pool as there is a lower rate for students under a local program aimed at increasing youth activity and fitness. She has lost 8 lbs and has also been following a more balanced diet. She feels great. Her mom notes that they have decided to undertake the HPV vaccination after reading the literature. You advise her that since she is included within the provincially funded ages, there is no additional cost. She agrees to fill a prescription and return for the injection after school the next Friday. At that time, she advises that since she has lost some weight and is confident she will continue with her improved lifestyle habits, she would like to start a low dose oral contraceptive.

The billings for Ms. K are:

Service #	Service	Fee Code	Dx Code
1	Office Visit Personal Health Risk Assessment	00100 14066	625 783
2	Office visit	00100	626
3	Office visit – contraceptive advice HPV immunization	00100 10028	34A 33A

Case 2. Mr. D is a 36 year old patient who presents to your office in March with concerns about his health as he is a smoker and has a body weight above ideal (BMI 35). He and his wife have just had newborn twins and he knows that he needs to make some changes in his lifestyle to ensure he sees them grow up. He has a family history of Coronary Artery Disease with both his father and a paternal uncle having had heart attacks before they were 60. His Past History is negative for any medical conditions and his only surgical history is that of an appendectomy at age 10, but he has not seen you for the past 5 years. He has not had a tetanus shot since becoming and adult and has never had the flu shot either. You discuss the need to update his Tetanus immunization but also the recommendation that he should have the flu shot annually in the fall due to the presence of infant children in the home. He agrees to have the Tetanus shot

that same day, which you provide for him. He feels he is ready to seriously consider stopping smoking as he has read about the impact on childhood asthma and other illnesses if there are smokers in the home.

On examination, Mr. D's BP at this time is 170/95 and his pulse is 88 and regular. He has no history of chest pain or dyspnea. You review his status send him for blood work including a CBC, Fasting Blood Sugar, Lipid profile, Creatinine, Electrolytes and TSH. You advise him to do home BP checks and to write them down in a notebook and return to see you in 2 weeks. You discuss with him the various options for stopping smoking and refer him to the QuitNow program for more information.

When Mr. D returns 2 weeks later, you review his BP readings at different times during the day, and find his systolic levels range from 150 – 180 and diastolic from 90 – 105 (Mostly ~ 165/100). His BP at this visit is 170/100 and pulse is 82. You review the lab results and his efforts to stop smoking. His labs are as follows:

Total Cholesterol	6.8	FBS	5.2
HDL Cholesterol	0.88	Creatinine	105
LDL Cholesterol	4.1	Lytes, CBC, TSH	Normal
Triglycerides	1.80		

After advising Mr. D of the limitations of the Framingham Risk Scoring sheet, you calculate that his Total points are 9. This gives him an estimated 10 year CHD risk of 20%. With the low 10 year CHD risk for the population of 3%, his relative risk is 7 times that of the low 10 year population risk. You discuss this relative risk and the areas that he can change through lifestyle interventions. He has checked out the information on the QuitNow website and is preparing to stop smoking. He also agrees to undertake some exercise and diet changes, including reducing his salt intake. At this visit you give him a copy of your BP management sheet which has space for him to track his home BP. After the visit, you enter him in your CDM registry as he fulfills the criteria for hypertension.

He returns for follow up of his lifestyle interventions in 3 months, and his BP has only decreased to 155/95 at home on an average. You undertake a BP true reading and find his average is 155/100 today. He has been cigarette free for 4 weeks. He has lost 10 lbs and is walking every day. You discuss the risks and benefits of using medication for his hypertension given his family history. He agrees to start medication. Your office nurse phones him after 2 weeks to see how he is progressing and he reports he is tolerating the medication and his BP at home has been between 140/90 and 130/85. You reassess him in 3 monthly intervals until his BP is at an acceptable level (home readings averaging 125/80), by which time he has lost another 15 lbs. This has taken almost 10 months from the diagnosis of his hypertension. You provide his flu shot in the fall. At this time you advise him it is appropriate to repeat his laboratory testing before his next visit. At that follow-up exam, his BP is 120/80, and his lipids have also improved. You encourage him to maintain his new lifestyle choices, and follow his hypertension every 3 – 6 months as clinically indicated. Since it has been 1 year since the diagnosis of hypertension, you are eligible to bill the hypertension CDM.

The billings for Mr. D are:

Service #	Service	Fee Code	Dx Code
1	Office Visit Personal Health Risk Assessment	00100 14066	786 786
2	Office Visit for confirmation of hypertension	00100	401
3	Office Visit	00100	401
4	Telephone follow-up with RN	14076	401
5	Office Visit	00100	401
6	Office Visit	00100	401
7 (1 yr from Dx)	Office Visit Hypertension CDM	00100 14052	401 401