GPSC
General Practice Services Committee

General Practice Solutions

A Quarterly Newsletter from the GPSC

Train-the-trainer sessions for PSP End-of-Life module

On 9 December 2010, the GPSC's Practice Support Program (PSP) held the first of two scheduled End-of-Life train-the-trainer sessions at the Westin Wall Centre Hotel in Richmond.

One hundred and eighty-nine participants from across BC, including GPs, MOAs, home and community health care providers, and three specialist physicians attended. They came together to review learning and resource materials designed to assist care providers in delivering the most effective, integrated, and coordinated care to patients approaching end-of-life, including patients with cancer, HIV/AIDS, and end-stage medical conditions such as COPD, chronic heart disease, renal failure, neurological conditions, and dementia.

"Table sessions were buzzing," says presenter, Dr Cathy Clelland. "This is an intense topic, but attendees had really positive responses to what they learned."

Many participants will go on to play an integral role within their communities as peer physician trainers, working toward the integration of primary, specialty, and community care in the treatment of patients nearing end-of-life.

"These sessions focus on building a team to support patients and their families, as well as each other, rather than on the medical management of patients," says Dr Clelland. "Our aim is to communicate more efficiently with each other and to develop community strategies in the shared treatment of palliative patients."

The End-of-Life module material has been in development for more than 17 months, and while it is largely completed, feedback from session attendees will assist its authors in determining final refinements.

A second train-the-trainer session in March 2011 will review the effectiveness of the tools that were presented at the first session as well as look at the role of specialists in palliative treatment, the Community Healthcare and Resource Directory (CHARD), and physician billing issues.

While uptake is high among GPs, the PSP is hoping to recruit more specialist physicians to participate in the March session, including nephrologists, cardiologists, respirologists, geriatricians, and any specialists involved in the circle of palliative/end-of-life patient care. "Ideally, we'd eventually have a GP and a specialist working together as peer trainers in their community," says Dr Clelland.

The rollout of the PSP End-of-Life learning module is expected by fall 2011.

CHARD – Connecting GPs with mental health and addiction resources

Your patient is a 17-year-old female with moderate depression. You've completed an assessment and have decided to refer her to an appropriate mental health professional for follow-up. What resources are nearby? Who is accepting new patients? What are the referral criteria? Do you phone or fax? Does she qualify for an adolescent program or does she need to be seen as an adult?

The Community Healthcare and Resource Directory (CHARD) is here to help.

With over 12 000 listings for mental health and addiction resources across BC, CHARD helps you find contact information and details about inclusion criteria, referral forms and procedures, as well as patient brochures.

Continued on page 2

"Our aim is to communicate more efficiently with each other and to develop community strategies in the shared treatment of palliative patients."

— Dr Cathy Clelland, PSP session presenter

BRITISH COLUMBIA
The Best Place on Earth

BRITISH COLUMBIA MEDICAL ASSOCIATION

CHARD—Connecting GPs with mental health and addiction resources
– Continued from cover

An initiative of the GPSC, CHARD has been designed by physicians for physicians. Close to 1000 users have already discovered how quickly and easily they can identify and select an appropriate resource for their patient through the CHARD web site.

You can search by:

- Name of a service.
- Name of a practitioner.
- Organization that delivers the service.
- Patient's condition.
- Type of practitioner.
- Geographic location.
- Phone number of a practitioner or service.

To sign up for CHARD today, go to **www.info.chardbc.ca** or call us at 1 877 330-7322 and find out how quickly and easily you can have comprehensive mental health and addiction resources at your fingertips.

Coming soon: CHARD will soon be even more comprehensive, with listings in the areas of cancer, cardiac, musculoskeletal, neurodegenerative, palliative, renal, and respiratory care. It will also include listings for every specialist physician in the province. Look for details in the next GPSC newsletter or at **www.info.chardbc.ca**.

CASE STUDY

Innovative group medical visits benefit both dementia patients and their caregivers

Many family doctors in British Columbia are holding group medical visits to see patients with similar conditions in a larger setting, but for Karin Blouw of Smithers, group visits are a chance to expand her work in geriatric psychiatry. She is the first BC doctor to hold group visits for patients with dementia and their caregivers.

"We're holding these group visits monthly for six months, and to date it's been very successful," says Blouw." The group dynamic is working better than I expected."

> *"…after we'd done a couple, I saw that the group dynamic was working better than I expected…The participants are very comfortable discussing their issues together."*

Group medical visits are one of the practice innovations becoming popularized by the GPSC, a partnership between the BC Ministry of Health and the BC Medical Association. The GPSC supports doctors by developing and implementing programs that improve primary health care for patients and job satisfaction for family physicians.

Blouw attended Practice Support Program (PSP) sessions from the GPSC on practice efficiency methods like group medical visits. The learning modules of the PSP deliver education sessions, action periods, and physician mentoring to help family doctors adopt new initiatives.

Blouw is both a general practitioner and consults in geriatric psychiatry. She has many patients with dementia, so she decided to start up a group for them. Her sessions have had six to eight patients per visit, along with one or two caregivers per patient. Each monthly session features a speaker, such as a dietician, occupational therapist, mental health expert, or pharmacist.

The group visits are held in a large central space at the community healthy living centre and snacks are served. First, confidentiality agreements are signed, then there is a presentation from the speaker. Next Blouw holds a round-table discussion to find out how things are going for each patient, and there is time for questions, medical checks, and prescription renewals.

"At first, it was tough to adjust to the group setting with patients," says Blouw. "I'm used to doing things one-on-one in a closed office. But after we'd done a couple, I saw that the group dynamic was working better than I expected, and I'm getting used to it. The participants are very comfortable discussing their issues together."

The patients in Blouw's group have mild to moderate dementia. "They are all very respectful of each other, and there's good interaction, lots of interest, and positive feedback."

Kim De Sensi has been bringing her father to Blouw's group visits and finds they offer a different level of interaction.

Continued on page 4

BILLING GUIDE HIGHLIGHT

The Chronic Disease Management incentives – Congestive Heart Failure (G14051)

Heart failure is a complex syndrome associated with a high rate of hospitalization and short-term mortality, especially in elderly patients with co-morbidities. Early diagnosis and treatment can prevent complications.

In 2003, the GPSC identified a gap in the care of patients with congestive heart failure (CHF) and developed the CHF Chronic Disease Management (CDM) incentive (now billed using G14051) to encourage family physicians to provide guideline-informed care for these patients.

The CHF CDM may be billed for eligible patients:

- By the GP who is providing the ongoing longitudinal coordinated care for the patient in the community.
- After a GP has provided guideline-informed care for at least 1 year following the diagnosis of CHF (see "Diagnosing heart failure" below). NB: The GP must have provided at least two visits in the previous 12 months and completed at least two columns of a CHF flow sheet (paper or electronic).

Billing the CHF incentive

While the proportion of patients with CHF who have had the CDM incentive billed for them has slowly increased, it has significantly lagged behind the other CDM incentives [i.e., diabetes (14050), hypertension (14052), and chronic obstructive pulmonary disease (COPD) (14053)]. Feedback from family physicians has identified challenges in diagnosis confirmation as a barrier to providing guideline-informed care to these patients; the inability to access a timely echocardiogram (if accessible at all) is a common obstacle.

NB: The Guidelines and Protocols Advisory Committee (GPAC) CHF guideline (www.bcguidelines.ca/gpac/pdf/heart_failure.pdf) indicates that if echocardiogram/ radionuclide ventriculogram (RNV)/brain natriuretic peptide (BNP) confirmation is not available, a detailed history and physical examination supporting a clinical diagnosis of CHF, along with a therapeutic trial, is acceptable to confirm the diagnosis.

Continued on page 4

GPSC Billing Guide tutorial videos now online

Video of the GSPC Billing Guide tutorial held on 10 November 2010 at the Wall Centre Hotel in Vancouver can now be viewed online. Visit **www.gpscbc .ca/billing-fees/billing-guide-tutorial** for guidance on how to apply the GPSC billing incentives for chronic disease management, palliative care, complex care, maternity care, mental health care, house calls and facility care, and patient conferencing.

GPSC
General Practice Services Committee

GPSC columns in the *BC Medical Journal*

Information about the GPSC and its programs is distributed to BC's physicians through a number of channels, including this quarterly newsletter and the GPSC web site. Another channel is the BCMA's flagship publication, the *BC Medical Journal (BCMJ)*, which is sent out ten times a year to the more than 11,000 BCMA members throughout the province.

The *BCMJ* maintains a tight focus on BC medical stories and advances and is a natural place for the GPSC to share information with BC physicians on the successes and continuing development of its programs.

Since 2007, the GPSC has run a regular column in the *Journal* that highlights current and upcoming developments in the Practice Support Program, Family Practice Incentive Program, Divisions of Family Practice, and CHARD.

In November 2010, the *Journal* revitalized its online presence and launched its new and improved web site—bcmj.org. The *BCMJ* online has a steady following that continues to grow since the addition of enhanced features such as video content and user commenting, both of which provide new ways to keep BC's physicians informed on GSPC programs.

Find links to the monthly GPSC columns in the *Journal* on the GPSC's own web site at **www.gpscbc.ca/ news/other-publications**, or visit the new *BCMJ* web site directly at **www.bcmj.org** to read Clay Barber's January/February 2011 article on how Shared Care initiatives are bringing specialists and family doctors closer for better patient care.

CASE STUDY—Innovative group medical visits benefit both dementia patients and their caregivers – *Continued from page 2*

"At first, I wasn't sure what the group visit was about, but by the second one, we were sharing medical information and feeling completely comfortable about that," says De Sensi. "The speakers offer great information, and this is definitely more medical than my usual caregiver support group. I'm glad to see new stuff like this."

Blouw believes the group visits have been valuable for the patients and for her so far. "I've already had requests from others wanting to join the next group," she says.

BILLING GUIDE HIGHLIGHT—The Chronic Disease Management incentives – Congestive Heart Failure (G14051) – *Continued from page 3*

Patients with CHF confirmed by the process detailed below are eligible.

Diagnosing heart failure

Evaluation of heart failure should include:

- A thorough history and physical examination focusing on:
  - Current and past symptoms of heart failure (i.e., fatigue, dyspnea, decreased exercise capacity, and fluid retention/weight gain).
  - Functional limitation by New York Heart Association (NYHA) Class.
  - Cardiovascular risk factors, cardiovascular disease, and other co-morbid conditions.
  - Assessment of a patient's endurance, cognition, and ability to perform activities of self-management and daily living.
  - Clinical assessment of volume status (e.g., peripheral edema, rales, hepatomegaly, ascites, weight, jugular venous pressure, and postural hypotension).
- Initial investigations in all patients (where available):
  - Complete blood count, serum electrolytes, creatinine, eGFR, urinalysis, microalbuminuria, fasting blood sugar, fasting lipid profile, AST, albumin, and thyroid-stimulating hormone (TSH).
  - Twelve-lead ECG and CXR.
  - If available, all patients should have an objective determination of left ventricular ejection fraction (LVEF) by transthoracic echocardiogram or RNV.
  - BNP has high diagnostic value for heart failure and is recommended where available when the diagnosis is unclear.
  - *In cases of doubt or when an objective determination of LVEF is not immediately available, response to a therapeutic trial may increase the diagnostic accuracy and is acceptable for making the diagnosis.*

Benefits

Evaluation of those patients for whom the CHF CDM has been billed shows lower rates of hospitalization and morbidity, resulting in significant cost savings to the system.

By supporting the delivery of complex patient care by full-service family practitioners, the CHF incentive—along with the suite of CDM incentives developed by the GPSC—can help BC family physicians meet the growing demands of caring for an aging population with more complicated conditions.

—Dr Cathy Clelland,
Family physician and Executive Director,
Society of General Practitioners

For more information on the complete suite of CDM incentives, visit **www.gpscbc.ca**.

BCMA Communications
Clare O'Callaghan, Editor
Suite 115 – 1665 West Broadway
Vancouver, BC V6J 5A4
T: 604.736.5551 F: 604.638.2920
www.bcma.org

General Practice Solutions is produced by the General Practice Services Committee, a joint committee of the British Columbia Ministry of Health Services and the British Columbia Medical Association.

Formed under the 2004 Agreement between BC's doctors and the provincial government, the GPSC is responsible for developing and implementing strategies that support improvements in primary care.

For more information, visit **www.gpscbc.ca** or **www.bcma.org**.