GPSC Personal Health Risk Assessment Initiative Information and FAQs

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 September, 2010, BC's Provincial Health Officer released the paper *"Investing in Prevention Improving Health & Creating Sustainability"*. In order to reduce the burden of disease on families and communities, the need for health care services, and the impact of disease, disability and premature death on the economy, this report advocates for strengthened provincial strategy for and investment in prevention. The report raises concerns about the increasing prevalence of obesity and weight-related illnesses, such as high blood pressure (hypertension) and Type 2 diabetes across the population.

One of the recommendations of this paper was to "Continue to work with the British Columbia Medical Association and other health professional organizations to build a primary care system that will effectively deliver evidence-based lifetime preventive services and integrate prevention into chronic disease management." The BC Guidelines and Protocols Committee (GPAC) will also be releasing a revised "Obesity Guideline" in the near future.

In response to recommendations stemming from the above stated reports a new GPSC prevention initiative will come into effect on January 1, 2011This new initiative will replace the initial prevention incentive that was narrowly focused on Cardiovascular Risk Assessment. The new Personal Health Risk Assessment Incentive will be available to patient populations with the one or more of following risk factors:

* Smoking
* Unhealthy eating (Excess calories, fat, cholesterol and/or low fibre)
* Physical inactivity (Does not undertake 30 + minutes, several times per week)
* Medical Obesity (BMI of 30 or more)

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 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 $50.00
This fee is payable to the general practitioner who undertakes a Personal Health Risk Assessment with their patients who belong to one of the designated target populations (obese, smoker, physically inactive, unhealthy eating) either as part of proactive care or in response to a request for preventative care from one of these patients. 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 must be billed in addition to the age appropriate office visit fee.
Eligibility:

- Eligible patients are community based, living in their home, with family, in supportive housing or assisted living. Facility based patients are <u>not</u> eligible.
- 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.
- Not payable to physicians who have been paid for any specialty consultation fee in the previous 12 months.
- 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.
- Not payable to physicians working under salary, service contract or sessional arrangements and whose duties would otherwise include provision of this care.

Notes:

i. Payable only for patients with one or more of the following risk factors: Smoking, unhealthy eating, physically inactive, medical obesity.

ii. Only applicable to services submitted using one of the following diagnostic codes: Smoking (786), Unhealthy Eating (783), physically inactive (785), Medical Obesity (783)

iii. Requires chart entry documenting discussion and preventative plan of action.

iv. Face to face visit required with patient or patient’s medical representative on the same calendar day that the personal health risk assessment is billed.

v. Payable in addition to the office visit billed on the same day.

vi. Not payable on the same day as fee items G14015, G14017, G14033, G14043, G14063.

vii. Payable to a maximum of 100 patients per calendar year, per physician.

viii. Payable once per calendar year per patient.

BC Lifetime Prevention Schedule Recommended Actions

Clinical Condition		MEN	WOMEN
Colorectal Cancer Screening (Fecal Occult Blood Testing q1-2 years starting age 50)		•	•
Mammography Screening (40-79 yrs, q 1-2 years)			•
Pap Smear Screening (sexually active until age 69, q 1 – 2 years)			•
Hypertension Screening		•	•
Hyperlipidemia Screening (Male 40 yr; Female 50 yr or postmenopausal; or sooner if at risk either sex)		•	•
Diabetes Screening (Fasting Blood Sugar at least q 3 yrs age 40 yr or sooner if at risk either sex)		•	•
Discussion of ASA use as clinically indicated (if high risk of Cardiovascular Disease or Stroke)		•	•
Smoking Cessation		•	•
Adult Immunization:	Influenza (Annually if at risk)	•	•
	Pneumococcal (if ↑Risk q 10 years)	•	•
	Tetanus /Diphtheria (q 10 years)	•	•
Immunizations for patients < 19 years of age as per age appropriate publically funded schedule		•	•
Diet Modification (if Cardiovascular Disease Risk)		•	•
Exercise Recommendation (if Cardiovascular Disease Risk)		•	•

Frequently Asked Questions

1. **Why was the initial prevention fee (cardiovascular risk assessment fee) replaced by the new Personal Health Risk Evaluation fee?**

   In reviewing the various prevention papers that have been released over the past year, the GPSC felt it needed to broaden the prevention target population. The BC Guidelines and Protocols Committee (GPAC) will also be releasing the revised "Obesity Guideline" in the near future. (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; 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 office visit fee (00100, 15300, 16100, 17100, or 18100) 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 mandate of the GP Services Committee is to support and enhance Full Service Family Practice, and this style of practice routinely accepts responsibility for longitudinal, coordinated care of a patient. Also, just as important as the risk evaluation is what is done with that evaluation over the course of time, and that full value 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. **Is this billable by a locum in my office?**
   If covering for a family physician who has accepted the role of being the most responsible for the longitudinal coordinated care of the patient for that calendar year, and has not already provided a personal health risk assessment for the patient in that calendar year, a locum physician can provide this service and bill for it. Each locum has the same maximum number (100) of 14066's that can be billed in any calendar year. The locum physician must track their utilization of this incentive regardless of how many practitioners they are providing locum services for over that calendar year. If more than 100 are billed by any one physician (by billing number), the GPSC will reverse the payment and recover the excess number billed.

7. **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.

8. **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. Programs such as those at local recreation centers, weight-loss management programs, disease specific self-management programs, or telephone support such as HealthlinkBC or QuitNowBC. See Appendix A for some examples and links.

9. **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.

10. **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"* outlined a proposed mechanism to ensure the specific services recommended in a lifetime prevention schedule remain current with the evidence. As such, the specific recommendations will change over time, and the new initiative has the flexibility to accommodate these changes as additional funding becomes available. While the target population for this new fee 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.

11. **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.

12. **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.

13. **Are the payments eligible for the rural premiums?**
    No.

Appendix A – Resources for Additional Patient Support

1. **Hypertension GPAC Guideline Lifestyle Change recommendations**
   bcguidelines.ca/gpac/pdf/hypertension_appendix_d.pdf

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

3. **BC Healthy Living Guide for patients**
   bcguidelines.ca/gpac/pdf/healthy_active_pg.pdf

4. **ActNow including:**
   i. **Health Eating**
   ii. **Physical Activities**
   iii. **Seniors**
   iv. **Health Schools**
   actnowbc.ca/

5. **Aboriginal ActNow BC**
   aboriginalactnow.ca/

6. **Healthy choices in Pregnancy** (Component of Act Now Platform)
   hcip-bc.org/

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

8. **BC Recreation and Parks Association Walking programs** (in partnership with ActNow)
   bcrpa.bc.ca/walking/

9. **Walk BC**
   walkbc.ca/activities-programs

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

11. **Screening Mammography Program**
    www.bccancer.bc.ca/PPI/Screening/Breast/default.htm

Appendix B – Background Documents and Resources

1. Lifetime Prevention Schedule
health.gov.bc.ca/library/publications/year/2009/CPPR_Lifetime_of_Prevention_Report.pdf

2. BCMA "Partners in Prevention: Implementing a Lifetime Prevention Plan"
bcma.org/files/Prevention_Jun2010.pdf

3. GPAC Guidelines

i. Cardiovascular Disease Primary Prevention
bcguidelines.ca/gpac/guideline_cvd.html

ii. Preventative Health
bcguidelines.ca/gpac/submenu_preventative.html

iii. Revised Obesity Guideline – TBA

iv. Detection of Colorectal Neoplasms in Asymptomatic Patients
www.bcguidelines.ca/gpac/pdf/colorectal_det.pdf

v. Mammography
www.bcguidelines.ca/gpac/pdf/mammo.pdf

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
www.rourkebabyrecord.ca
www.cfpc.ca/HealthProfessionalResources/?filter=139

6. SGP Chronic Disease Prevention Flow Sheet (SGP Members sign in to access)
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)
www.sgp.bc.ca/billing.php

ii. MOH/HealthLink BC
www.healthlinkbc.ca/immunization.stm

8. Other Flow Sheets
impactbc.ca/files/documents/Flowsheet_-_Prevention.pdf

Appendix C

THE LUNG ASSOCIATION™ British Columbia

Your patients trust you with their health. Talk to them about tobacco use.

QuitNow Services have developed a series of short videos (all less than 3 minutes) on brief intervention counselling and using pharmacotherapy. Watch them here.

Where to Start

1. **ASK** your patients if they have smoked in the last six months.

Easy Ways to Provide Effective Support

Upwards of 70% of smokers want to quit at any time and in BC about 50% considered quitting in the next 12 months. Your advice alone can increase a smoker's chances of quitting successfully by 30%.

Questions to ask:

- "Do you ever smoke or use any tobacco?"
- "[Name of medical condition] is often caused or worsened by smoking.
  Do you or someone in your household smoke? "

2. **ADVISE** your patients of the importance of quitting.

Messages to convey: It's important to convey a clear, strong and personal message:

- "It's important that you quit as soon as possible, and I can help you."
- "I realize that quitting is difficult but it's the most important thing you can do
  to protect your health now and in the future."

3. **ASSESS** how ready your patient is to quit.

Ready to quit in the next 30 days: Encourage them to set a quit date.

Not ready to quit in the next 30 days: Encourage them to think about quitting and go to QuitNow.ca to learn more about quit smoking tools and information available for free. *Remember most smokers quit and relapse multiple times before they are successful. This is normal.*

4. **ASSIST** your patients with practical information and offer evidence-based treatment.

Complete a simple QuitNow Fax Referral Form and arrange for a trained quit specialist at our FREE QuitNow By Phone Helpline Centre to follow up with your patient directly to help them plan a successful quit. Referral forms are available at quitnow.ca under the Healthcare Provider section here.

Encourage patients to call for FREE confidential help directly at 1.877.455.2233

OR refer patients to other FREE services available at QuitNow.ca:

quitnow.ca 1-877-455-2233

QuitNow Online – A 24/7 Online Community where day or night hundreds of smokers in the process of quitting and ex-smokers are on-line ready to help & support each other. www.quitnow.ca

QuitNow By Text – A mobile texting service to help smokers quit smoking or stay quit. Once registered, users receive quit - tips and support sent straight to their mobile phone for 14 weeks. (New Service coming soon)

Prescribe Nicotine Replacement Therapy (NRT) and Pharmacotherapy – Using these therapies will at least double the chance of achieving abstinence (when compared to placebo in clinical trials).

5. **ARRANGE** a follow-up visit around the time your patient is preparing to quit.

If all you are able to do is ask if your patients smoke, advise that they quit and refer them to QuitNow Services (www.**quitnow.ca**), that alone will increase their likelihood of a successful quit.