G14053 – Chronic Obstructive Pulmonary Disease (COPD)

Effective Date: September 15, 2009

The GP Services Committee (GPSC) mandate under the Physician Master Agreement is to find solutions to support and sustain full service family practice in B.C. Evaluation of the GPSC incentives confirms that patients with chronic and complex illnesses who have a Majority Source of Care (MSOC) GP who has accessed the Complex Care or CDM incentives have lower overall health care costs. In 2009, GPSC agreed that it would adopt the Institute for Health Improvement's *Tripe Aim Initiative* as a lens by which to assess the extent to which new (and existing) initiatives contribute to the provision of more coordinated, integrated, and comprehensive patient care. Specifically, the Triple Aim lens examines whether a health care delivery model/approach has a positive impact on the:

1. Improved overall health for the defined population i.e. people diagnosed with COPD – currently 92,000 people
2. Improved care experience for both patients and providers
3. health care cost/spending as measured by per capita costs

Given the evaluation findings and using the Triple Aim lens, the GPSC has determined that the expansion of the chronic disease management incentive payments to include the diagnosis and management of Chronic Obstructive Pulmonary Disorder (COPD) is an important next step in improving the health of British Columbians, supporting full service family practice, and sustaining the province's public health system.

Diagnosis

The first step in improved management of COPD is accurate diagnosis. The diagnosis of COPD is confirmed by spirometry (FEV_1 less than 80% and $FEV_1/FVC^* < 0.7$ post-bronchodilator).

Spirometry testing for patients at high risk should include:

- Smokers or ex-smokers 40 years or older;
- Patients with persistent cough or sputum production;
- Patients with frequent respiratory infections;
- Patients with unexplained shortness of breath; and
- Chest X-ray may suggest COPD or be used to rule out other diagnoses, but definitive diagnosis requires spirometry.

It is important to note that COPD and asthma commonly coexist. Asthmatic patients will have a 12% or greater improvement in FEV_1 (and >180 ml in adults from the baseline 15 minutes after use of an inhaled short-acting $beta_2$-agonist. In some situations a corticosteroid trial may be appropriate to differentiate COPD from asthma. If clinical uncertainty remains, refer to a specialist.

If a patient has had a previously confirmed diagnosis of COPD it is not necessary to repeat the spirometry testing or specialist referral unless there is a new clinical indication.

*FEV_1: Forced expiratory volume in 1 sec., FVC: forced vital capacity

Patients Focus
COPD is a respiratory disorder most commonly caused by smoking, and involves progressive airway obstruction with breathlessness, cough and sputum production and increasing frequency and severity of exacerbations. A flare-up or exacerbation of these symptoms is the most common reason for admission to hospital.

Chronic ill health and death due to COPD is preventable in many cases. However, the progression and outlook of COPD is poor if left unmanaged. As of March 31, 2008 there were over 92,000 British Columbians with a confirmed diagnosis of COPD – moreover, approximately 11,000 new cases are diagnosed each year. Prior to their death, many of these individuals have several years of ill health and poor quality of life due to poor management of their COPD.

At the same time however, a clinical guidelines based model of care directed by health professionals can significantly improve the health status of people living with COPD and reduce their health system utilization.

Practitioner Focus
The MoHS/BCMA Guidelines and Protocols Advisory Committee's COPD clinical guideline had identified evidence-based strategies for the improved diagnosis and management of adults with chronic bronchitis and emphysema (chronic obstructive pulmonary disease) at the community level. The standards of care identified in the guideline include:

- Accurate diagnosis
- Smoking cessation
- Education and self-management
- Structured exercise and pulmonary rehabilitation
- Immunization
- Optimal maintenance therapy
- Special attention to exacerbations
- End of Life Care
- Clinical review at least twice a year

Smoking cessation, even in long-term smokers, is the cornerstone of treatment. Accurate diagnosis is required, and exercise, rehabilitation and pharmacological management are important components of a disease management strategy.

Research indicates that a chronic disease and self-management approach directed by health professionals can significantly improve health status and reduce hospital admissions for COPD exacerbations by 40%[1]. In this regard, patients with COPD require education about the disease process, treatment and prognosis and ongoing support.

To this end, the GPSC has identified the need for the GP or practice group that is most responsible for the on-going care of the patient to receive additional targeted

[1] Bourbeau J, Julien M, Maltais F et al. Reduction of hospital utilization in patients with chronic obstructive pulmonary disease. Arch Intern Med 2003, 163:585-591.

compensation to support and compensate them for the time taken with the patient and their family to develop an action plan for managing acute COPD exacerbations.

Health System Focus
In 2007/08, COPD was the top diagnosis for patients being admitted to B.C. hospitals through the Emergency Department with over 7,500 admissions. In 2007/08, patients with COPD utilized approximately $222 million in hospital services, $114 million in Medical Service Plan services, and $96 million in pharmaceutical services for an average cost of $4,700 per patient.

In addition to the incentive payment to support family physicians to work in partnership with their COPD patients to control exacerbations, through the GPSC funded *Practice Support Program,* a "Shared Care with Focus on COPD" module is being developed to improve clinical skill and practice design to achieve better health outcomes and patient experience with COPD management. The module design will include a shared care component for GPs/specialists (and teams) and be influenced by the COPD Collaborative recently completed in the Interior Health Authority.

Other initiatives that support and complement the COPD initiative are:

- Access to community-based patient self management training and supports
- Access to 'Bounce Back' - if anxiety and depression are factors in active self management
- Provincial service framework for COPD and successes from Interior Health Authority's COPD collaborative
- Integrated Health Networks – team approaches, strong links to community supports, and common patient care plans
- Divisions of Family Practice – providing GP infrastructure to support improved aligned of full service family practice with community-based supports to meet the health needs of the population
- Enhanced clinical decision support through improvements to the functionality of the CDM toolkit, access to office-based IT hardware and connectivity and the introduction of EMRs to clinical practice
- Continuation of the Practice Support Program –changing and improving family practice in terms of advanced access, chronic disease management, patient self - management and group clinical visits.
- Development of a PSP module for a shared care COPD approach.

EXPECTED MEASURABLE OUTCOMES

Patient Outcomes

- Increased number of patients with a COPD action plan in place
- Reduced rate of patient COPD exacerbations
- Improved patient confidence

GP Outcomes

- Improved GPs connect with other health care providers and their health authority through the shared care model resulting in increased practice support when managing patients

Health System Outcomes

- Reduce Emergency Room visits and hospital admissions for COPD exacerbations.
- Reduced per capita costs.

PRINCIPLES FOR THE COPD INCENTIVE PAYMENT

- Empower patients and their families to participate in behaviors aimed at reducing the occurrence of COPD exacerbations
- Reward the coordination of care and continuity of information and care planning at the interface between community-based services of family physicians, specialists, and other health care providers.

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COPD PAYMENT DESCRIPTION

This new incentive is an expansion of the Full Service Family Practice Condition Payment introduced in 2003. The program payments recognize that additional work, beyond the office visit payments, is required to provide guideline based care to patients over a year. The purpose of the condition based payments is to improve patient care.

CDM Incentive Bonuses are payable in recognition of the work that has already been done and are not payable in advance of the work being done or yet to be done. The program has been enhanced through the addition of Chronic Obstructive Pulmonary Disease (COPD) as an eligible condition. Effective September 15, 2009, there will be an annual bonus amount of $125 (G14053) for clinical guidelines based management of patients with COPD. This may be billed anytime after September 21, 2009 with a date of service from September 15, 2009 onward.

Additionally, once the COPD CDM incentive (G14053) has been successfully billed there will be access to up to 4 telephone/e-mail follow-up management fees (G14073) for these patients over the following 12 months.

Effective June 1, 2009, the GPSC instituted an “Acute Care Discharge Planning Conference Fee” (G14017) that is payable when the community GP of patients with complex supportive care needs, including complex COPD patients, attends a discharge planning conference for review of the patient condition and planning for safe return to the community or transition to a different acute care or supportive care or long term care. These incentives will complement each other for the improved management of COPD patients with a goal to reduced hospital ER admission.

Eligibility:
These payments are available to all general practitioners who have a valid B.C. Medical Service Plan practitioner number (registered specialty 00), except those who have billed any specialty consultation fee in the previous 12 months, and:

- Whose majority professional activity is in full service family practice as described in the introduction, and
- Who have provided the patient the majority of their longitudinal general practice care over the preceding year, and
- Have provided the requisite level of guideline-based care.

G14053 Annual Chronic Care Bonus (Chronic Obstructive Pulmonary Disease- COPD)…….. ..... $125.00

Notes:

i) General Practitioners who have a valid MSP practitioner number (registered specialty 00) are eligible to bill. Physicians who have billed a specialty consultation fee within the preceding 12 months are not eligible.

ii) Payable to the general practice full service family physician who has provided the majority of the patient's longitudinal general practice care over the preceding year and who has provided the requisite level of guideline-based care.

iii) Applicable only for patients with confirmed diagnosis of COPD.

iv) Care provided must be consistent with the BC clinical guideline recommendations for COPD and may only be billed after one year of care has been provided and the patient has been seen at least twice in the preceding 12 months. ***The patient must be given a copy of their personalized COPD action plan.***

v) Claim must include the ICD-9 code for chronic bronchitis (491), emphysema (492) bronchiectasis (494) or chronic airways obstruction-not elsewhere classified (496).

vi) This item may only be claimed once per patient in a consecutive 12 month period.

vi) Payable when other CDM items 14050, 14051 or 14052 have been paid on the same patient.

viii) If a visit is provided on the same date the bonus is billed; both services will be paid at the full fee.

G14073 – COPD Telephone/Email Management Fee…….$15.00

This fee is payable for 2-way communication with eligible patients via telephone or email for the provision of clinical follow-up management of a patient's COPD by the GP who has billed and been paid for the GPSC Annual Chronic Care Bonus for COPD (G14053) This fee is not to be billed for simple appointment reminders or referral notification.

Notes:

i. Payable to a maximum of 4 times per patient in the 12 months following the successful billing of the GPSC Annual Chronic Care Bonus for COPD (G14053) ;

ii. Not payable unless the GP/FP is eligible for and has been paid for the GPSC Annual Chronic Care Bonus for COPD (G14053;

iii. Telephone/Email Management requires 2-way communication between the patient and physician or medical office staff on a clinical level; it is not payable for simple notification of office or laboratory appointments or of referrals;

iv. Payable only to the physician paid for the GPSC Annual Chronic Care Bonus for COPD (G14053) unless that physician has agreed to share care with another delegated physician;

v. G14016, Community Patient Conferencing Fee, payable on same day for same patient if all criteria met. Time spent on telephone with patient under this fee does not count toward the time requirement for the G14016;

vi. Not payable on the same calendar day as a visit or service fee by same physician for same patient with the exception of G14016;

vii. Chart entry must record the name of the person who communicated with the patient or patient's medical representative, as well as capture the elements of care discussed;

Frequently Asked Questions:

1. How do I claim the COPD condition-based payment?

The incentive payment for COPD guideline-based care is payable if the patient has a confirmed diagnosis of COPD. Only one payment per diagnosis is payable per patient per year. Condition-based bonus claims are submitted through the MSP Claims system the same way you would submit a MSP fee-for service claim. The submission must include one of the relevant ICD-9 codes

- 491 for Chronic Bronchitis;
- 492 for Emphysema;
- 494 for Bronchiectasis;
- 496 for "Chronic Airways Obstruction not elsewhere classified."

The codes for claiming the condition-based bonuses are as follows:

- G14053 COPD (value $125)
- G14073 COPD telephone/e-mail follow-up management fee (value $15)

2. Is it possible to claim for the COPD as well as the diabetes, heart failure or hypertension payments?

The bonus G14053 (COPD) is also payable if the bonus payment(s) G14050 (diabetes mellitus), G14051 (congestive heart failure) or G14052 (hypertension) have been paid for the patient in the preceding year.

3. When should the COPD incentive bonus be billed?

The Chronic Care Incentive bonus fee for COPD may be billed annually for the provision of care consistent with B.C. Clinical Guidelines. There is no flow sheet requirement with the COPD CDM. **Patients must have been provided with a personalized COPD Action Plan as part of this care.** The Family Physician providing this care is eligible to bill this incentive after one year of care has been provided. If the requisite care has been provided prior to September 15, 2009 including provision of a personalized COPD Action Plan it is billable after September 21, 2009, with a DOS from September 15, 2009 onward.

4. When can I start submitting the new G14053 code?

This initiative is available after September 21, 2009 with a date of service from September 15, 2009 onward. The Family Physician providing this care is eligible to bill this incentive after one year of care has been provided. If the requisite care has been provided for 1 year prior to September 15, 2009 including provision of a personalized COPD Action Plan it is billable after September 21, with a date of service from September 15, 2009 onward

5. Will payment item G14053 replace the usual visit fees for those patients who have COPD?

No. As with the existing condition based payments for diabetes, CHF and hypertension, billing for office visits continues as usual. This bonus is billed in addition to any other fees incurred by usual patient care. It is a management bonus, intended to compensate for the time taken to maintain patient care plans in accordance with the B.C. clinical guidelines.

6. Do I have to see the patient to bill the payment?

You must have seen the patient at least twice in the 12 months prior to submitting the COPD G14053 fee code.

7. Do I have to provide all follow up care to the patient face to face?

After successfully billing the G14053, some follow up management may be provided to patients by telephone or e-mail, for which you can bill the G14073 COPD up to 4 times in the following 12 months.

8. Can I still bill if the patient is in a long-term care facility?
Patients in long-term care facilities are eligible; however clinical judgment may be needed about the appropriateness of following these guidelines in patients with dementia or very limited life expectancy. If this incentive is billed for resident in a long-term care facility a personalized Clinical Action plan must be entered in the patient's chart.

9. Where can I find the clinical guidelines?
The COPD guideline is found on the Guidelines and Protocols page of the Medical Services Plan web site, http://www.bcguidelines.ca.
A link is also provided on the BCMA web site,
http://www.bcma.org/public/CDM/CDMIncentivePaymentInfo.htm.

10. Where can I obtain a copy of the COPD Care plan template?
As part of the patient self management handout, a COPD Care plan template can be found at the end of this document.

11. Must I give the patient a copy of the COPD care plan?
Yes. One of the goals of the COPD CDM is to decrease patient admission to the hospital and ER. Patient self management is a major part of management of acute exacerbations, and the care plan is an important part of self management. This fee must not be billed unless a personalized COPD Action Plan has been discussed with and given to the patient.

12. Can I bill the payment even if the clinical or laboratory objectives have not been met?
The Chronic Disease payments are provided for the provision of guideline-based care, and are NOT a payment simply because the patient has a diagnosis of diabetes, congestive heart failure, hypertension or COPD. However, you may still claim for the payment if you have attempted to provide the appropriate level of care but for some reason care objectives have not been met. If this is the case, however, for audit purposes you must have clear chart entries that show that you attempted to provide the recommended level of care.

13. Can I bill for patients covered by other provinces?
Patients covered by other provinces who are temporarily in B.C. are not eligible as their regular physician is in the other province. If they stay in B.C. and obtain coverage under the Medical Services Plan then they become eligible for the program. In a few border communities a B.C. physician may provide the majority of care for an Alberta or Yukon patient, and these patients will be eligible.

14. I have assumed the practice of another GP within the last 12 months. May I still bill for patients' Chronic Disease Management (CDM) fees?
If the practice you assumed has provided the requisite care to the patient (see question 3 in this section) you may bill the CDM payment for COPD on or after September 1, 2009, without having to wait a full 12 months from the time you assumed responsibility for the practice. You may not bill the CDM fees if a patient did not receive the requisite level of care in the past 12 months (see question 6.).

15. Are the payments eligible for the rural premiums?
No.

16. Are general practitioners who are paid by service contract, sessional or salary payments eligible to receive the CDM bonus payments?
Yes, GPs on alternate payments are eligible to bill any of the CDM payments. How this is billed and flowed through to the physician is between the GP and the health authority.

Chronic Obstructive Pulmonary Disease

A Guide for Patients
Adapted from 2005 GPAC COPD Guideline

Chronic Obstructive Pulmonary Disease (COPD)

Chronic obstructive pulmonary disease includes respiratory disorders such as chronic bronchitis and emphysema that make breathing difficult. Smoking is the most important cause of these diseases. If you smoke, quitting will reduce the severity of the disease and help you improve the quality of life over a much longer time.

Chronic bronchitis and emphysema

In chronic bronchitis, inflammation occurring in the bronchial tubes may cause narrowing, which makes breathing difficult. A chronic cough that brings up sputum is present.
In emphysema, lung tissue and the small air sacs (alveoli) at the end of the airways become damaged and air becomes trapped in the lungs leading to shortness of breath.

COPD Exacerbations

An exacerbation is a worsening of the condition that includes the following signs:
• rapid increase in cough
• mucus production (especially if yellow or green)
• increased shortness of breath
• blue lips or fingers
Exacerbations can be serious and life-threatening. Prompt and effective treatment can help most people recover to the level of breathing before the exacerbation.

Diagnosis

A medical history, physical examination and breathing tests are used to diagnose COPD.

Treatment

Although there is no cure for COPD, the best way to slow the progression of the disease is to quit smoking. Medications may reduce or relieve symptoms. Counseling, education, and exercise can help improve quality of life. Pulmonary rehabilitation programs are available in some areas and these have been proven effective.
The use of a COPD Action Plan that has been jointly developed with your physician will assist you in managing your symptoms on a daily basis.

Quitnow by Phone

A free telephone service offering advice, information and support about quitting smoking. Call toll-free within British Columbia: 1 877 455-2233. The Quitnow Helpline is staffed from 10am to 6pm. After hours and on weekends, callers are invited to leave a message and a Quit Specialist will return the call during service hours.

The BC Smokers' Helpline service is tailored to the individual needs of each caller.
• **Smokers who want to quit** can get information about all the different methods, help with deciding what method may be best for them, and what to expect once they quit.
• **People who have just quit** may wish information about coping with withdrawal, and how to manage concerns about things like weight gain or sleep disturbance.
• **Smokers who are thinking of quitting** can discuss the pros and cons with a trained Quit Specialist. And the best thing is: no hassle, no pressure.
• **Smokers who wish to keep smoking** are also welcome to call the line; they don't push anyone to quit smoking and don't judge people for smoking, and a chat may provide useful information.
• **Friends and family members concerned about someone's smoking** are encouraged to call to discuss what they can do to help.

Living with COPD
Remove factors that can worsen your condition such as smoking. Balance exercise and rest periods. Participation in a pulmonary rehabilitation program or a chronic disease self-management program can be helpful. The BC Lung Association has a list of contacts for Better Breathers clubs in different areas of the province (see web site below) or call **1 800 665-5864** for further information including other programs such as Breathworks **1 866 717-2673**.

End of Life Planning
Planning for end of life circumstances is necessary for many patients in the advanced stages of COPD.

Consider discussing end of life concerns with your physician and writing a legal document (advance directive) that helps ensure your health care wishes will be respected. An advance directive contains your preferences for treatment, a living will and a power of attorney. More details related to end of life care can be found at the BC HealthGuide web site listed below.

British Columbia Internet Resources

The BC Ministry of Health Chronic Disease Management web site has more detailed information about the management of diseases such as COPD.
http://www.health.gov.bc.ca/cdm/patients

The BC HealthGuide Online provides detailed information on managing COPD and end of life planning.
http://bchealthguide.org

BC Lung Association offers excellent materials for the control of COPD.
http://www.bc.lung.ca

Contact the BC Lung Association or your local Heath Authority for access to a Pulmonary Rehabilitation Program

BRITISH COLUMBIA
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BRITISH COLUMBIA MEDICAL ASSOCIATION

COPD ACTION PLAN

Patient Name: _____ Date: _____
PHN: _____ Date of Birth: _____
Family Contact: _____ Phone #: _____
Physician: _____ Phone #: _____
After Hours Phone #: _____

You have been diagnosed with **C**hronic **O**bstructive **P**ulmonary **D**isease (COPD). As someone with COPD, you are either in your stable, everyday state or having a flare up. This Flare up Plan is a written contract between you and your doctor about how you will manage your COPD flare ups. This Plan will help you and your doctor to quickly recognize and treat flare ups to improve your health.

COPD (chronic obstructive pulmonary disease) has 2 states:
When you are am stable:
1. Breathing without shortness of breath
2. Able to do daily activities
3. Mucous is easy to cough up
4. Sleep well
5. Able to exercise as directed by physician

How to tell if you are having a flare up
A flare up may occur after you get a cold, get run down or are exposed to air pollution or very hot or cold weather. There are 3 things that define a flare up:
1. Increased shortness of breath from your usual level
2. Increased amount of sputum from your normal level
3. Sputum changes from its normal colour to yellow, green or rust colour

Some people may feel a change in mood, fatigue or low energy prior to a flare-up.

If any 2 or all of these symptoms persist for 48 or more hours do the following:
(Your physician will check the desired action plan for <u>you</u>)

☐ Take your rescue inhaler 2-4 puffs as needed (up to 4-6 times per day) for shortness of breath.

☐ Contact your family doctor immediately for a check up and medication review.

☐ Take your prescribed antibiotic for a COPD flare up (see over).

☐ Take your prescribed prednisone for a COPD flare up (see over).

☐ Contact your doctor if you feel worse **or** do not feel better after 48 hours of treatment.

☐ Other _____

If you are extremely breathless, anxious, fearful, drowsy or having chest pain, call 911 for an ambulance to take you to the emergency room.

Physician Signature_____

Patient/Caregiver Signature_____ ***Please turn over***

COPD MAINTENANCE MEDICATION RECORD

Patient Name: _____ Date: _____

PHN: _____ Date of Birth: _____

Family Contact: _____ Phone #: _____

Physician: _____ Phone #: _____

After Hours Phone #: _____

Patients: Take the following maintenance medications **every day** to help maintain control of your COPD symptoms.

Physicians: Please fill in prescribed maintenance medications.

Medication Prescribed	How Much to Take	When To Take

COPD FLARE-UP MEDICATION RECORD

Patients: Please fill in date when you start and finish your flare-up medications.

Physicians: Please fill in prescribed flare-up (antibiotics & prednisone) medications.

Medication Prescribed	Start Date / Finish Date	Start Date / Finish Date	Start Date / Finish Date

Make sure to take prescribed medication until all finished.