What community physicians could offer during a disaster

Throughout British Columbia and Canada the majority of health sector emergency preparedness activities have involved first responders, public health, and hospitals, along with their associated emergency departments. Surge capacity planning for acute and prolonged disasters relies on divergence to a lower level of care; however, community resources, particularly family physicians, have typically not been included in disaster planning.[1] Recent disasters and events such as the 4.7 magnitude earthquake that rattled BC's south coast in December 2015 and the prolonged power outage in the Lower Mainland in August 2015 are reminders that all levels of the health system need to be prepared to respond to an emergency. The power outage and absence of backup power in August resulted in the closure of many primary care offices and significant vaccine wastage in some clinics (Fraser Health Windstorm After Action Report 2015, internal document). Planning and coordination across the health care system, including primary care physicians, is needed to be able to respond adequately to the full range of potential disasters.

In February 2011 a devastating earthquake in Christchurch, New Zealand, caused widespread destruction, resulting in 182 deaths and over 6500 injuries within the first 24 hours.[2] The region's only acute care hospital suffered significant damage. To ease the stress on that hospital, coordinated groups of local primary care physicians and clinics organized by the Canterbury Primary Response Group (CPRG) and the local health authority managed lower acuity patients. While many clinics also suffered damage, the CPRG was able to respond with its community-wide collaboration of general practitioners, clinics, pharmacies, home and residential care groups, Aboriginal health associations, and allied health services thanks to its updated community health emergency plans, which had been in place since the 2009 H1N1 pandemic (e-mail communication with Dr P. Schroeder, Primary Care Coordinator, CPRG, 29 June 2015). Engaging both hospital and community physicians and providers in emergency preparedness helped to reduce disaster morbidity and mortality.[3-5]

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For many, worry about a rare but catastrophic event does not stimulate preparedness activities. However, even smaller disasters and events such as a highway bus crash, industrial accident, flood or landslide, or prolonged utility disruption can stall a community and health system.

Emergency preparedness has led many first responder groups to practise mass casualty incidents (MCI) and many hospitals to develop MCI plans, referred to as *code orange*. However, most of those plans and exercises have not engaged primary care practitioners in the community or incorporated the potential roles they could play. Community practitioners are essential to addressing the immediate and less-severe physical and mental health issues that arise immediately following a disaster, as well as the longer-term health maintenance of the population when other services are disrupted or overwhelmed.[3,5]

Recently the Victoria Division of Family Practice began several projects to help family physicians respond to a variety of disasters at the individual practice level and system wide. In collaboration with the Ministry of Health Emergency Management Unit, a Practice Continuity Guide and interactive workbook were created to help family physicians develop practice continuity plans that would maintain clinic functionality should emergencies or disasters occur in their building, neighborhood, or region.[6]

The Comox Valley Division of Family Practice collaborated with community and health authority emergency planners to develop a plan for local clinics to help triage and manage less-serious injuries and support the local hospital to manage more critical patients.[7,8] The Victoria Division also began similar planning with their local community emergency planners and stakeholders. Both examples highlight ways for community providers to contribute during an emergency and ways that local divisions can support collaborative planning for and with communities before a disaster strikes.

Unfortunately, emergency preparedness planning and the roles involved in disaster response receive little attention during medical training in Canada.[9] It is necessary to address this gap. As demonstrated by other countries, properly trained and engaged health care providers are essential to reducing disaster morbidity and mortality.[10-12] For this to be successful in BC, providers need support to participate in planning activities that will contribute to emergency response and community resilience.

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The past few decades have seen a steady rise in the number of disasters occurring globally.[13] BC will not remain immune to a large disaster in the future and will continue to experience smaller disasters affecting resource-challenged communities. The timing, magnitude, and impact of these events remain unpredictable, but the involvement of health care resources and practitioners, including family physicians, will always be necessary.

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References

Available at bcmj.org.

billing tips

When to bill fee item 14033 (complex care)

Recent audits have revealed that physicians may be claiming fee item 14033 (complex care) when there is no confirmed diagnosis of a second chronic condition.

Fee item 14033 was developed to compensate GPs for the management of complex patients residing in the community who have documented confirmed diagnoses of two chronic conditions from at least two of the eight categories listed below.

Eligible complex care condition categories:

1. Diabetes mellitus (type 1 and 2).
2. Chronic kidney disease.
3. Heart failure.
4. Chronic respiratory condition (asthma, emphysema, chronic bronchitis, bronchiectasis, pulmonary fibrosis, fibrosing alveolitis, cystic fibrosis, etc.).
5. Cerebrovascular disease, excluding acute transient cerebrovascular conditions (e.g., TIA, migraine).
6. Ischemic heart disease, excluding the acute phase of myocardial infarct.
7. Chronic neurodegenerative diseases (multiple sclerosis, amyotrophic lateral sclerosis, Parkinson disease, Alzheimer disease, brain injury with a permanent neurological deficit, paraplegia or quadriplegia, etc.).
8. Chronic liver disease with evidence of hepatic dysfunction.

There must be supporting documentation in the patient's medical record (i.e., a diagnostic test or consultation report) for both chronic conditions to meet the criteria to bill fee item 14033. Submitting a claim under 14033 when there is no confirmed diagnoses for both conditions could be considered deliberate misbilling. Deliberate misbilling can result in de-enrollment from the Medical Services Plan. Also, indicating a false diagnosis may have a negative impact on the patient, such as denied insurance or other benefits.

For more information on complex care, visit www.gpscbc.ca.

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This article is the opinion of the Patterns of Practice Committee and has not been peer reviewed by the BCMJ *Editorial Board. For further information contact Juanita Grant, audit and billing advisor, Physician and External Affairs, at 604 638-2829 or jgrant@doctorsofbc.ca.*

calendar

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