Auckland Waitemata RURAL ALLIANCE

It is hard to believe that the last update to you all was in November 2016. Since that Newsletter Update, the Auckland Waitemata Rural Alliance has been working to get inaugural Work Plan projects underway.

Chair's Update

The Rural Point of Care Testing Service (R-POCT) has now been implemented in over half of the rural general practices across both Auckland DHB and Waitemata DHB areas and is currently on schedule to be available to all rural general practices by the end of May 2018 (details inside).

Another project underway is Auckland DHB's funding of the digital upgrade of x-ray equipment on Great Barrier Island which will also include development of a nurse-led x-ray taking service.

Coming soon will be a 5 month pilot project providing access to funding for rural practices to administer Ferinject infusions, details of which will follow shortly.

Along with activities in our work plan, the Rural Alliance provides a rural lens on issues which impact rural primary healthcare and rural community services, examples being; providing formal feedback on the PRIME Review, linking with the Suicide Prevention work underway in both DHBs including supporting SafeTALK and Safe Hands, Safe Plans workshops, providing support for the Waiheke Island Service Review, input into Emergency Systems Planning, and providing a rural perspective on the POAC and ATD Review, to name a few.

In 2018, we look forward to continuing to realise rural specific activities which assist primary care services in rural areas to be comprehensive, sustainable, providing continuity of care by the right person, at the right time, in the right place.

Dr John Elliott
The Chair of the Auckland Waitemata Rural Alliance and GP at Kumeu Village Medical

The Rural Alliance represents rural general practices covering the areas of Wellsford, Warkworth, West Rodney, Waiheke Island and Great Barrier Island, servicing a combined enrolled population of 59,293 patients.*

**The above figure is only a proxy for the rural resident population as it doesn't include people who aren't enrolled with a general practice, or who may live in a rural area, say Wellsford, but are enrolled in a general practice in say Albany, because that is where they work.*

Rural Alliance Membership

Dr Tim Malloy represents
The Wellsford primary care team (Coast to Coast Healthcare)

Dr Kate Baddock represents
The Warkworth primary care team (Kawau Bay Health, Kowhai Surgery)

Dr John Elliott represents
The West Rodney primary care team (The Doctors Huapai, Kaipara Medical, Kumeu Village Medical, Silver Fern Medical Centre, Waimauku Medical)

Currently vacant
The Waiheke Island Primary Care team (Piritahi Health Centre, Oneroa Accident and Medical and Waiheke Health Trust)

Leonie Howie represents
The Great Barrier Primary Care team (Aotea Health)

PHO Representatives:
Barbara Stevens – Auckland PHO
Craig Murray – Comprehensive Care PHO Limited
Johnny O'Connell – ProCare Networks Limited

DHB Representatives:
Tim Wood
Jean McQueen
Stuart Jenkins

Chair - Dr John Elliott. Deputy Chair - Dr Kate Baddock.
Secretariat support - Lis Cowling, Auckland and Waitemata DHBs.

Rural Alliance Work Plan

The Auckland Waitemata Rural Alliance works to ensure that all people, no matter where they live, have a reasonable ability to live, work, and to contribute to, and be part of, New Zealand society by ensuring rural people have equitable outcomes to those living in urban areas.

To achieve this, the Rural Alliance has agreed to focus on certain priority areas in their work plan which will reduce a patient's need to travel by increasing access to diagnostics and interventions in the rural areas. The work plan will be a living document that is built on over time.

The following was decided by the Rural Alliance Members on 3 September 2016.

Agreed Goals:

- avoid hospitalisations
- keep people in the community
- provide clinical commitment
- and target high needs, Maori, Pacific and Q5 populations

It was further agreed by the Rural Alliance Members on 1 February 2018 that the following priority areas would be retained in the work plan:

Agreed Priority Areas

Initial Projects:

- Providing oversight on the review of health services on Waiheke Island
- Increasing the reach and access to diagnostic services in rural communities (e.g. Rural Point of Care Testing Service)
- Increasing access to treatments – e.g. Aclasta, Iron infusions, Venesection, Chemotherapy – sharing practice guidelines and increasing competency
- Increasing access to therapeutics – dispensing practices; structure and rules
- Accessing services via Telehealth – e.g. outpatients appointments

Future Projects:

- Development of Multi-Disciplinary Teams; Mental Health, Shared Care, Specialists in the Community
- Step Up, Step Down Beds in clinics and rest homes

The Rural Alliance is currently working to provide feedback and support for the Waiheke Island general practices, the Rural Point of Care Testing Service (R-POCT) is currently being implemented and the Ferinject Pilot Project is being readied for implementation during May 2018.

The initial work plan projects will assist rural GPs to work more efficiently in the provision of care, with less administrative and waiting time burden, for the benefit of patients.

Goals of the Rural Alliance

- **Reduce Ambulatory Sensitive Hospitalisations (ASH)**
- **Keep people in the community by providing timely access to the appropriate level of care**
- **Clinical commitment**
- **High needs, Maori, Pacific populations targeted**

Rural Alliance Work Plan

Rural Point of Care Testing (R-POCT) Service

Overview:

The Rural Point of Care Testing Service (R-POCT) is the first Auckland Waitemata Rural Alliance project to be supported across both Auckland and Waitemata DHBs. It is anticipated that training and implementation will be completed by the end of May 2018 for all rural general practices.

R-POCT Support:

R-POCT is supported by the Waitemata DHB Point of Care Testing Team for both DHBs. Contact information below:

Point of Care Testing Mobile Phone:
021 622 913

Name	Email Address
Generic email:	Pointofcaretesting@waitematadhb.govt.nz
Stephanie Williams:	Stephanie.williams@waitematadhb.govt.nz
Melanie Adriaansen:	Melanie.adriaansen@waitematadhb.govt.nz
Benjamin Jones:	Benjamin.jones@waitematadhb.govt.nz

POAC Claiming for R-POCT activities:

Please claim on-line via the POAC site from **1 May 2018**. Please use the Referral and Claim Codes as follows:

POAC Referral:

Use diagnosis coding based on the initial diagnosis (e.g. Chest Pain, DVT, Pneumonia)

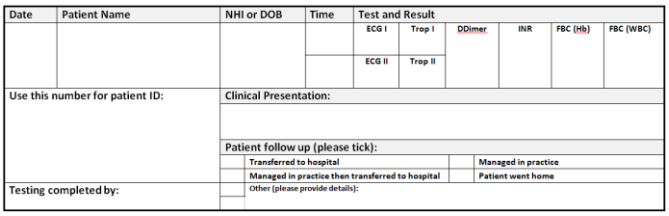
POAC Service Claim codes:

RPOCT Venous Sample $45.00 (including GST)
Plus list each of the tests completed:
RPOCT Trop
RPOCT D-dimer
RPOCT INR
RPOCT FBC (Hb)
RPOCT FBC (WBC)
ECG $45.00 (including GST)

Please enter the 'time of the R-POCT test' in the available text box when you enter a service code.

Retrospective claiming can be made on the basis that all fields within the manual form left with you during training and installation, are completed.

Please retain all R-POCT Manual Forms for audit purposes



Date	Patient Name	NHI or DOB	Time	Test and Result					
				ECG I	Trop I	DDimer	INR	FBC (Hb)	FBC (WBC)
				ECG II	Trop II				
Use this number for patient ID:		Clinical Presentation:							
		Patient follow up (please tick):							
		Transferred to hospital			Managed in practice				
		Managed in practice then transferred to hospital			Patient went home				
Testing completed by:		Other (please provide details):							

On completion of the on-line claim, POAC will reimburse rural general practices providing the R-POCT service for each venous blood sample taken, noting that one sample can be used for multiple POCT tests run simultaneously.

POAC reimbursement:

Patient's Venous Blood Sample:
For the patient's venous blood sample, regardless of the number of POCT tests completed for Troponin, D-Dimer, INR, or Full Blood Count:

- **$45.00** (including GST) per venous sample
- **Total $45.00 (including GST)**

Where an initial Troponin test is underway, an ECG will also be performed. The ECG can be claimed at the POAC ECG rate on the same reimbursement claim. In this instance, the maximum claim will then amount to $90.00 (including GST), as below:

- **$45.00** (including GST) for first venous sample
- **$45.00** (including GST) first ECG
- **Total $90.00 (including GST)**

Should a second Troponin be required, a second venous blood sample will be taken and POCT test performed. A second ECG may also be completed, if required. The maximum reimbursement will be $180.00 (including GST, as below:

- **$45.00** (including GST) for first venous sample
- **$45.00** (including GST) first ECG
- **$45.00** (including GST) second venous sample
- **$45.00** (including GST) second ECG, if required
- **Maximum total $180.00 (including GST)**

One Administration fee per patient episode of **$15.50 (including GST)** can be claimed.

Rural Point of Care Testing (R-POCT)

Auckland Regional HealthPathways:

R-POCT does not replace HealthPathways but provides an option within each pathway for the rural practices utilising the R-POCT analysers

The Auckland Regional HealthPathways for Acute Chest Pain and Deep Vein Thrombosis have been updated to reflect the use of R-POCT analysers.

Acute Chest Pain:

Troponin I on iSTAT:
For use on intermediate/ low risk patients. Not a high sensitive method. If the result is >0.04 ug/L the patient is moved to secondary care. If the result is <0.04ug/L and the patient is assessed as low risk then continue to follow Auckland regional pathway to manage patient in the community, ***with retesting 2 hourly.***

If there are still concerns that the chest pain is likely to be due to acute coronary syndrome, despite a troponin level of < 0.04ug/L, please discuss the case with secondary care.

How it appears on the Acute Chest Pain Pathway:

Pathway Link: *http://aucklandregion.healthpathways.org.nz/27916.htm*

1. Take a detailed history:
   - Pain history
   - Consider any life-threatening causes and admit acutely if there are any red flags
   - Check comorbidities and cardiovascular risk factors
   - Consider other causes of chest pain
2. Examine:
   - Look for sweating
   - Check temperature, blood pressure, heart rate, oxygen saturation
   - Look for complications of acute coronary syndrome e.g., pulmonary oedema, arrhythmia, cardiogenic shock
   - Fully examine the chest and abdomen, looking for non-cardiac causes
3. ECG (if available):
   - If requesting hospital admission, send the ECG report to hospital with the patient, providing it will not delay admission.
   - If the cost of ECG is prohibitive to the patient, consider using ProExtra, POAC, or other additional funding resources.
   - Results:
     - Note that a normal ECG does not exclude ACS.
     - New ECG changes.
     - If the ECG is ambiguous or further interpretation is required, seek cardiology advice. They will provide a number to fax the ECG to.
4. Risk stratification:
   - Decide whether the risk is high, intermediate, low, or unlikely that the chest pain is due to ACS, to help determine the best management.
   - Assess only low-risk patients in the community.

Risk	Features	Management
High	• High clinical suspicion of ACS • Ongoing chest pain • Haemodynamic compromise • Recent history of exertional angina • Deterioration of previously stable angina • Pain similar to previous angina or MI • New ECG changes • Presentation suggestive of other potentially life-threatening condition	• Immediate management • Acute general medicine assessment
Intermediate	• No high-risk features • Known ischaemic heart disease • Cardiovascular 5-year risk > 10%	• Use clinical judgement and either treat as high-risk or low-risk. • Assess the risk of both acute coronary syndrome, and social factors and comorbidities that may make management in hospital more appropriate.
Low	• No high or intermediate risk features • Clinician still considering ACS	• Measure troponin (hs-cTn) and manage according to results
Unlikely to be ACS	• No high or intermediate risk features	• Routine measurement of troponin is not advised • Treat the most likely cause

If relevant, arrange laboratory troponin testing or, if available,
Rural Point of Care Test (R-POCT) for troponin.

Rural Point of Care Test (R-POCT) for troponin

- If the result is ≥ 0.04 microgram/L, request acute general medicine assessment.
- If the result is < 0.04 microgram/L and patient is low risk, continue to manage in the community. Repeat test after 2 hours.
- Seek cardiology advice if a troponin level of < 0.04 microgram/L, and there are still concerns about acute coronary syndrome.

Rural Point of Care Testing (R-POCT)

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Deep Vein Thrombosis (DVT)

D-dimer on H232:

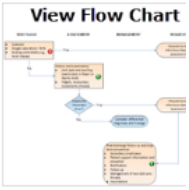
Must be used in conjunction with the pathway/scoring system.
A D-dimer less than 500 ng/mL is considered negative,
above 500 ng/mL considered positive.
This test has 100% negative predictive value in patients risk stratified as low risk.
The D-dimer is raised in a number of physiological and pathological conditions including VTE.

How it appears on the DVT Pathway:
Pathway Link: *http://aucklandregion.healthpathways.org.nz/21919.htm*

Deep Vein Thrombosis (DVT)

If suspected pulmonary embolism, see Pulmonary Embolism (PE) pathway.
If acutely unwell with comorbidities, seek general medical advice.

View Flow Chart



Assessment

1. Assess for signs and symptoms. Consider PE, or superficial thrombophlebitis.
2. Exclude other causes of leg swelling i.e., cellulitis, heart failure, ruptured Baker's cyst.
3. Arrange DVT ultrasound (risk stratification not required) if:
   - suspected superficial thrombophlebitis.
   - upper limb DVT.
   - pregnant.
4. Complete Wells Score (risk stratification tool) to determine the pre-test probability score of a DVT.
   - If score ≥ 2, arrange DVT ultrasound. Consider enoxaparin if ultrasound is delayed more than 6 hours.
   - If score < 2, arrange urgent laboratory D-dimer blood test, and review result same day. In a rural general practice, use Point of Care Testing (R-POCT) where available.
5. If suspected DVT, and aged:
   - < 15 years, seek paediatric advice.
   - 15 to 18 years, seek haematology advice.

Management

Practice Point!
Age-adjusted reference ranges are only used for laboratory testing. Do not make use of age-adjusted reference ranges for POCT devices.

1. Manage according to test results.
   - Laboratory tests – Check results in line with new age-adjusted D-dimer range.
   - R-POCT practices – Check results in line with cobas h 232. Do not use age-adjusted reference ranges for POCT devices.

Cobas h 232
This test has 100% negative predictive value in patients risk stratified as low risk.
- Negative – D-dimer < 500 nanogram/mL.
- Positive – D-dimer ≥ 500 nanogram/mL.

2. If results are:
   - negative, risk of DVT is low. Provide patient information and review in 7 days.
   - positive, arrange ultrasound.

R-POCT Tests without Pathways

(information contained within R-POCT training manual):

Warfarin starting and monitoring:
INR on iSTAT: *Use hospital patient reference ranges and for any INR above 5, action should be taken in some form and a repeat blood sample collected for the lab. Please follow guidelines from the transfusion service on managing high INR's. In most cases these patients can be safely managed in the community.*

Full Blood Count:
FBC on QBC Star: *Results as printed except Hb reported in g/dL will need a x10 until the next software upgrade. Analyser validated with lab assay. Use patient reference ranges but if NO result for white cell count then the patient results are abnormal and patient should be managed accordingly along with a repeat blood sent to laboratory.*

Contact: Lis Cowling, secretariat
Lis.Cowling@waitematadhb.govt.nz