Please note: This manual is a living document and will be updated from time to time. We encourage you to access this document online for the most up-to-date version instead of relying on a printed version.

Created March 2019
Table of Contents

Introduction ........................................................................................................................................... 1
Administrative Section ......................................................................................................................... 2
Clinical Section .................................................................................................................................... 4
  Diabetes in Pregnancy- Insulin Initiation: Waikato; (PMHN only) .................................................. 5
  ED high users primary care reconnection service: Tairawhiti ....................................................... 7
  Insulin Initiation: All localities; (PMHN only) ................................................................................ 11
  ICCT – Physical and Transition of Care Pathway for patients with long term mental illness: Waikato ..................................................................................................................... 13
  Iron infusions for the management of iron deficiency anaemia: Tairawhiti and Lakes .................. 16
  Iron infusions for the management of iron deficiency anaemia: Waikato ........................................ 19
  Primary Options Mental Health & Addictions (POMHA): Tairawhiti ............................................ 21
  Rheumatic Fever Prevention Programme: Waikato and Tairawhiti(PMHN only) ...................... 24

This document supports the agreement between Pinnacle MHN and providers wishing to claim via the Advanced Primary Options service. In order to claim for services under Advanced primary Options your practice must have a current contract with Pinnacle MHN.

Each service is operated by Pinnacle MHN under contract to local District Health Boards. This document is to be read in conjunction with your agreement for Primary Options services.

In addition, this document aims to provide both clinical and administrative information supporting each service under Advanced Primary Options. This manual can be used by anyone who wishes to understand more about what services are available through Advanced Primary Options, their patient’s eligibility for a service and what can be claimed by general practice.
Introduction

Advanced Primary Options supports general practice to provide access to a range of funded community treatment, diagnostics and logistical services to treat patients in the community. The aim is to reduce non-acute presentations at the hospital for these services. The service is managed by the Pinnacle MHN Primary Options team. Services

- Support general practice to safely manage patients who meet service eligibility criteria in the community.
- Support the patient’s family doctor to manage their ongoing care closer to home.
- Provide patients with access to community-based, in-clinic and third-party health services.
- Encourage the best health outcomes for patients
- Ensure all communities have equitable access to services available in their region
- Facilitate the claiming and co-ordination process to all parties involved by providing a single point of entry.

The services currently available are:

<table>
<thead>
<tr>
<th>Service</th>
<th>Locality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes in Pregnancy Insulin Initiation</td>
<td>Waikato: PMHN only</td>
</tr>
<tr>
<td>ED High User Reconnection Service</td>
<td>Tairawhiti</td>
</tr>
<tr>
<td>Insulin Initiation</td>
<td>All localities: PMHN only</td>
</tr>
<tr>
<td>Integrated care for people with long-term mental illness</td>
<td>Waikato</td>
</tr>
<tr>
<td>Iron Infusions</td>
<td>Tairawhiti and Lakes</td>
</tr>
<tr>
<td>Iron Infusions</td>
<td>Waikato</td>
</tr>
<tr>
<td>Primary Options Mental Health &amp; Addiction (POMHA)</td>
<td>Tairawhiti</td>
</tr>
<tr>
<td>Rheumatic Fever Sore Throat Swabs</td>
<td>Waikato and Tairawhiti: PMHN only</td>
</tr>
</tbody>
</table>

This manual has two sections:

**Administrative** – containing guides on how to refer, invoice and outcome a case and business rules for Advanced Primary Options Services.

**Clinical** – containing individual service information
Administrative Section

Business rules for all services

Advanced Primary Options services may be modified from time to time. The Primary Options team will notify providers through PHO communication channels of any changes to policies, procedures and the information manual. It is the provider’s responsibility to ensure they are following the most up to date policies and guidelines. This manual is available electronically at www.pinnacle.co.nz/uploads/advanced-primary-options-manual.pdf

Patient eligibility criteria

- Be eligible to access funded New Zealand health care services. To ascertain eligibility for primary healthcare funding please refer to the Ministry of Health’s web site https://www.health.govt.nz/new-zealand-health-system/eligibility-publicly-funded-health-services
- meet the individual eligibility criteria for the service
- have given their consent to the recommended treatment
- have been advised and agree that they may be liable for costs should the claim be declined

Please refer to individual service information documents for specific service eligibility criteria.

Providers must ensure:

- it is clinically safe and appropriate to manage the patient’s care in the community
- the treating clinician can take responsibility for the patient’s care, or has the option to hand over the patient to another clinician
- the services will be delivered within the business rules.

Exclusions

Please refer to the individual service information documents (Clinical Section) for specific exclusions.
**Lodging a Referral**

All cases require a referral/request for funding from a primary care/service provider (e.g. GP or nurse practitioner). Each referral must meet individual service eligibility criteria and contain the necessary information required to process the referral.

All invoices will be held for payment until the outcome of the case has been lodged.

A referral should be submitted as soon as possible following the episode of care.

These are DHB funded service designed to improve patient outcomes. GPs are required to provide sufficiently detailed consultation notes to allow internal audit and ensuring we meet our contract obligations. It has been recommended that in addition to a good assessment and history, the full range of appropriate observations should be documented and included in your referral.

The notes can be added to the referral/invoice/outcome by clicking the ‘add clinical notes’ button, or by copy-pasting your notes into the text box.

**Contact details**

Call the number below to speak directly with the Primary Options team. In the unlikely event that all the team are busy, the caller will be asked to hold or leave a message (during business hours only). Should a message be left, the team will respond in the priority order it was left.

Primary Options Team
Phone: 0800 646 764
Fax: 07 838 8485
Email: infoprimarystrokes@pinnacle.health.nz

**One-point lessons**

These can be found on our website: [https://www.pinnacle.co.nz/programmes/primary-options-acute-care-waikato](https://www.pinnacle.co.nz/programmes/primary-options-acute-care-waikato)

a) **How to lodge a referral**
   - Electronic: Medtech, Indici,
   - Manual (faxed)

b) **How to lodge an invoice**
   - Electronic: Medtech, Indici,
   - Manual (faxed)

c) **How to lodge an outcome/close a case**
   - Electronic: Medtech, Indici,
   - Manual (faxed)
## Clinical Section

Select (Ctrl click) the service for which you would like to find out more information:

<table>
<thead>
<tr>
<th>Service</th>
<th>Locality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes in Pregnancy Insulin Initiation</td>
<td>Waikato: PMHN only</td>
</tr>
<tr>
<td>ED High User Reconnection Service</td>
<td>Tairawhiti</td>
</tr>
<tr>
<td>Insulin Initiation</td>
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<tr>
<td>Iron Infusions</td>
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</tr>
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<td>Primary Options Mental Health &amp; Addiction (POMHA)</td>
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</tr>
<tr>
<td>Rheumatic Fever Sore Throat Swabs</td>
<td>Waikato and Tairawhiti: PMHN only</td>
</tr>
</tbody>
</table>
**Diabetes in Pregnancy- Insulin Initiation: Waikato**

**Available to Pinnacle MHN practices only**

This is NOT a clinical guideline

Detailed relevant clinical notes to clearly support the claim are required.

**Overview**

- This programme is available for women with diabetes in pregnancy who need to start insulin and have been referred by the Diabetes in Pregnancy team.
- The initial education of meter use, diet and subsequent assessment of blood glucose results with a decision to start insulin will be done by the Diabetes in Pregnancy team.
- A script and insulin starter pack will be provided to the patient by the Diabetes in Pregnancy team.

**Exclusions**

- Women who are pregnant and already on insulin

**Entry criteria (eligibility)**

- Pregnant women who have been referred from the Diabetes in Pregnancy team at Waikato Hospital and require insulin initiation.
- The pregnant woman must be enrolled at a Pinnacle MHN practice
- Women who are eligible for New Zealand funded health care

**Exit criteria**

- The programme covers a one-off appointment for insulin start education.
- On completion of this appointment an outcome can be lodged.
- The Diabetes in Pregnancy team must be informed when the insulin start education has been completed.

**Claiming guidelines**

- Claims can be initiated by PN/GP and must include related clinical notes.
- Only 1 claim per patient will be accepted.
- No co-payment is to be charged to the patient.

<table>
<thead>
<tr>
<th>Service item</th>
<th>Description</th>
<th>GST incl.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes in Pregnancy insulin start</td>
<td>Includes GP/PN consult time and any consumables. Max of 1 per patient</td>
<td>$90.00</td>
</tr>
</tbody>
</table>
FAQs

1. **Why will pregnant women need to be referred for insulin start up?**
   This will generally occur when a woman live in a rural area or is not able to attend the Waikato Regional Diabetes Service to see the Diabetes in Pregnancy team for insulin initiation education.

2. **Can I claim any additional invoices for cases that take more time than usual?**
   No, this programme is an all-inclusive one-off payment for all time spent with clinicians and supplied consumables. No co-payment can be charged for insulin start education.

3. **Who will follow up on the insulin titration for this patient?**
   Once the insulin start education has been done the Diabetes in Pregnancy team will take over the insulin stabilisation for this patient and are responsible for their on-going care.

4. **Who will provide the insulin script and insulin starter pack?**
   The Diabetes in Pregnancy team will give the script to the patient or fax the script to the patient’s pharmacy of choice. On most occasions the insulin starter pack is given to the patient at the antenatal clinic and the patient will bring along this with them to the practice for their insulin initiation demonstration and education.

5. **What other information do I need to know?**
   The Diabetes in Pregnancy team will provide the practice or patient with a pack including GDM insulin education in general practice, insulin plan and GDM insulin initiation guidelines for General Practice. Always follow the insulin plan, demonstration of pen device is necessary, and the patient will usually start the insulin that evening or follow insulin plan as given by diabetes and pregnancy team.

6. **Who do I contact if I have more questions?**
   Liz Lewis-Hills, Team Lead for the Diabetes in Pregnancy Team at the Waikato Regional Diabetes Service can be contacted for any questions related to the insulin initiation.
   Phone number 07 859 9180 Ext. 23731
   Mobile 021 761 891
ED high users primary care reconnection service: Tairawhiti

Available to all practices

This is NOT a clinical guideline

Detailed relevant clinical notes to clearly support the claim are required.

Overview

The ED High Users Primary Care Reconnection Service is designed to re-establish (or establish) the connection of individuals and whanau with their primary care team by providing funded consultations to develop and implement a comprehensive shared care plan alongside the relevant care partners to empower increased self-management and planned access to health services.

The following table outlines the care package components and Appendix 1 provides a diagram of the overall service.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engagement Contribution (Initial and ongoing)</td>
<td>Person enrolled into programme</td>
</tr>
<tr>
<td>1 Hour Extended GP/MDT Consultation (including relevant DHB clinical personnel e.g. disease specific CNS or clinician, and whanau)</td>
<td>Care plan developed and agreed with person and whanau and shared with ED, St Johns, other care partners</td>
</tr>
<tr>
<td>Up to 4 free planned follow up consultations with general practice team (GP, Nurse, Kaiawhina dependent on care plan)</td>
<td>Reduced unplanned health service attendances</td>
</tr>
<tr>
<td>Up to 2 additional free follow up consultations if patient has an exacerbation or re-presents to ED</td>
<td>Prevention of condition exacerbations through earlier intervention</td>
</tr>
</tbody>
</table>

Exclusions

- People who are not eligible for NZ funded health services.
- Patients who do not meet the ED attendance criteria as follows are excluded from the service.

Entry criteria (eligibility)

Entry criteria for this programme is any individual who has attended ED 8 or more times in the preceding 12 months or 5 or more times in the preceding 6 months. Entry to this programme will be via either of two pathways:

1. **Data initiated entry** – Pinnacle MHN will provide an NHI list of eligible patients based on the criteria above to each practice who can then initiate the programme. There will be
one initial eligible cohort determined at the start of the programme. A review of eligibility criteria and process will be undertaken after 6 months of the programme, but the initial cohort will remain eligible until further notice.

2. **ED or GP team-initiated entry** – identification of individuals who are not in the initial cohort and have attended ED multiple times, meeting the entry criteria above. In the case of ED identification this will be referred to the general practice for initiation of the programme.

**Exit criteria**

The patient exits the programme when the care package is completed. In this service the patient will access the different components of the package over a period of up to 12 months. The patient can be exited from the service by the general practice before all elements of the package are utilised or they will be automatically exited from the service at the completion of the 12 months from the initial extended consultation.

**Claiming guidelines**

<table>
<thead>
<tr>
<th>Charges to primary options</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service item</strong></td>
</tr>
<tr>
<td>Engagement contribution (initial and ongoing)</td>
</tr>
<tr>
<td>Extended MDT consultation</td>
</tr>
<tr>
<td>Up to 4 free planned follow up consultations</td>
</tr>
<tr>
<td>Up to 2 additional follow up consultations</td>
</tr>
</tbody>
</table>

*please refer to Appendix One – ED High Users Primary Care Reconnection Pathway Diagram

$328 maximum per patient only
FAQs

1. **Does the patient have to pay?**
   
   No, patients eligible for this programme cannot be charged a co-payment for GP or nurse consultations included in the package of care.

   If any additional investigations or services are required for the patient, this programme does not fund the associated costs.

2. **How can claims be made for this service?**

   Claims can be made via Primary Options. When you have the initial consultation with the patient lodge a new referral and select the ED High Users category for the patient. The case number generated will be used for the 12 months duration of the patient’s care.

   At each consultation lodge a single invoice using the original case number, add the consult notes and select the appropriate invoice. For example, for a consultation with the GP claim a GP standard consult ($18).

   Please be aware if you do not ‘outcome’ the case you will receive this case as part of the reminder email sent out on a regular basis. If you do not want to receive a reminder for this case, please ‘outcome’ the case. You will still be able to lodge single invoices for this case number regardless of whether this case has had an ‘outcome’ submitted or not.

3. **When should an episode of care end?**

   The conclusion of this programme for each patient is 12 months after their initial consultation or once a patient has used the full allocation of funded consults under this programme.

4. **Can I still claim Primary Options for Acute Care if a patient presents with an exacerbation of their condition and is acutely unwell?**

   Yes, please claim as usual for cases where a patient presents acutely with an exacerbation of their condition and the treatment provided in general practice is preventing an admission to the emergency department. Please remember the patient still funds the initial consult.
Primary Care Reconnection Pathway for high users of services

Goal: Re-establish the connection of individuals with their primary care team and establish a comprehensive shared care plan to empower increased self-management and planned health service supports for health conditions for whānau currently accessing health services at a high rate.

Diagram

<table>
<thead>
<tr>
<th>Entry Pathways</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data initiated entry</td>
</tr>
<tr>
<td>ED or GP team initiated entry</td>
</tr>
<tr>
<td>- ED utilisation data provided by Pinnacle</td>
</tr>
<tr>
<td>- Report identifying individuals who have been to ED 8+ times in last 12 months or 5+ times in last 6 months provided to practices</td>
</tr>
<tr>
<td>- Proactive identification of individuals who have attended multiple times that aren’t in initial cohort (also 8+ times in last 12 months or 5+ times in last 6 months)</td>
</tr>
<tr>
<td>Funding</td>
</tr>
<tr>
<td>$50 engagement contribution</td>
</tr>
<tr>
<td>$170 free consultation</td>
</tr>
<tr>
<td>Up to 4 * $18 (co-payment)</td>
</tr>
<tr>
<td>Up to 2 * $18 (co-payment)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Initial cohort analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Range</td>
</tr>
<tr>
<td>-----------</td>
</tr>
<tr>
<td>U13</td>
</tr>
<tr>
<td>13-24</td>
</tr>
<tr>
<td>25-45</td>
</tr>
<tr>
<td>46-65</td>
</tr>
<tr>
<td>66-75</td>
</tr>
<tr>
<td>75+</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

Diagram

Care Plan

Includes:
- Nominated GP team lead
- Planned sessions
- Whānau goals
- Condition specific plan
- Pocket script (if applicable)

Provided to:
- Whānau
- ED
- GP Team
- St John’s
- Other providers

If individual presents outside of Care Plan (ie to ED, GP, St John’s) a follow up mechanism is enacted with GP team lead to follow up with an additional funded consultation.
Insulin Initiation: All localities

Available to Pinnacle MHN practices only

This is NOT a clinical guideline

Detailed relevant clinical notes to clearly support the claim are required

Overview

This programme is available for people with type 2 diabetes who need to start insulin.

The service provides funding for an initial consultation to start insulin and one follow up face to face appointment.

Exclusions

- People who are already on insulin and need their insulin doses titrating as part of their on-going care or changing their type of insulin use are ineligible for funding under this pathway.

Entry criteria (eligibility)

- People with type 2 diabetes who require insulin initiation and are registered at a Pinnacle practice
- People that are eligible for New Zealand funded health care

Claiming guidelines

- Claims can be initiated by a registered nurse/GP and must include related clinical notes.
- Only 1 claim per patient will be accepted.
- Each referral can contain a maximum of 1 initial and 1 follow up claim.
- No co-payment is to be charged to the patient.

<table>
<thead>
<tr>
<th>Service item</th>
<th>Description</th>
<th>GST incl.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial insulin start</td>
<td>Includes GP/PN consult time and any consumables. Max of 1 per patient</td>
<td>$90.00</td>
</tr>
<tr>
<td>Insulin start follow-up</td>
<td>Includes GP/PN consult time and any consumables Max of 1 per patient</td>
<td>$50.00</td>
</tr>
</tbody>
</table>
FAQs

1. **Can I claim any additional invoices for cases that take more time than usual?**
   No, this programme is an inclusive one-off payment for all time spent with clinicians and supplying consumables. No co-payment can be charged for insulin start or insulin follow up. Any further follow up can be charged to the patient but please make sure the patient is aware of this.

2. **Can I utilise this programme for patients who need on-going insulin dose titration?**
   No, this funding is only available for starting insulin and 1 subsequent follow up.

3. **Can I claim a telephone consult as the insulin start follow up consultation?**
   No, it must be a face to face consultation which can occur at any time. Clinician discretion will determine the timing of the follow up appointment.

4. **What is the best way of claiming the initial insulin start and the subsequent follow up appointment?**
   Submit the referral including the notes for the initial insulin start consultation and use the ‘invoice only’ to claim the initial insulin start consultation. The practice will receive a reminder to close the case by submitting an ‘outcome’; this can serve as a prompt to check if the patient has had their face to face follow-up consultation. If the patient has had a follow-up consultation, submit the ‘outcome and invoice’ form including the follow-up consultation notes and add the insulin start follow-up consultation in the invoicing section of the form. This will close the case and payment will be made.
ICCT – Physical and Transition of Care Pathway for patients with long term mental illness: Waikato

Available to Pinnacle MHN practices only

This is NOT a clinical guideline

Detailed relevant clinical notes to clearly support the claim are required

Overview

As part of the Integrated Care Coordination Team (ICCT) 12 months of free care is available to eligible patients. Each patient is placed on one of the following two pathways.

- The **physical care pathway** aims to provide the patient with free GP consultations to address any physical needs. Their mental health condition continues to be managed by secondary services.
- The **transitional care pathway** aims to support the transition of the patient from secondary care to primary care for the management of their physical and mental health.

The service focuses on collaboration between the patient, their GP and mental health providers.

The goal is to remove barriers for these patients to access primary care, and to assist the patient to reach a stage where they are able to self-fund their primary care.

Entry criteria (eligibility)

Selection of patients for this programme will be by the secondary services ICCT. The ICCT will advise the PHO who the patient is and which practice the patient is enrolled with. The PHO will then pass those details to the relevant practice and indicate whether the patient is on the physical or transitional care pathway

The patient’s general practitioner assesses the patient as clinically safe and appropriate to manage their care in the community

The patient’s general practitioner can take responsibility for the person’s care or has the option to hand over the patient to another clinician.

Exit criteria

Each patient receives funding for 12 months, starting from the date of the patient’s first appointment and ceasing 12 months later regardless of whether the patient has used all their funded appointments. Alternatively, the patient exits the programme if they have used their allocation of funded appointments (see claiming guidelines).
### Claiming guidelines

**Physical care patients are eligible for the following funded consultations**

<table>
<thead>
<tr>
<th>Service Item</th>
<th>Description</th>
<th>Amount available</th>
<th>GST incl.</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICCT: physical initial care plan</td>
<td>Extended nurse consultation. This is the first appointment with the patient and is used for planning and developing the nurse/patient relationship.</td>
<td>1</td>
<td>$43.56</td>
</tr>
<tr>
<td>ICCT: GP standard consult</td>
<td>Standard GP consultation. This appointment would generally be used for the patient to have check-ups every three months.</td>
<td>6</td>
<td>$87.11</td>
</tr>
<tr>
<td>ICCT: Physical annual review</td>
<td>Extended nurse consultation. This is the last appointment with the patient and is used to review the initial 12 months of care.</td>
<td>1</td>
<td>$43.56</td>
</tr>
</tbody>
</table>

**Transitional care patients are eligible for the following funded consultations**

<table>
<thead>
<tr>
<th>Service Item</th>
<th>Description</th>
<th>Amount Available</th>
<th>GST incl.</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICCT: Trans Initial care plan</td>
<td>Extended GP consultation. This is the first appointment with the patient and is used for planning and developing the GP/patient relationship.</td>
<td>1</td>
<td>$130.67</td>
</tr>
<tr>
<td>ICCT: GP standard consult</td>
<td>Standard GP consultation. This appointment would generally be used for the patient to have check-ups every three months.</td>
<td>4</td>
<td>$87.11</td>
</tr>
<tr>
<td>ICCT: extended nurse consult</td>
<td>Extended nurse consultation.</td>
<td>12</td>
<td>$43.56</td>
</tr>
<tr>
<td>ICCT: Trans IMI injection</td>
<td>IMI injections. If required for administration of IMI’s.</td>
<td>26</td>
<td>$20.90</td>
</tr>
<tr>
<td>ICCT: Trans annual review</td>
<td>Extended GP consultation. This is the last appointment with the patient and is used to review the initial 12 months of care.</td>
<td>1</td>
<td>$130.67</td>
</tr>
</tbody>
</table>
FAQs

1. **How can claims be made for this service?**

   Claims can be made via Primary Options. When you have the initial consultation with the patient, lodge a new referral and select the appropriate category for the patient, either **ICCT: Transition of Care** or **ICCT: Physical Care Needs**. The case number generated will be used for the 12 months duration of the patient’s care.

   At each consultation lodge a single invoice using the original case number, add the consult notes and select the appropriate invoice. For example, for a consultation with the GP claim a GP standard consult.

   Please be aware if you do not ‘outcome’ the case you will receive this case as part of the reminder email sent out on a regular basis. If you do not want to receive a reminder for this case, please ‘outcome’ the case. You will still be able to lodge singular invoices for this case number regardless of whether this case has had an ‘outcome’ submitted or not.

2. **How do I keep track of what has already been claimed for this patient or if they are still eligible for the service?**

   It is recommended that an alert is put on the patient’s record, indicating which category (Transitional or Physical) they are eligible for, the case number being used for claiming as well as the start date and end date for the patient. The start date is the date of the initial consultation and the end date is one calendar year from the initial consult. Patients are only eligible for this service for one year from the date of the initial consult. The Primary Options team will also send the practice an email once the year has been completed, whether the patient has used their allocation of consults or not.

   To keep track of what has already been claimed for the patient you can view each advanced form submitted to the team by clicking in to the ‘forms’ section in the patient record. Alternatively, you may contact the Primary Options team on 0800646764 if you wish to check what has been paid.

3. **Can I claim any additional invoices for consults that take more time than usual?**

   No. This service only funds what is listed in the tables in the claiming section. If the patient requires additional services such as ECGs, dressing changes as part of the consult please advise the patient there may be an additional cost.

4. **Who can I contact for further support?**

   GP’s can access additional support through the Integrated Care Coordination Team by phoning 07 834 6902 or by email: [ICCT@waikatodhb.health.nz](mailto:ICCT@waikatodhb.health.nz).
Iron infusions for the management of iron deficiency anaemia: Tairawhiti and Lakes

Available to all practices

This is NOT a clinical guideline

Detailed relevant clinical notes to clearly support the claim are required

Overview

This programme provides funding for IV iron infusions for patients who meet the PHARMAC special authority criteria for prescribing subsidised ferric carboxymaltose (Ferinject) in the community.

The infusion is to be provided in the community by the patient’s general practitioner.

Please consider the underlying cause of the iron deficiency anaemia and investigate as per best practice. For guidance on diagnosing and managing iron deficiency anaemia, see Anaemia on full blood count: investigating beyond the pale.

Exclusions

- Patients not enrolled in a Lakes or Tairawhiti DHB general practice.
- Out of region patients do not have funding provided under this programme.
- IM administration of iron (Ferrum H).
- Patients with anaemia not due to iron deficiency.
- Patients with evidence of iron overload or disturbance in utilisation of iron.
- Anyone with the following contraindications.

Contraindications to using Ferinject in patients:

- aged under 14 years
- in the 1st trimester of pregnancy (at other stages of pregnancy please consult an obstetrician regarding the risks and benefits of treatment with IV iron)
- with previous or known hypersensitivity to parenteral iron products.

NB: allergic reactions are more common in people with a history of inflammatory diseases such as asthma, eczema and rheumatoid arthritis. Close observation is recommended for all patients whether or not they have had an iron infusion in the past.
Entry criteria (eligibility)

Special authority criteria for subsidised ferric carboxymaltose (Ferinject: patients with iron deficiency anaemia with a serum ferritin $\leq$ to 20mcg/L) who:

- have trialled and been adherent with oral iron and
  - it has been ineffective OR
  - they have had intolerable side effects.
- OR require rapid correction of iron deficiency due to severe symptoms/pre-operative
- OR on recommendation from a specialist when patients have a condition where evidence favours the use of IV iron over oral iron (symptomatic heart failure/chronic kidney disease stage 3 or more/active inflammatory bowel disease).

Please refer to the PHARMAC special authority criteria for Ferinject.

Exit criteria

- The patient exits the iron infusions programme once the care is completed.
- Under no circumstances, should a patient be managed in primary care if the treatment/infusion is beyond the service provider’s capability and compromises patient safety.

Claiming guidelines

IV delivery of iron medication includes:

<table>
<thead>
<tr>
<th>Service item</th>
<th>GST incl.</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP initial consultation</td>
<td>$45</td>
</tr>
<tr>
<td>Nurse administration, observation time and consumables</td>
<td>$105</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$150</strong></td>
</tr>
</tbody>
</table>

A referral must be submitted via Primary Options using the initial condition coding: **Iron infusion**.

When invoicing for the service please lodge an ‘invoice only’ or the ‘outcome and invoice’ form and select the ‘iron infusion’ invoice. The total cost is $150 including GST.

Please be aware the claim is all inclusive of the GP consult, the administration of the infusion, observation time and consumables.

Payment will be made once the patient’s treatment has been completed and an outcome has been lodged for the case.
FAQs

1. **Does the patient have to pay?**
   No. A patient co-payment should not be charged. This service funds the administration of the infusion and there is no cost for the infusion to the patient, provided entry criteria are achieved. The funding for the service includes the co-payment for the initial GP consultation followed by the nurse administration of the infusion.

   This service does not include the cost of Ferinject on special authority, this is the responsibility of the patient to purchase.

2. **Can funding be accessed for the same patient for more than one episode?**
   A second claim may be made if the patient requires a divided dose of iron but please add this to the original case number.

3. **When should an episode of care end?**
   On completion of the infusion delivery and observation time. The iron infusion service funds the GP consultation and the nurse administration, observation time and consumables. The patient should be discharged from the iron infusion service once the patient is considered clinically safe to leave the practice. Observation is recommended for 30 minutes post infusion.

4. **References**
   - **Intravenous ferric carboxymaltose: now available for the treatment of iron deficiency.**
   - **Anaemia on full blood count: investigating beyond the pale.**
   - **Intravenous iron – safe prescribing - calculate and measure.**
   - **Application for subsidy by special authority.**
Iron infusions for the management of iron deficiency anaemia: Waikato

Available to all practices

This is NOT a clinical guideline

Detailed relevant clinical notes to clearly support the claim are required

Overview

This programme provides funding for IV iron infusions for patients when the medication has been prescribed by a Waikato DHB anaesthetist.

The infusion is to be provided in the community by the patient’s general practitioner.

Exclusions

- Patients not enrolled in a Waikato DHB general practice.
- Out of region patients do not have funding provided under this programme.
- IM administration of iron (Ferrum H).
- Anyone with the following contraindications.

Contraindications to using Ferinject in patients:

- aged under 14 years
- in the 1st trimester of pregnancy (at other stages of pregnancy please consult an obstetrician regarding the risks and benefits of treatment with IV iron)
- with previous or known hypersensitivity to parenteral iron products.

Under no circumstances, should a patient be managed in primary care if the treatment/infusion is beyond the service provider’s capability and compromises patient safety.

NB: allergic reactions are more common in people with a history of inflammatory diseases such as asthma, eczema and rheumatoid arthritis. Close observation is recommended for all patients whether or not they have had an iron infusion in the past.

Entry criteria (eligibility)

- Only Ferinject prescribed by a Waikato DHB anaesthetist for a pre-op patient is funded under this service

Please refer to the PHARMAC special authority criteria for Ferinject. Application for subsidy by special authority.

Exit criteria

- The patient exits the iron infusions programme once the care is completed.
Claiming guidelines

IV delivery of iron medication includes:

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</tr>
<tr>
<td><strong>Total</strong></td>
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</tr>
</tbody>
</table>

A referral must be submitted via Primary Options using the initial condition coding: **Iron infusion**.

The referral must include the name and speciality of the prescribing doctor and the patient’s proposed operation date.

When invoicing for the service please lodge an ‘invoice only’ or the ‘outcome and invoice’ form and select the ‘iron infusion’ invoice. The total cost is $150 including GST.

Please be aware the claim is all inclusive of the GP consult, the administration of the infusion, observation time and consumables.

Payment will be made once the patient’s treatment has been completed and an outcome has been lodged for the case.

**FAQs**

1. **Does the patient have to pay?**
   
   No. A patient co-payment should not be charged. This service funds the administration of the infusion and there is no cost for the infusion to the patient, provided entry criteria are achieved. The funding for the service includes the co-payment for the initial GP consultation followed by the nurse administration of the infusion.
   
   This service does not include the cost of Ferinject on special authority, this is the responsibility of the patient to purchase.

2. **Can funding be accessed for the same patient for more than one episode?**
   
   A second claim may be made if the patient requires a divided dose of iron but please add this to the original case number.

3. **When should an episode of care end?**
   
   On completion of the infusion delivery and observation time. The iron infusion service funds the GP consultation and the nurse administration, observation time and consumables. The patient should be discharged from the iron infusion service once the patient is considered clinically safe to leave the practice. Observation is recommended for **30 minutes post infusion**.
Primary Options Mental Health & Addictions (POMHA): Tairawhiti

Available to all practices

This is NOT a clinical guideline

Detailed relevant clinical notes to clearly support the claim are required

Overview

As part of the Tairawhiti DHB Mental Health and Addiction Services, 12 months of free care is available to eligible patients. Each patient is referred for one of the following two pathways and packages of care.

- The physical care pathway aims to provide the patient with free GP consultations to address any physical needs. Their mental health condition continues to be managed by secondary services.
- The transitional care pathway aims to support the transition of the patient from secondary care to primary care for the management of their physical and mental health.

The service focuses on collaboration between the patient, their GP and mental health providers.

The goal is to remove barriers for these patients to access primary care, and to assist the patient to reach a stage where they are comfortable within the general practice environment and are able to self-fund their primary care.

Entry criteria (eligibility)

- Tairawhiti DHB Mental Health and Addiction Services will select patients for this programme.
- The patient has given their consent and is eligible for New Zealand funded health care.
- Tairawhiti DHB Mental Health and Addiction Services will advise the Primary Options team, as well as the practice, who the patient is, the name of their support worker and which pathway the patient is eligible for. Notification is received via email.
- The patient’s general practitioner assesses the patient as clinically safe and appropriate to manage their care in the community
- The patient’s general practitioner can take responsibility for the person’s care or has the option to hand over the patient to another clinician.

Exit criteria

Each package of care/pathway is available to the patient for one financial year (1 July – 30 June); starting from the date the patient is added to one of the packages of care. If the funding rolls over to the next financial year and the patient has not been removed from the
list, the funding will continue, and the patient’s package of care renews for another financial year.

Alternatively, the patient will exit the programme for the current financial year if they have used their allocation of funded appointments (see claiming guidelines).

Practices will be notified via email if the Tairawhiti DHB Mental Health and Addictions Services remove a patient from either the transitional or physical care packages.

**Claiming guidelines**

**Physical care pathway**
Patients who are not being transitioned for discharge and are still under the care of Tairawhiti DHB Mental Health & Addictions services. The physical care pathway is intended to support greater access to general practice for POMHA patients for their physical health needs.

<table>
<thead>
<tr>
<th>Service Item</th>
<th>Description</th>
<th>Eligible For</th>
<th>GST incl.</th>
</tr>
</thead>
<tbody>
<tr>
<td>MH GP Standard Consult</td>
<td>15min GP standard consultation</td>
<td>6</td>
<td>$75.00</td>
</tr>
</tbody>
</table>

**Transitional care pathway**
Patients who are being transitioned for discharge from Tairawhiti DHB Mental Health & Addiction services. The transitional care pathway is intended to support greater access to general practice for POMHA patients for both their mental and physical health needs.

<table>
<thead>
<tr>
<th>Service Item</th>
<th>Description</th>
<th>Eligible For</th>
<th>GST incl.</th>
</tr>
</thead>
<tbody>
<tr>
<td>MH GP Standard Consult</td>
<td>15min GP standard consultation</td>
<td>4</td>
<td>$75.00</td>
</tr>
<tr>
<td>MH GP Extended Consult</td>
<td>30min GP consultation</td>
<td>4</td>
<td>$112.50</td>
</tr>
<tr>
<td>MH PN Standard Consult</td>
<td>30min nurse consultation</td>
<td>12</td>
<td>$37.50</td>
</tr>
<tr>
<td>MH GP Consult Liaison</td>
<td>30min GP consultation with MHAS Psychiatrist</td>
<td>1</td>
<td>$112.50</td>
</tr>
</tbody>
</table>

Some transitional patients may be eligible for the additional funding below. This funding covers the administration of their depot injections. Selection is made by Tairawhiti DHB Mental Health & Addiction Services and they will clearly indicate those patients who are eligible for this in the initial notification to the practice manager.

<table>
<thead>
<tr>
<th>Service Item</th>
<th>Description</th>
<th>Eligible For</th>
<th>GST incl.</th>
</tr>
</thead>
<tbody>
<tr>
<td>MH Depot Injection</td>
<td>Administration of depot injection only</td>
<td>26</td>
<td>$18.00</td>
</tr>
</tbody>
</table>
FAQs

1. **How can claims be made for this service?**

   Claims can be made via Primary Options. When you have the initial consultation with the patient lodge a new referral and select the appropriate category for the patient, either **MH Transitional** or **MH Physical**. The case number generated will be used for the remainder of the financial year.

   At each consultation lodge a single invoice using the original case number, add the consult notes and select the appropriate invoice. For example, for a consultation with the GP claim a GP standard consult.

   Please be aware if you do not ‘outcome’ the case you will receive this case as part of the reminder email sent out on a regular basis. If you do not want to receive a reminder, please ‘outcome’ the case. You will still be able to lodge singular invoices for this case number regardless of whether this case has had an ‘outcome’ submitted or not.

   NB: One case number per financial year. When the new financial year starts, lodge a new referral if the patient remains eligible.

2. **Who can help with specialist mental health and addictions advice?**

   Contact the Psychiatric Assessment and Treatment Team on 0800 243 500.

3. **Can I claim services retrospectively for eligible patients?**

   A claim needs to be lodged by the referring clinician at the time the decision is made to use POMHA funding to provide a service. A clinician should invoice for every consultation as it occurs.

4. **Who takes clinical responsibility for the patient when they are referred to POMHA?**

   The doctor who initially receives the discharge letter and handover from Tairawhiti DHB’s clinician carries clinical responsibility. This doctor can hand over the patient’s care to another doctor by mutual agreement only.

5. **Can I secure funding for a patient receiving ongoing depot injections at my practice?**

   No. Patients are made eligible for this service by the Tairawhiti DHB Mental Health & Addiction Services team only.

6. **Who do I contact to check if a patient has been made eligible for this programme of services?**

   Contact the Primary Options team on 0800 646 764
Rheumatic Fever Prevention Programme: Waikato and Tairawhiti

Available to Pinnacle MHN practices only

This is NOT a clinical guideline

Detailed relevant clinical notes to clearly support the claim are required

Overview

As part of the Rheumatic Fever Prevention Programme, free throat swabs can be offered to eligible populations with suspected Group A streptococcal throat infections. PHARMAC has increased the amount of certain antibiotics that practitioners can obtain through a Practitioner Supply Order (PSO), as part of the Rheumatic Fever Prevention Programme (RFPP).

These medications will be dispensed free to the patient in accordance with the clinical protocol via a PSO.

Exclusions

- Patients who are not eligible for New Zealand funded health care.
- Patients who do not meet the eligibility criteria.

Entry criteria (eligibility)

General Practitioners and nurses are able to provide patients with a free throat swab service if the patient meets the following criteria:

Waikato

- Patients aged between 4-19 years and of Maori/Pacific ethnicity
  OR
- Patients aged 4-19 years and living in deprived areas (Quintile 5)
- Household contacts (aged between 3-35 years) of eligible patients (above criteria) who have had a positive swab result.

Tairawhiti

- Patients aged between 4-19 years old
- Household contacts (aged between 3-35 years) of eligible patients (above criteria) who have had a positive swab result.

Lodge a referral for the eligible patient and select the RF sore throat swab pathway/coding on the form. Include the GP or nurse notes.
Exit process

Once the result for the swab is received, practices are required to lodge an ‘Outcome’ for the case.

Due to reporting requirements, the result of the swab must be included as well as the name of the antibiotic prescribed if the result of the swab is positive. Reporting is on a monthly and quarterly basis to the relevant DHB so both the referral and outcome must be submitted in the month the swab was taken.

Payment for the swab will not be made until the outcome has been lodged with the required information.

Claiming guidelines

<table>
<thead>
<tr>
<th>Service item</th>
<th>Description</th>
<th>GST incl.</th>
</tr>
</thead>
<tbody>
<tr>
<td>RF Throat Swab – Eligible Pop</td>
<td>The claim for a throat swab for a patient who meets criteria for eligible population</td>
<td>$18.40</td>
</tr>
<tr>
<td>RF Throat Swab – Household contact</td>
<td>The claim for a throat swab for a patient how meets the criteria for household contact.</td>
<td>$18.40</td>
</tr>
</tbody>
</table>

FAQs

1. **Why can’t I lodge a referral for a free throat swab for any patient?**
   
   Waikato and Tairawhiti DHBs have set the criteria for the Rheumatic Fever Prevention Programme for their own localities and are targeting patients who are considered high risk.

2. **Can I lodge another referral for a patient that has returned to the practice with another episode of a sore throat, if the previous swab was negative?**
   
   Yes, as long as the patient meets criteria for a free throat swab. Another swab under a new referral can be funded if clinically indicated.

3. **Why are team members from Primary Options calling practice nurses for swab results?**
   
   The team is required to submit a report to the DHB every month. If there are any RF sore throat swab referrals with missing outcomes or the notes submitted do not contain the swab result and/or antibiotics prescribed, the team will call the practice in order to complete the report.

4. **Can Nurses lodge a sore throat swab referral?**
   
   Yes. As this is a nurse led initiative, nurses can submit a referral using their own consultation notes for patients who have not seen a GP.