

## ***C&C DHB Partner Update***

4 June 2010

Capital & Coast DHB will regularly be providing information packs to stay in touch with our colleagues in primary health and to keep everyone up to date with what's going on.

Please help us by distributing this to other Primary Health Care Providers who you think might find this information useful.

This edition and previous editions are available to view on [healthpoint.co.nz](http://healthpoint.co.nz) under the Medical Professional section – News.

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See below for further details on each of these issues. Documents attached to the newsletter are identified in **bold and underlined**

## ***New electronic discharge summary***

On 6 July, C&C DHB will be rolling out a new electronic discharge summary that replaces the current Webdocs program. The discharge summary is more user-friendly for the doctors filling it out, more reliable, and supports better capture of information.

It includes a number of new sections:

- admission medications, changes in medications and discharge medications are now all included enabling Primary Care to see what medications have been started, stopped and change during the in-hospital admission. A section on warfarin is specifically included.
- all discharge scripts including prn and short course medications will now be included
- the diagnoses section is now compulsory
- procedures, smoking status and ACC number where applicable are now included.
- the discharge will be signed by the clinician who finalises the discharge summary and include the name of the responsible consultant.

The new discharge summary will be easy to read and is similar in appearance to the discharge summaries currently sent by Hutt Hospital.

A key difference between the C&CDHB discharge summary and the Hutt's is that the order in which the sections appear in Medtech has been designed in consultation with GPs (eg smoking and ACC information at the bottom)

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## ***Bariatric Surgery Reminder***

Unfortunately, C&C DHB no longer funds Bariatric Surgery and therefore does not carry out assessments for this kind of procedure. Any patient referred to C&C DHB will be referred back their GP for their ongoing care needs.

You may want to advise your patients that if they wish to pursue Bariatric Surgery, this may be available at a private hospital and that they may discuss this option and the associated costs with you.

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## ***Wellington Regional TIA Service Up and Running***

In the first 4 months since the regional TIA service has been in place, 92 people have been assessed at the clinic. Key findings from the first quarter audit are:

- 75% of people were reviewed within 1 working day of referral, all were seen within 2 working days.
- 68% of referrals had a final diagnosis of TIA or stroke.
- 36% of people delayed more than 48 hours before seeking any medical review (C&C DHB is considering the need for a strong public health message, which outlines the key indicators to look for).
- 80% of those with TIA had a change in therapy initiated.

- the median time for carotid imaging was 2 days and 5 people underwent urgent endarterectomy .
- there were significant delays to outpatient CT imaging.

All in all, the results are encouraging. Further details of the audit are available from Dr Gerry McGonigal ([gerry.mcgonigal@ccdhb.org.nz](mailto:gerry.mcgonigal@ccdhb.org.nz)).

We are working with radiology to improve access to MRI. UK guidelines state that not all patients with TIA require imaging. Imaging is recommended when the vascular territory is uncertain, the pathology is uncertain, or in those whose history may suggest haemorrhages; such individuals require urgent MRI rather than CT scan and this will be our area of focus. We plan to reduce the demand on CT scan to ensure we get MRI scans on those individuals that need them semi-urgently (Clinical Medicine 2010; Vol 10:164-7).

Please refer to the TIA clinic by faxing a letter or the referral form (available on Healthpoint) to 04 385 5393 or e-mail to: TIA.Clinic@ccdhb.org.nz

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### ***Introduction of New Test for Troponin T***

A new, highly sensitive test for troponin T (hsTnT) was introduced on 17 May. This test has important differences from the existing test, with the potential to change clinical practice. Other laboratories in New Zealand will also be making this change.

The new test has greatly improved sensitivity, with the capacity to measure levels at least 6 fold lower than the current test. This will allow us to report to levels of 0.005ng/ml, in comparison with the existing reporting limit of 0.03ng/ml. A necessary corollary is that there will be decreased specificity of a **single** raised level of hsTnT (i.e. more positive tests in the absence of myocardial infarction). In practice, specificity can be improved by following the algorithm described below.

To avoid confusion with zeros after the decimal point, we will report the new test in units of ng/L. For example, 0.03ng/ml will now be reported as 30ng/L and we will be able to report to as low as 5ng/L.

The improved sensitivity will allow measurement of hsTnT at the levels found in healthy subjects and a reference interval will be reported that will be <5-13ng/L. This interval includes up to the 99<sup>th</sup> percentile of the healthy population - a key point built into the universal definition of myocardial infarction. Therefore, results of 14ng/L or greater with the new test are very likely to represent an abnormal result, whether due to myocardial infarction or to one of the many other causes of raised cardiac troponin. In non-coronary situations, raised troponin frequently has prognostic significance.

The main role of TnT is in the diagnosis of myocardial infarction but it is important to note that this is not the only condition that can increase TnT. Therefore it is crucial to use the test in a way that maximises clinical specificity and sensitivity and likelihood of correctly diagnosing or ruling out myocardial infarction. The first principle is that the test should be ordered only in clinical circumstances which are consistent with acute myocardial ischaemia.

To fulfil the definition for diagnosis of myocardial infarction there must be a change in hsTnT demonstrated over time. This criterion may be met earlier after chest pain than with the old test, allowing earlier triage, but infarction cannot be ruled out until the usual 9-12 hour time lapse after onset of symptoms.

To avoid over-interpretation of change which may reflect only normal biological and analytical variability, the percent change required to indicate myocardial infarction should be greater at low [but already abnormal] levels of hsTnT than at higher abnormal levels.

The algorithm below outlines the diagnostic protocol that should be followed. The level of 50ng/L, below which change of 50% is required, is approximately equal to the old level of 0.03ng/ml.

**In summary, one main change will be the need to have at least TWO samples to make a firm diagnosis of myocardial infarction and, whatever the results, clinical judgement is required to interpret their relevance to the particular presentation.**

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### ***Wellington Sexual Health Clinic has moved***

The Wellington Sexual Health Clinic has moved from Adelaide Road to the new Cuba Street Clinic, on the ground floor of 275 Cuba Street.

Their opening hours are 9.00am – 4.30pm Monday, Thursday and Friday, and 9.00am – 8.00pm on Tuesday, and they offer counselling services on Monday and Wednesday, 9.00am – 5.00pm. They can be contacted on (04) 385 9879

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### ***New MAPU Medicines Reconciliation Programme***

On 15th June, C&C DHB will roll out our pilot Medicines Reconciliation programme in the MAPU for all patients >65years or prescribed 5 or more regular medicines. This is the end result of the HDC investigations into 2 deaths at other DHBs, is a Ministry of Health requirement under the Safe Medicines Management Programme (SMMP), and is the formalisation of a process that our clinical pharmacists have been undertaking for over a year.

Medicines reconciliation is defined as the process to collect, compare and communicate the most accurate medication and allergy/ADR list in order to reduce discrepancies and errors. As you will all be aware, many patients enter our hospital with limited medication documentation, especially if they are not referred by their GP (eg. arrive acutely unwell via ambulance to ED, and are transferred to MAPU). It is not always possible for the admitting registrar to elicit an accurate medication and allergy history at admission.

Medicines reconciliation is a safety net for patients as it allows the hospital to get the most up to date history from the GP and/or the community pharmacy, as well as from the patient/whānau/rest home.

**What does this mean for GPs?**

The medicines reconciliation process will mean that more phone calls requesting information about patients' current drugs and allergy status are received by GP practices.

The pharmacists will usually take a verbal list of the medicines/allergies from the GP/nurse – a faxed copy is not usually required. The pilot scheme will involve about 10 patients per day, so the workload on individual practices is not expected to be onerous, but we appreciate that a GP practice is a busy place with lots of phone calls.

Currently, we do not have the workforce or funding to offer medicines reconciliation at discharge, although this would clearly be our future aim. We appreciate your help with prioritising these requests from our clinical pharmacists – it is another opportunity for us all to work together to improve patient care delivery and cooperation between primary and secondary care.

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### ***Changes to Water Fluoridation by Kapiti Coast District Council***

Currently the Kapiti Coast District Council adds fluoride to treated water for the Waikanae, Paraparaumu and Raumati Water Supply. Their 2010/11 draft Annual Plan proposes to end the addition of fluoride to treated water for the water supply from 1 July 2010.

The Capital and Coast District Health Board Dental Service is extremely concerned that the Council is considering ceasing the addition of fluoride to water in the Waikanae, Paraparaumu and Raumati water supplies as part of this annual plan.

The Dental Service has made a submission urging the Council to continue water fluoridation, as it is an integral part of the Dental Service's management of dental decay for children and adults in these communities. This proposal is concerning not only for the health of the population in the Kapiti Coast but it also has implications for the maintenance of fluoridated water supplies regionally and nationally.

If water fluoridation were to cease we estimate that treatment needs would increase by at least 20-30 percent in the Kapiti Coast population that C&C DHB care for. These additional treatment needs will involve extra fillings, extractions and surgical procedures that will add to the staff needs, facility needs and costs for the service.

The Ministry of Health recommends the adjustment of fluoride to between 0.7 ppm and 1.0 ppm in drinking water as the most effective and efficient way of preventing dental caries in communities receiving a reticulated water supply, and strongly recommends the continuation and extension of water fluoridation programmes where technically feasible.

This policy is also supported by *The Drinking Water Standards for New Zealand 2005* which recommend the adjustment of water fluoride to between 0.7 mg/L and 1.0 mg/L for oral health reasons.

These policies are supported by the Capital and Coast District Health Board and underpin the District Health Board's approach to funding and delivering dental services.

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### ***C&C DHB Integrated Model for Anticoagulation Management***

The C&C DHB Primary/Secondary Clinical Governance Group has endorsed the C&C DHB Integrated Model for Anticoagulation Management. This model developed by the Anticoagulation Working Group will be unique, due to its collaborative approach across the interface, and includes a number of components including standardised provider education, patient information systems, patient care across the interface, anticoagulation protocols as well as quality and safety systems.

Following the approval by the Primary / Secondary Clinical Governance Group, the Anticoagulation Working Group is progressing with a number of workstreams to enable the implementation of the programme. This includes the development of:

- a robust audit plan and the collection of baseline data;
- an IT system to support the integrated model (using Medtech32 and electronic messaging); and
- clinical guidelines for warfarin and enoxaparin use.

The Working Group is also planning timelines for the implementation of the programme – so we look forward to coming and meeting with you about the programme in the future.

If you have any questions regarding this please contact Astuti Balram, C&C DHB Service Development Manager ph: 04 806 2422 or email [astuti.balram@ccdhb.org.nz](mailto:astuti.balram@ccdhb.org.nz).

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### ***C&C DHB Cellulitis Management in Primary Care Pilot***

Following the completion of the initial 12 months of the Cellulitis Management in Primary Care Pilot, based on initial analysis of admissions, it has been identified that a review of the project is required in order to determine its future.

The C&C DHB Primary/Secondary Clinical Governance Group has endorsed that a Clinical Pathway Collaborative be established to guide the review. A group of clinicians from across primary and secondary care have indicated their interest in being part of the process and their first meeting is planned for 15 June 2010. Updates on the progress made through this process will continue to be shared through this newsletter.

If you have any questions regarding this please contact Astuti Balram, C&C DHB Service Development Manager ph: 04 806 2422 or email [astuti.balram@ccdhb.org.nz](mailto:astuti.balram@ccdhb.org.nz).

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## ***Claiming for Immunisation by Authorised Non-Medical Vaccinators employed within a PHO***

On 20 May 2010 a change to the PHO Agreement now allows authorised non-medical vaccinators employed within a PHO to claim for immunisation. It would be appreciated if the DHB could inform the DHB NIR Coordinator and PHOs of this new change.

### **Amendment to the PHO Agreement Schedule F2 – Payment for Immunisation Services Clause 6 Conditions of Payment**

- 6.1 We will pay the fees set out in this Schedule F2 provided that:
- a) the immunisation has not already been given or a reasonable effort has been made to check whether the immunisation has not been given; and
  - b) the fee is claimed in accordance with the claiming and NHI number requirements of this Agreement; and
  - c) the Claim complies with the information requirements set out in clause 1.2 of Part I; and
  - d) **the Claim is from an authorised non-medical vaccinator employed within a PHO.**

Nurses employed by providers outside of a PHO are not able to make claims in their own right. They would need to have an agreement with their DHB for these services, or a standard operating procedure relationship with a general practice.

### **Process to initiate claiming**

PHOs and/or providers in a PHO are advised to send a list of nurses who are authorised non-medical vaccinators to their local DHB NIR Coordinator who will load the nurses into the NIR system as an “Immunisation Provider” (they are already loaded as a “Vaccinator”). To enable easy location of each nurse in the system please include both the name and nursing council number. There is no need to communicate this information to Sector Services. When an immunisation claim is received by Sector Services the nursing council number will be verified through a link with the NIR.

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## ***Clinical Pathway Collaborative***

The four workstreams of the Clinical Pathways Collaborative continue to work on the priorities as identified in the last newsletter with good input from both Primary and Secondary Care. The draft implementation plan was shared at the Primary/Secondary Clinical Governance Group last week and generated some good discussion.

- Group 1 - Palliative care
- Group 2 - Paediatric to Adult Transition
- Group 3 - Cancer
- Group 4 -GI

The groups will continue to work on the plans with a view to finalising the Implementation plan by June/ July. After this, the required improvements/ changes will take place and the impact monitored by the individual services.

An evaluation study proposal has been accepted from Victoria University to ensure that the deliverables of both this Clinical Engagement change process, and service development impact's is demonstrated as to be successful or not.

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### ***Requests by Patients and Private Specialists for GPs to Order Laboratory Tests***

It has come to our attention that there has been an increasing trend for certain private specialists to formally request that GPs order laboratory tests on their behalf including laboratory tests that the public health service would not routinely fund. GPs have raised concerns with the DHBs about the ordering of these tests. **Please see the attached letter for more information.**

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### ***Intellectual Disability Service Survey***

As part of the CPC, Group 2 have identified an area of need which presently appears to be a gap in service provision. This is in regard to clients aged over 16 with Intellectual Disability, where presently there is no identified clinical input other than GP.

In order to progress the work around the possibility of a Transition Co-coordinator, we need to identify what the needs/issues are and what percentage of the population this relates to. A link to a survey will be sent to all GPs in the next few weeks with a few questions to gather some data around how many clients exist across the practices. We are grateful for your assistance with this, and would appreciate input from all GPs to look at this issue across the whole DHB. It will be a short survey and not take up too much of your time.

Several other DHBs are at a similar stage and are wishing to develop some joint work across this area.

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### ***Wound Care Clinic Pilot***

The Cannons Creek Specialist Wound Care Clinic pilot is being run until October this year and is in direct response to a Community Health Service questionnaire request for CHS outreach into Primary Health Care.

The specialist services include:

- Lower limb assessment (Doppler)
- Compression bandaging
- Treatment of acute and chronic wounds
- Assessment of patient with a history of ulcers

The referral criteria for this clinic are:

- The patient lives in the region around Cannons Creek.
- The patient has a wound which shows no evidence of healing/improvement.

- The patient is an existing patient of Community Health Service but would like to attend the clinic.
- The patient has a new wound and a history of recurrent wounds which are slow to heal.
- The patient must have a physical health problem and be referred by a GP, practice nurse/lead maternity carer or health professional.
- Failure to provide this intervention may result in the patient being admitted to hospital.
- The patient has a personal health problem which places them at significant risk of deterioration in health status.
- The patient is entitled to receive ACC funded services as per regulations and contracts secured.

The patient referral is made via the Care Coordination Centre:

Phone: 0800 28 22 00

Fax: 04 238 2022

Please document that the referral is for the Cannons Creek Wound Care Clinic.

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If you have any feedback, suggestions or questions regarding these communications please do not hesitate to contact us.

Raylene Bateman  
External Communications Advisor  
Capital & Coast District Health Board  
Phone: 04 385 5480  
Email: raylene.bateman@ccdhb.org.nz

**Or**

Adrian Gilliland  
Clinical Advisor Primary and Integrated Care  
Capital & Coast District Health Board  
Email adrian.gilliland@ccdhb.org.nz

**Or**

Vicky Noble  
Director Primary Nursing and Integrated Care  
Capital & Coast District Health Board  
Email: vicky.noble@ccdhb.org.nz

For C&C DHB information for the general public about Primary Care, visit:  
[http://www.ccdhb.org.nz/planning/Primary\\_Care/Primary\\_Care.htm](http://www.ccdhb.org.nz/planning/Primary_Care/Primary_Care.htm)

**Capital & Coast District Health Board, Riddiford St, Newtown, Wellington.  
Private Bag 7902, Wellington South 6039, New Zealand.**