# COORDINATED PRIMARY OPTIONS (CPO): ORIENTATION

## Background

Coordinated Primary Options (CPO) is the delivery of services, by recognised health professionals within a primary care or community care setting that would otherwise have been delivered by a secondary-hospital based service inclusive of outpatient services, ED provided services and in patient delivered services.

This programme operates under the guidance of the Medical Advisor, Clinical Programme Coordinator and CPO Steering Group which consist of HBDHB Planning and Performance, general practice representatives and HHB management

CPO recognises that people may often be admitted to hospital because of financial and/or other barriers in gaining access to services in the community. Therefore, CPO's purpose is to:

- enable Primary Care teams to access community based services, offering alternatives to acute hospital admission;
- build knowledge about various service options including optimum skill-mixes, client focus and cost effectiveness;
- identify and where appropriate, address communication and service gaps that contribute to hospital admissions;
- support practice changes required to achieve the goals of reducing the level of acute admissions and achieving integrated services.

A range of community diagnostic, therapeutic and logistic services are available at no cost (excluding the initial GP consultation) to the patient. Examples of these include:

- Diagnostic tests – ultrasound
- Home visits by GP and/or practice nurse;
- Follow up and return visits to GP locations;
- Transportation
- Age Related Residential Care Facility
- Community IV therapy
- Access to Medications

Coordinated Primary Options is flexible and easy to use – accessing the services requires forwarding completed referral and invoice forms, either electronically through the patient management system.

CPO Programmes

- Acute Care
  - Cellulitis (Adult), Lower Limb DVT Suspected and Management, Tonsillitis, Pyelonephritis, Dehydration (Adult), Eczema (Child),
- Hospital Discharge
- High Cost Gynaecological and Contraception
  - Vasectomy
  - Ring Pessary
- Skin Cancer Pathway
- Sexual Health - Youth
- LARC Pathway for Mirena/Jaydess for Menorrhagia/or Contraception
- Restore in ARRC - Short and Intermediate Stay in Age Related Residential Care (ARRC)

When considering CPO

- Would this patient be admitted to the HBDHB?
- Can we safely look after this patient within primary care?
- Funding only available for the agreed pathways.
- Patients must meet all the criteria specified in the terms and conditions of contract and be suitable for CPO
- If unsure contact Clinical Coordinator and/or the Medical Advisor.

Clinical Responsibility

Initiated by Primary Care

- **GP/NP is responsible for patient management during episode of care**
- **If the patient is utilising the Restore in ARRC Pathway, the GP/NP must agree to take clinical responsibility for the patient for the duration of time the patient is in Age Related Residential Care (ARRC).**

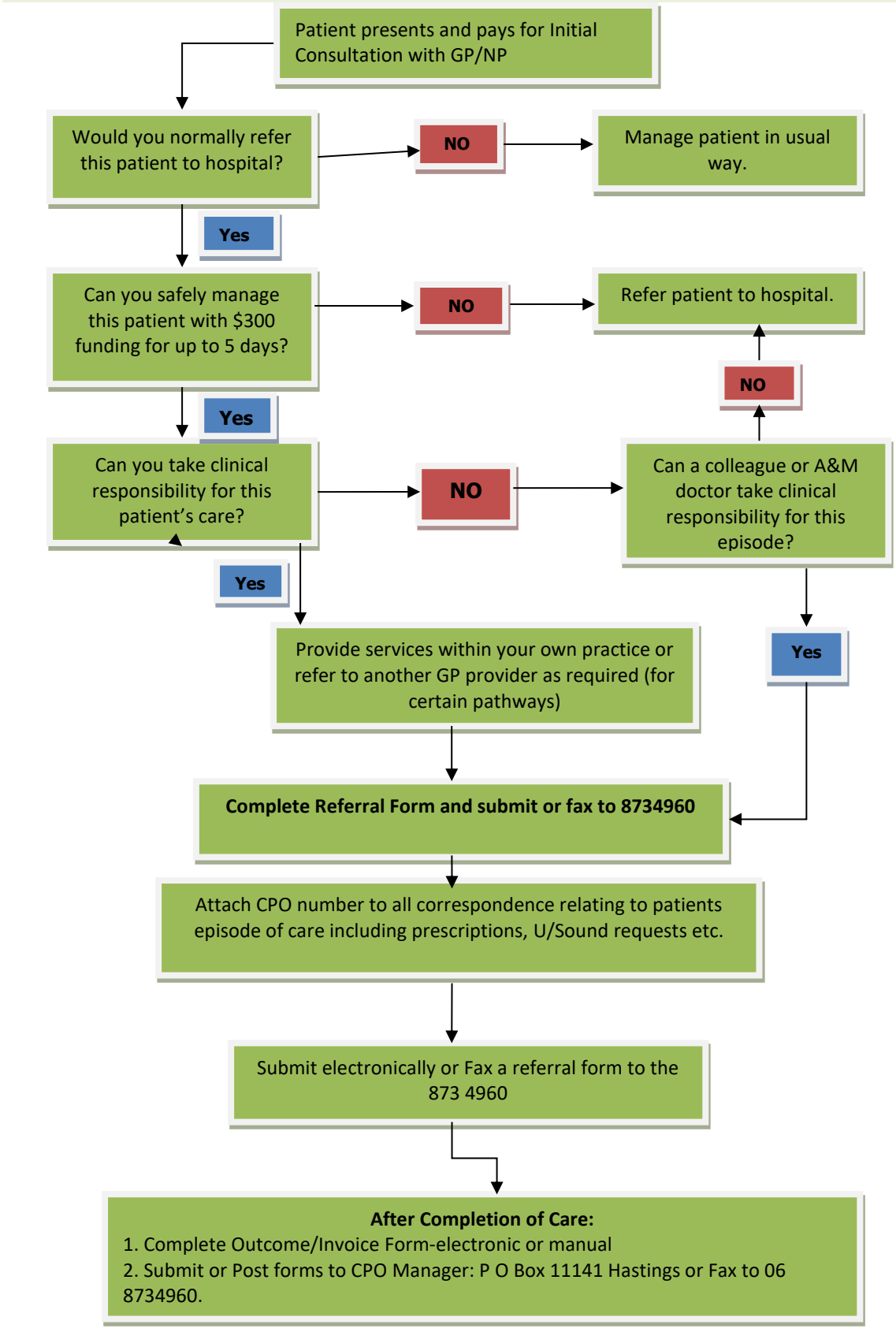
A range of community diagnostic, therapeutic and logistic services are available at no cost (excluding the initial GP consultation) to the patient. Examples of these include:

- GPs Consults/ Home Visits
- NP Consults/Home Visits
- Practice Nurse Consults/Home Visits
- Age Related Residential Care Facility
- Transportation
- Diagnostic Tests-Ultrasound
- IV Therapy with General Practice or Community Based Nurses referred through GP/NP
- Pharmaceuticals- Only specified non-subsidised medication.
  - Enoxaparin
  - Cefazolin
  - Gentamycin
  - Probenecid

***How can further information be obtained if the need arises?***

Contact the Clinical Programme Coordinator:
Health Hawkes Bay (06) 871 5646
E-mail: sonya@healthhb.co.nz

## CPO ACUTE CARE PATHWAY



## REFERRING A PATIENT TO CPO

***FREQUENTLY ASKED QUESTIONS***

***Which patients are eligible to access CPO Acute Care services?***

Any patient who resides in Hawkes Bay (including Wairoa, Central Hawkes Bay), and would have otherwise been referred acutely to hospital. Patients don't need to be enrolled with the PHO or the practice they attend.
(Exceptions - Vasectomy, Mirena and Ring Pessary Pathway- where patients must be enrolled with the PHO).

***How are services accessed for the patient?***

Complete an electronic referral form and submit, OR fax a manual form to 8734960. If the Clinical Coordinator assistance is required, phone (027) 245 4015.
Electronic referrals are installed on the practice PMS as advanced forms

***Who has clinical responsibility for the patient while receiving CPO services?***

By accessing CPO, the referring GP/NP agrees to take clinical responsibility for ongoing care for the patient in the community.

***What happens if a patient requires admission after all?***

Refer to hospital services in the usual way. It is essential that patients receive the safest and clinically appropriate treatment and be admitted when necessary – risks should never be taken to avoid an admission. CPO will pay for services already provided within primary care.

***How much can be charged for services?***

A schedule of fees is on the outcome/ invoice form.

***How many days can a patient be under CPO?***

The episode of care is likely to have completely resolved in five days.

***Can the practice team provide CPO services?***

Yes. Some examples of practice based services are:

- Practice nurse consultation or observation;
- Intravenous therapy
- General Practitioner/Nurse Practitioner /Practice Nurse home visits

***Can I refer to another General Practitioner if I don't provide this service?***

Yes, you can refer to another GP within the practice, another practice or an A&M Centre.

***How are practice-based services claimed back?***

Complete claiming on the CPO Advanced form and submit electronically. This is usually completed by an assigned person within the practice.
You will receive payment by the 20th of the month if all documentation is in order.

***Does the patient pay for CPO?***
No. Their initial GP consultation incurs the usual practice charge and thereafter, all services are provided at no cost to the patient.

***Can the practice claim GMS or is their claw back for seeing patients not enrolled within the practice.***
GMS and claw-backs are not able to be claimed under CPO

***Can CPO services be accessed for the same patient for more than one episode of care?***
Yes, funding is allocated per patient, per episode of care.

***Are there some conditions not covered by CPO?***
- Only conditions specified as pathways are funded under CPO

***Who can provide with clinical support***
- Dr Alan Wright
  CPO Medical Advisor
  Telephone: 873-8999

- Appropriate Registrar at HBDHB
- Physician of the Day at HBDHB

## *Accessing CPO Forms*
### *Acute Care/Hospital Discharge/Ring Pessary/ Vasectomy/EngAGE/Mirena*
Select the menu options Module -> Advanced Forms -> New Form (**Shift+F3)** or from within the Patient Manager ->Forms ->New Form.

Choose the "Hawkes Bay Primary Options" form, then Click OK

### *Skin Cancer Pathway*
Select the menu **Module** / **Outbox** / **New Document** or click onto the New Outbox Document icon on your toolbar. 

From the Select the Skin Lesion Referral Document (SKINLR) from the drop down listing.

### *Sexual Health*
Select the menu options Module -> Advanced Forms -> New Form (**Shift+F3)** or from within the Patient Manager ->Forms ->New Form.

Choose the "Sexual Health" form, then Click OK

## CPO PROGRAMMES

See Health Hawkes Bay website healthhb.co.nz for further information on each CPO programme and individual pathways

## ACUTE CARE PATHWAYS

Aims

- Transitioning of services from secondary care to primary care
- Deliver health care services closer to home

Criteria

- Available to all Hawke's Bay Residents
- Can be utilized by all Hawke's Bay GPs/NPs.
- **Only Clinical Pathways listed below will be accepted- There are no exceptions.**

Clinical Pathways

- Cellulitis
- Back Referral from ED for cellulitis
- DVT Confirmed/Excluded
- Back Referral from ED for DVT
- Childhood Eczema
- Pyelonephritis
- Tonsillitis/Quinsy
- Constipation in Children
- Dehydration/Rehydration including minor hyperemesis

Exclusions

- Maternity (except minor Hyperemesis)
- Palliative Care

ED Back Referral for Cellulitis

Initiated by ED staff HBDHB referring patient back to GP or A&M Centre for patients with cellulitis requiring IV Therapy. General practice is required to complete the CPO Referral.

## HOSPITAL DISCHARGE PATHWAY

Aims to reduce hospital re-admission rates, support re-engagement with primary care at transition and provide seamless service from secondary to primary care with improved support for ongoing chronic disease management.

Funding Includes

CPO funds **1** consultation with the GP following discharge any HBDHB Hospital, including Wairoa and Central Hawkes Bay

Access Criteria:

1. Hawkes Bay Resident
2. Maori or Pasifika or Reside in Quintile 4 or 5 or hold a current Community Service Card **AND**,
3. **The patient will have been an in-patient for 1 night or more AND**
4. Service must be delivered within **14 days** of discharge from hospital **AND**

5. The patient will have had an admission for one or more of the following:

- Cardiac conditions – includes cardiac surgery, myocardial infarction, hypertension.
- heart failure
- Gastro-intestinal
- Abdominal surgery
- Respiratory- asthma, , Pneumonia
- COPD
- Musculoskeletal
- Neurological, CVA/TIA
- Renal
- Cellulitis & Infection
- Diabetes
- Breast Surgery

Exclusions
- Admissions following acute trauma or ACC covered conditions
- Private hospital patients unless under HBDHB contract
- Maternity Care except severe hypertension requiring follow up post pregnancy
- Mental Health
- Minor admissions e.g. dental
- Treatment at A&M or after hours centers
- Follow up from Outpatients

Entry into Pathway
- Initiated by GP/NP or from HBDHB Specialists back to the GP

Medication Review
- Patients to have medication review as part of this pathway

Benefits
- Easy transition of care from secondary to primary.
- Beneficial for continuity of care particularly those with long term conditions
- Ensure patient follow up by GP as requested by secondary care.
- Clarifies any confusion with treatment and follow up
- Address's ongoing concerns for the patient
- Reduces the risk of medication errors for the patient.
- Enables early detection of a deterioration in patient condition where early intervention can often avoid re admission
- Removal of financial disincentive for patients to attend a planned GP/NP check as requested by secondary care.

## VASECTOMY PATHWAY

Provides long term contraceptive health for those unable to afford Vasectomy for those of the lower socio-economic group particularly Maori, Pacific and those living in Geocode 4 and 5 areas

Background
- Available for Vasectomy only
- High Cost Contraception HHB contract available to HHB enrolled population only
- If GP unable to provide service- refers to another GP or practice to provide service.

into Pathway
**MAORI, PACIFIC, QUINTILE 4 or 5 or COMMUNITY SERVICES CARD**

## Ring Pessary

A funded pathway for a small number of women who require ring pessary changes. These patients must be assessed by the Gynaecology clinic prior to accessing this pathway.

## SKIN CANCER EXCISION PATHWAY

A funded Skin Cancer Excision Pathway, for medium complexity skin cancer excisions, for eligible people domiciled in Hawke's Bay to be delivered in the community by accredited general practitioners, free of charge to eligible patients.

Access:

Access to this service is specifically for:
- Residents of Hawke's Bay (not necessarily enrolled patients)

CPO Service Scope:
The primary care CPO Skin Cancer Excision Service specifically covers:

- Lesions highly suspicious of Melanoma or growing non-melanoma skin cancer- BCC, SCC
- Excision of up to two lesions (undertaken consecutively) of medium complexity by an accredited GP provider.
- Follow up appointment with the accredited GP provider for removal of sutures and discussion of pathology.

Exclusions:

| | |
|---|---|
| • squamous cell carcinoma in situ on trunk or limbs | • benign naevi<br>• |
| • superficial basal cell carcinoma | • all other non-malignant lesions |
| • sebhorrhoeic keratoses | • non-healing ulcers |
| • lipomas | • chrondodermatitis nodeularis helicis ears |
| • sebaceous cysts | • pyogenic granuloma |
| • warts | • epidermoid cyst |
| • solar keratoses | • pilar tricholemmal cysts |
| • dermatofibroma | • milia |

Referrals Process:

- All referrals in regard to skin cancer excisions, are be referred to the CPO Skin Cancer Service at Health Hawkes Bay or through e- Referrals at HBDHB.
- Patients will have their referral triaged to either an accredited GP or the HBDHB for the removal of the lesion.

- Include 2 photographs per lesion with the referral. Photographs should be a close up of the lesion and another showing where the lesion is situated on the body. If the referral is for a wider excision, photographs are still required. Photographs do not need to be high in megapixels.

## SEXUAL HEALTH PATHWAY

This pathway provides youth timely access to sexual and reproductive health services. This is delivered within primary care through contracted practices by clinically skilled staff and is free of charge to the patient.

Access

- Eligible patients are 20 years and under, with the exception of Wairoa where eligible patients are 24 years and under
- Domiciled within the Hawke's Bay region
- Entry for eligible patients is by referral from any source including self-referral

The patient exits the service when:

- The STI treatment and follow up as per guidelines have been completed
- Contraception provision and follow up as per medical guidelines and/or standing orders have been completed
- The patient elects to self-discharge or relocates out of the district

Exclusions

- Any service for which alternative funding sources are specifically provided are excluded from the scope of this service
- Domiciled outside Hawke's Bay
- Contraception patients that are funded through the Ministry of Social Development.

The following services are not included in the scope of this service:

- Specialist Sexual Health Services
- Sexual Abuse and Assault Services (including forensic, non-forensic, historical and paediatric services)
- Termination of pregnancy counselling services
- Primary medical consultations outside of this service
- School based nursing and GP services, youth health service, whanau ora services

Pharmaceuticals

Supply of pharmaceuticals will be provided by Hawkes Bay District Health Board and provided to the practice through a faxed order form provided to each practice. Medications are provided to patients at no cost. Medications are only for patients eligible for the CPO Sexual Health Pathway.

Service funding and co-payments

Eligible patients will not be liable for any co-payments.

There will be no claw-backs charged by GPs/NPs when treating casual patients and a CPO claim is made.

**Complex Jadelle Excision Pathway-** (component of the Sexual Health Pathway)
As an extension of the Sexual Health Pathway, funding is available for eligible patients to have access for removal of Jadelles with a high degree of complexity. There is funding available for 6 patients yearly. Dr Hugh Findlay at City Medical has been contracted to provide this service.

Access

- Eligible patients are 20 years and under, residing in in Hastings, Napier or CHB
- 24 years and under, residing in Wairoa
- Domiciled within the Hawke's Bay region

**Approval by the CPO Medical Advisor MUST be obtained prior to removal- patients will be liable for payment if approval not received.**
Must be either:

- A failed attempt by the GP to remove the Jadelle implant or
- Completely impalpable

Exclusions

- Jadelles that can be removed by the patients GP (Funding is available for eligible patients under the CPO Sexual Health Pathway)
- Domiciled outside Hawke's Bay

Pathway

1. Complete the fax back form and a referral letter providing patient details (addressed to Dr Hugh Findlay, City Medical; Napier. This will be forwarded to Dr Findlay when approved).
2. Fax **BOTH** the fax back form and referral letter to Health Hawkes Bay on 8734960
3. Practices will be advised of approval status.
4. The referral letter, including confirmation of prior approval, will be forwarded to Dr Findlay once approved.
5. Patients to contact City Medical to arrange appointment ph: 8354999 once approved (allow 2 weeks for the above process)
6. Ultrasound will be arranged by Dr Findlay prior to removal.

## LARC PATHWAY FOR MIRENA/JAYDESS

This pathway funds the insertion cost of Mirena or Jaydess for Contraception and Menorrhagia for eligible patients according to access criteria below.

**Access Criteria:**

- **Maori, Pacific or reside in Quintile 5**
- Enrolled with Health Hawkes Bay

If the patient meet Access Criteria, CPO will fund the insertion costs for the Mirena or Jaydess. The Mirena and Jaydess devise is available on prescription through the Pharmacies, with the patient funding the prescription fee of $5.

**Fax Back Request Form for Funding Approval**

- Prior approval **MUST** be obtained from Health Hawkes Bay via the fax request form before the service can be delivered. A copy of this form is available on the Health Hawkes Bay website.
- **Accepted referrals are valid for 3 months from approval date**. Please ensure this is utilised or funding will be offered to another patient due to the limited volumes available.

## RESTORE in ARRC

Provides funding to support stay in Aged Related Residential Care (ARRC) for short or intermediate stay.

**Visits to ARRC Facility**

GP/NP/practice nurse consultation/s with the patient in ARRC and telephone consultation/s between the GP/NP and the ARRC RN are funded while the patient is in the ARRC under the CPO Programme.
Should be face-to-face visits with their patients in the ARRC Facility, as clinically appropriate. These visits can be provided by either their GP/NP (or delegate) or a Registered Nurse (RN) under the instruction of their GP/NP (or delegate). As appropriate, a visit may be replaced by a phone consultation between the patient's GP/NP and the ARRC facility RN.

The GP/NP (or delegate)

- **Must agree to take clinical responsibility for the patient while they are in the ARRC facility under CPO.**
- Complete the CPO referral form and provide the ARRC facility with the valid unique CPO reference number

## Short Stay

The Restore in Aged Related Residential Care (ARRC) Short Stay covers three pathways:

(a) GP Short Stay
(b) Non-Weight Bearing Stay
(c) Convalescence Flexi Stay

**Pathways**

**(a) GP Short Stay**

Service Users

- Aged 65 years of age or older or
- Aged 50 to 64 with age related needs and
- Reside in Hawke's Bay DHB region

- require very little or no therapy input but are unable to manage at home temporarily (up to five days) with referral and input from only their own GP/NP (or delegate);
- the lead referrer is the patient's GP/NP (or delegate) and only rest home level of care is available. Admission is for up to five bed nights, with no prior approval/consultation.
- Locate appropriate bed availability with a contract ARRC facility;
- Ensure service user enters the ARRC facility with the appropriate medication for their stay.

**(b) Non-Weight bearing Stay**

Service Users

- Aged 18 years of age or older
- Reside in Hawke's Bay DHB region

- for patients who are appropriate for an aged related residential setting with orthopaedic injuries that preclude them from going home, with referral and input from CNS Orthopaedics in conjunction with orthopaedic consultant and their own GP/NP (or delegate)
- the lead referrer is the HBDHB CNS Orthopaedics who will determine the appropriate level of care (rest home or hospital), whom will provide clinical input during the stay.

**(c) Convalescence Flexi Stay**

Service Users

- Aged 18 years of age or older or
- Reside in Hawke's Bay DHB region

- require very little or no therapy input but are unable to manage at home short-term with referral from CNS Gerontology in conjunction with their own GP/NP (or delegate), input may be from another CNS;
- The lead referrer is the HBDHB CNS Gerontology whom will determine the appropriate level of care (rest home of hospital), whom will provide clinical input during the stay. The lead referrer is responsible for submitting the Admission notification, and the ARRC facility is responsible for submitting the Discharge Notification

***Criteria:***

- *A person with an acute minor illness or injury who is currently unable to manage at home and expected to be able to be discharged home after five days.*
- *Person can be managed safely in an ARRC Facility.*
- *Person consents and family/whanau notified.*
- *Person remains under the care of their GP while in Short stay bed.*
- *GP/NP visits to the ARRC will be funded by CPO, therefore CPO documentation essential.*

**Exclusions:**

- *Patients who require residential care to provide respite to the carer who lives with them (carer fatigue/ carer unavailable for a period). Patients who are highly dependent on a live-in carer should be referred to NASC HB for assessment of eligibility for a respite allowance. Those with a respite allowance can make arrangements with an ARRC facility directly.*
- *Patients who require rest home admission for mental health issues.*
- *Patients who are Palliative. Pathway for up to 2 weeks funded residential care is in place through NASC HB.*
- *Patients expected to require longer than five days and need MDT in-put should be referred to the Intermediate care service. Please refer to the engAGE in ARRC Intermediate Care Service.*

## Intermediate Stay

Older people can be admitted to this service from their own homes or from the acute hospital and receive input from the engAGE MDT service. The GP/NP agrees to take clinical responsibility for the patient while they are in the Age Related Residential Care (ARRC) facility. Patient visits by

GP/NP/practice nurse are funded under CPO, and the ARRC facility charges will be funded directly by HBDHB.

GP/NP can access Intermediated Stays in ARRC for up to six weeks. Access to Intermediate Care Beds (ICB) occurs as either:

a. Admission from patient's home.
b. Admission from acute hospital (transition to home).

***Service Users***

- ***Aged 65 years of age or older or***
- ***Aged 50 to 64 with age related needs and***
- ***Reside in Hakes Bay DHB region***

***Criteria:***

- *A person who is medically stable but is not quite well enough to be at home/ return home from hospital. This may be for ongoing clinical management or for increased supports for a short period of time due to deconditioning.*
- *Person can be managed safely in an ARRC Facility*
- *Person consents and whanau notified*
- *Person's GP/NP or another GP /NP (i.e. a covering GP from same centre) must accept clinical responsibility for the person. This includes weekly GP/ NP/practice nurse visits to the facility and attendance at the engAGE MDT meeting.*
- *GP/NP/practice nurse visits to the ARRC facility will be funded by CPO, therefore CPO documentation essential.*
- *There must be documented goals with the goal to discharge home after a period of support, within an agreed timeframe being essential.*

***Exclusions:***

- *If the person requires permanent placement in an ARRC facility - assessment must be undertaken on the ward for placement by Options HB.*
- *People that could be managed at home with a package of care from Options or ACC should be referred for same and discharged home/ remain at home. Referral for engAGE MDT follow up at home could be considered.*
- *Medically unstable and/or needing inpatient investigations or inpatient care.*
- *End of life palliative patients. Pathway for up to two weeks funded residential care is in place through Options HB.*
- *Patient awaiting significant housing modifications or permanent placement under the PPPR Act.*

## Finding an Available Bed

GPs/ Practice Nurses can use the Elder Net Website (www.eldernet.co.nz) to identify which facilities have vacant beds. Follow the "Residential Care Vacancies" Quick Link at the bottom of the home page. This list is updated daily.

**Contracted ARRC Facilities**

** Please note that only the facilities in the left hand column have a contract to provide Intermediate Care. If a person is in a Short Stay bed but goes on to require Intermediate Care and they are not in a facility that has a contract to provide this, they will need to move to one of the facilities in the left hand column for their Intermediate Care stay. If it is anticipated that a person may need Intermediate Care, they should only be placed in a facility from the left hand column.

| **engAGE in ARRC – Intermediate & Short Stays** | **engAGE in ARRC – Short Stays ONLY **** |
|---|---|
| Atawhai Care | Bardowie Retirement Complex |
| Brittany House | Bryant House |
| Duart Care | Eversley Care |
| Glengarry Rest Home & Hospital | Gladys Mary Rest Home |
| Gracelands Care | Greendale Residential Care |
| Mary Doyle Trust Life Care | Otatara Heights Residential Care |
| Mt Herbert House | Roseanne Retirement |
| Princess Alexandra Retirement Village | Voguehaven Rest Home |
| Radius Hampton Court | Waverley House Rest Home |
| Summerset in the Bay | Woburn Rest Home |
| Summerset in the Vines | |
| Taradale Masonic Residential Home | |
| Waiapu House Rest Home | |