TE AWAKAIRANGI HEALTH NETWORK

PROGRAMMES AND SERVICES

Updated: September 2020

"Everyone in the Hutt Valley is healthy and well"

Te Awakairangi Health Network (TeAHN) Programmes and Services

TeAHN manages services and programmes which aim to reduce health inequities and improve health outcomes for the people of Hutt Valley. They are designed for use in general practices or to support general practice teams by extending the care they can provide. They are generally restricted to patients who are enrolled with a Hutt Valley general practice and/or resident in the Hutt Valley, while some are only for patients enrolled with Te Awakairangi Health Network.

The aims of each programme or service vary. Some are designed specifically to reduce health inequities by addressing financial and other barriers, while other programmes address specific health needs or conditions, such as diabetes.

Each programme has specific criteria designed to assist service providers to meet the needs of the targeted population groups. Service providers include general practices, marae-based healthcare workers, and other primary care providers.

Contact Details

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Services and Programmes Overview

Service or Programme	Description	More information
Access and Choice (Integrated Primary Mental Health and Addictions Services)	TeAHN employs Health Improvement Practitioners and Health Coaches who are based in general practice to provide brief interventions, under a behavioural health model, to any person in the enrolled population who is experiencing distress due to thoughts, feelings or behaviours. This service is free and open to all regardless of age, ethnicity or income. This service provides improved access by being available to clients on the same day that they visit the practice in most case. There is no referral form for this service; a warm handover is completed by the GP. Only in 8 Hutt Valley practices in 2020/21.	Access and Choice Team Leader | TeAHN | ☎ 04 566 5320
Acute Care	TeAHN works with local practices and Hutt Valley DHB to build the capacity and capability of general practice to manage people with acute conditions. This is supported through links with the Acute Demand Clinical Network; participation in winter planning; promotion of Health Pathways; uptake of packages of care (POAC) linked to Health Pathway conditions; and promotion of effective local after-hours arrangements.	Clinical Programmes Facilitator | TeAHN | ☎ 04 566 5320
Adult Immunisation	TeAHN promotes influenza vaccinations for eligible people across Hutt Valley general practices with a particular focus on LTC patients and older Māori people.	Clinical Programmes Facilitator | TeAHN | ☎ 04 566 5320
Better Access and Support for People with Disabilities	TeAHN provides support and information to practices to enhance their responsiveness to people with disabilities, by raising awareness of the issues identified by people with disabilities, tools such as the Health Passport and training opportunities within the CME and PNE and accreditation sessions.	Quality Lead | TeAHN | ☎ 04 566 5320
Better Help for Smokers to Quit	TeAHN provides ABC smokefree advice and support to practices and assists in improving referral systems from primary care to specialist cessation services for priority groups (Māori, Pacific, pregnant women).	Clinical Programmes Facilitator | TeAHN | ☎ 04 566 5320
Bowel Screening	TeAHN participates in bowel screening health promotion/education activities in the Hutt Valley, with a focus on Māori and Pacific populations. This service is for persons aged between 60-74 years, who are eligible for public funding and reside in the Hutt Valley or Wairarapa DHB districts. TeAHN manages the payments to practices for consultations for patients with positive results.	Clinical Programmes Facilitator | TeAHN | ☎ 04 566 5320
Cardiovascular Risk Assessment	TeAHN encourages practices to identify populations at higher risk of cardiovascular disease, aiming to reduce cardiovascular disease mortality and morbidity through cardiovascular disease risk assessment (CVDRA) and education. TeAHN works with primary care and community providers to encourage people to get their checks. TeAHN supports practices to undertake active treatment and management of high-risk patients, through the Long-Term Conditions programme.	Clinical Programmes Facilitator | TeAHN | ☎ 04 566 5320

Cervical Screening	TeAHN works with practices, Mana Wahine and the Regional Screening Service to increase the rates of cervical screening in the high needs population by removing the cost barrier and encouraging practices to focus on women's health. TeAHN provides funding to practices to subsidise cervical screening for women aged between 25-69 years requiring regular cervical screening who are either Māori, Pacific, or Quintile 5 (or under exceptional circumstances for women whom the practice knows would otherwise not be able to afford a smear). TeAHN offers funding for nurses working in a practice that has a predominantly "high needs" population or where the women do not have access to or choice of a female smear taker for Cervical Screening Training.	Clinical Programmes Facilitator | TeAHN | ☎ 04 566 5320
Child Protection Training	TeAHN provides Child Protection training for the staff of TeAHN and the general practices, to equip them in identifying and responding appropriately to child abuse and neglect.	Outreach Services Team Leader | TeAHN | ☎ 04 566 5320
Childhood Immunisation	TeAHN provides practice facilitator support to practices, to assist them to reach and maintain high immunisation coverage and to link with community organisations and agencies to reach families/ whānau who are not well engaged with their general practice. This programme aims to improve immunisation coverage for all children with the aim of reducing rates of vaccine preventable disease.	Clinical Programmes Facilitator | TeAHN | ☎ 04 566 5320
Clinical Pharmacist Service	TeAHN provides a practice-based clinical pharmacist service to general practices, as resources allow. Although practice-specific, overall the service objectives are to reduce severe avoidable medication-related harm in three key areas, namely high-risk situations (medications), polypharmacy and transition of care. The clinical pharmacists facilitate linkages between community pharmacists and general practice teams to reduce fragmentation of patient care. TeAHN provides a practice-focused education and support function, promoting evidence-based prescribing, and making outcome and prescribing data more available to local GPs. TeAHN's clinical pharmacists promote best practice management of patients with poorly controlled long-term conditions and provide unbiased and independent medicines information that can be used by prescribers.	Team Leader, Pharmacy | TeAHN | ☎ 04 566 5320
Community Health Worker/ Registered Social Worker Service (part of the Outreach Services Team)	TeAHN provides support and advocacy for Māori, Pacific or Quintile 5 clients who are experiencing social and other issues which are impacting on their ability to access primary care, and live healthy lives. The team work alongside general practices and a wide range of providers and other organisations to facilitate access to primary health care services, and services delivered by other Government agencies such as Work Income, Kāinga Ora (previously Housing New Zealand) and MSD Social Housing. The team also work alongside communities assisting and empowering them to address health and social issues.	Outreach Services Team Leader | TeAHN | ☎ 04 566 5320
Contraception Access (LARC)	TeAHN manages the Contraception Access programme. Trained primary care general practitioners (GPs) or registered practice nurses (PNs) are funded to provide free consultations to women in the eligible population. Following the contraceptive consultation, GPs/PNs provide free contraception to this group i.e. long acting reversible contraceptive, oral contraception, or Depo Provera. The purpose of this service is to decrease the high rates of unplanned pregnancy, which can negatively impact physical and mental health, and social wellbeing.	Clinical Programmes Facilitator | TeAHN | ☎ 04 566 5320
Diabetes Care Improvement Plan (DCIP)	The DCIP programme provides a package of care to assist patients with diabetes to better manage their condition. It includes free diabetes annual reviews for the target population, nurse education of patients with an emphasis on those who are newly diagnosed, and access to podiatry and retinal screening. It includes a strong focus on professional education, in particular extending the expertise and advanced skills of practice nurses to enable them to manage more complex cases, including insulin initiation. TeAHN also promotes effective self-management tools, and local initiatives that promote healthy lifestyle choices and equip people to take steps to improve their health.	Clinical Programmes Facilitator | TeAHN | ☎ 04 566 5320

Education and Professional Development	TeAHN provides education programmes designed to support the ongoing development of teams across the Network. These include but are not limited to: • Tikanga-a-Iwi training, connecting with Māori health experts and supporting practice staff and TeAHN staff to attend training in Te Ao Māori and cultural safety; • Continuing Medical Education (CME) sessions covering topics that are relevant to the day to day work of general practitioners and/or system improvements across primary care; • Professional Nursing Education (PNE) sessions covering clinical topics linked to local priorities and the needs of the nursing teams; • TeAHN will provide training and educational sessions to assist practices to meet accreditation requirements; • Joint CME/CPE that involves community physiotherapy and pharmacy colleagues; • Practice Manager sessions, covering topics linked to local priorities and the needs of the managers; • Practice administrators' sessions to extend their skills; • Child Protection training.	Office Manager or Executive Assistant | TeAHN | ☎ 04 566 5320
Emergency Management (including Pandemic Planning)	TeAHN supports the general practices to maintain their emergency management and business continuity arrangements, including the five geographical Local Emergency Groups (LEG). TeAHN also maintains its own emergency management arrangements and competence, undertaking exercises and development within the organisation. TeAHN links with the DHBs and WREMO as needed.	Quality Lead | TeAHN | ☎ 04 566 5320
Fragility Fractures (Falls Prevention)	TeAHN is implementing the Hutt Valley primary care component of the 3DHB falls programme which aims to reduce the incidence and impact of falls and fractures in older people. This covers follow-up for patients with fragility fractures. TeAHN manages the payments to practices for the programme.	Clinical Programmes Facilitator | TeAHN | ☎ 04 566 5320
Generation 2040	This equity project is aimed at reaching Māori māmā and pēpī in the antenatal and immediate postnatal period, so that they get the screening, referrals and care that is needed to improve equitable outcomes for Māori.	Clinical Programmes Facilitator | TeAHN | ☎ 04 566 5320
Good Food Programme	TeAHN's health promotion team provides hands-on cooking programmes for people who need extra support with cooking and preparing healthy kai. This programme is available to people enrolled with a TeAHN practice.	Manager Health Promotion | TeAHN | ☎ 04 566 5320
Health Care Home	TeAHN works with the Alliance (Hutt INC) partners to implement the Health Care Home model, a programme offering practice teams a pathway to transform their practice to meet the challenges of today and the future. The Health Care Home Model of Care is the building block to improved acute, proactive and preventative care. It has a clear focus on equity, builds primary care sustainability and business efficiency and strengthens integration with other community and primary care services. It is about services being delivered closer to home, more proactive care, improved self-care and improved patient experience. Over time, it assists practices to reduce avoidable hospitalisations which allows hospitals to better focus on providing episodic care to complex clients. TeAHN provides the programme management and change management functions and manages the DHB and TeAHN funding for the programme.	Health Care Home Programme Lead | TeAHN | ☎ 04 566 5320

Health Promotion	TeAHN's health promotion team partners with many organisations to deliver health promotion events and programmes that support high needs population groups to make sustainable lifestyle changes which enhance overall wellbeing, and reduce their risk of developing long term conditions. They support people to be healthier where they live, learn work and play. The team develop innovative programmes to respond to emerging issues among high needs populations e.g. collaborative work with Takiri Mai Te Ata and Naku Enei Tamariki to improve the wellbeing of 0 to 5 year olds under Te Roopu o Te Moana Nui a Kiwa.	Manager Health Promotion | TeAHN | ☎ 04 566 5320
Healthy Families	TeAHN participates in the Healthy Families New Zealand initiative which seeks to support people to be healthier where they live, learn work and play. Hutt Valley is one of 10 HFNZ communities across New Zealand. TeAHN is an active partner across all the work streams and in the governance group	Manager Health Promotion | TeAHN | ☎ 04 566 5320
Healthy Families Coach Service	TeAHN provides a Healthy Families Coach (HFC) service to Māori or Pasifika clients or low-income families enrolled in a TeAHN practice who have a long-term condition or are trending towards a long-term condition such as diabetes, heart disease or obesity. The service aims to enable positive lifestyle changes for the identified children, whānau, or adults through an individual or whānau centered approach. HFC service is mobile or PHO based depending on the client/s needs. Our exercise and dietitian experts create goals and action plans alongside the client or whānau to achieve improved eating habits and levels of physical activity, and connections that will sustain positive health and wellbeing outcomes. The team also deliver group programmes (in person and virtually) such as: • Good Food Programme – the health promotion team provides hands-on cooking programmes for people who need extra support with cooking and preparing healthy kai. This programme is available to people enrolled with a TeAHN practice. • Valley Fit Programme – the health promotion team provides or facilitates access to exercise programmes for people who need extra support around physical exercise and wellbeing. This programme is available to people enrolled with a TeAHN practice.	Manager Health Promotion | TeAHN | ☎ 04 566 5320
Interpreting Service	TeAHN manages a contract with the Interpreting New Zealand telephone interpreting service, which provides interpreters in approximately 70 different languages. General practices can book an interpreter either on the spot (phone), book online or can email booking details. The service to enables patients from non-English speaking backgrounds, who do not speak English to communicate in their own language when seeking and get appropriate healthcare. Deaf Aotearoa iSign Interpreting Services provide New Zealand sign language interpreting services for all GP appointments and medical visits. Bookings can be made via phone, email or on their website.	Outreach Services Team Leader | TeAHN | ☎ 04 566 5320
Long Term Conditions Programme	The Long-Term Conditions (LTC) programme aims to improve outcomes for people with long term conditions, supporting general practice to expand the clinical focus from one patient at a time to a proactive, population-based approach, especially for chronic care and prevention services. The plans promote enhanced patient self-management to improve patient outcomes and quality of life, while also reducing acute exacerbations. Practices provide LTC care through the implementation of an annual practice plan, supported by an annual allocation of funds. All LTC practice plans must have a component of care for their enrolled population with diabetes and for patients requiring follow up post hospital discharge for a long term, chronic condition related admission.	Clinical Programmes Facilitator | TeAHN | ☎ 04 566 5320

Outreach Nursing Service (part of the Outreach Services Team)	TeAHN offers complex clinical case management, working with and on behalf of the practice to connect Māori, Pacific or Quintile 5 patients enrolled with a TeAHN practice who are not accessing general practice or primary care to access ongoing support that meets their needs. The nurses work alongside general practice teams to assist them to engage high need patients, providing assistance with health education, advocacy and support at home. The aim is to extend the capacity of the practice to reach, engage and reintegrate high need patients back into regular care arrangements with the practice.	Outreach Services Team Leader | TeAHN | ☎ 04 566 5320
Palliative Care	TeAHN works closely with Te Omanga Hospice and supports practices to deliver a palliative care approach to those patients that can be managed within a primary palliative care service. Patients must reside in the Hutt Valley and be an enrolled and funded patient at a Hutt Valley general practice (this funding does not apply to patients living in residential care).	Clinical Programmes Facilitator | TeAHN | ☎ 04 566 5320
Piki – Youth Mental Health (until June 2021)	Piki's vision is to enhance the quality of life of Rangatahi by equipping them with tools to overcome adversity and strengthen their wellbeing. Piki is available to Rangatahi aged 18-25 years living in the Greater Wellington region. Piki offers free access to: • Easy and personalised access to therapy at a convenient place and time; • An emotional wellness app that helps you access support and track your progress; • Links to 24/7 support through phone and web services; • Trained peer support coaches.	Wellbeing Team Leader | TeAHN | ☎ 04 566 5320
POAC - Minor Gynaecology Procedures in General Practice	TeAHN manages funding for the provision of minor gynaecological procedures to patients who live in Quintile 5 or hold a current Community Services Card and who are not able to access services that are covered by other funding streams such as WINZ, ACC or maternity.	Clinical Programmes Facilitator | TeAHN | ☎ 04 566 5320
POAC - Primary Options for Ambulatory Care	TeAHN manages funding so that general practice teams can provide free services in the community (for specific conditions and in accordance with the 3DHB HealthPathways) where the aim is to prevent an ED visit, an outpatient visit, or a hospital admission. General practices can also claim when they undertake minor gynaecology procedures in primary care	Clinical Programmes Facilitator | TeAHN | ☎ 04 566 5320
Podiatry - Diabetes	As part of the DCIP, TeAHN funds access to free podiatry sessions for people with diabetes who have moderate to high foot risk and require regular foot care.	Clinical Programmes Facilitator | TeAHN | ☎ 04 566 5320
Radiology (Community Radiology)	TeAHN manages the community radiology programme, which provides clients referred by primary care with timely access to high quality radiology services, to facilitate a prompt, cost effective and accurate diagnosis of clinical problems and conditions. The service is free for people with Community Services Cards, or who live in Quintile 4 or 5 areas. TeAHN manages the funding and supports the Radiology Advisory Group (RAG), which provides clinical governance on how this fund is utilised.	Clinical Programmes Facilitator | TeAHN | ☎ 04 566 5320
Refugee Health	TeAHN manages funding so that contracted general practices actively enrol and support refugee families who settle in the Hutt Valley under the Red Cross scheme. In 2020/21, this scheme may not receive any new families, given the housing shortages in the Hutt Valley and the border restrictions due to COVID-19.	Clinical Programmes Facilitator | TeAHN | ☎ 04 566 5320
Respiratory Care	TeAHN works with Tu Kotahi Māori Asthma and Research Trust, the HVDHB specialist respiratory services and general practices to improve access to services and improved care for patients with established respiratory disease. TeAHN contracts with Tu Kotahi so that TeAHN Māori patients who have babies with bronchiolitis or whānau with asthma / COPD can benefit from receiving respiratory education and support in a group.	Clinical Programmes Facilitator | TeAHN | ☎ 04 566 5320

Retinal Screening - Diabetes	Compass Health Network manages the contract for Diabetic Retinal Screening with a select group of community-based optometrists throughout the Wellington and Hutt Valley region. Patients on referral from their GP are screened and monitored, and in some cases, referred to specialist services. The objective of the retinal screening programme is to prevent sight-threatening diabetic retinopathy which is largely preventable through regular screening and prompt treatment.	Clinical Programmes Facilitator | TeAHN | ☎ 04 566 5320
Rheumatic Fever Management – Bicillin Programme	TeAHN provides a follow-up treatment service for young people (aged 16 to 21 years) who have been diagnosed with rheumatic fever, to prevent recurrences and cardiac damage, and support healthy lifestyle choices. The service supports these young people in the community to ensure they are receiving their monthly prophylactic antibiotic injections. Where possible, the team will work to connect each of these young people to their general practice team.	Outreach Services Team Leader | TeAHN | ☎ 04 566 5320
Skin Lesions - Primary Care	TeAHN manages the skin lesion programme, which provides cost effective, early access for the removal of eligible skin lesions, free of charge to patients with Community Service Cards. This is a service provided through referrals and/or within the general practices.	Clinical Programmes Facilitator | TeAHN | ☎ 04 566 5320
Sore Throat Management - Rheumatic Fever - Prevention Programme	TeAHN partners with and funds general practices and local pharmacies to provide rapid response services with timely assessment and treatment of children and young people with sore throats, specifically Māori and Pacific children, youth and young adults (aged 4 to 19 years) or those (aged 4 to 19 years) with a family history of rheumatic fever. TeAHN also partners with community agencies to promote these services and spread key messages around the risks of rheumatic fever and works with the Well Homes service (a multi-agency partnership helping whānau with housing problems and connecting them to health and social services) to increase referrals from general practices.	Clinical Programmes Facilitator | TeAHN | ☎ 04 566 5320
Transport Service	TeAHN provides free, short-term transport support for Māori, Pacific or Quintile 5 patients (and others only in exceptional circumstances), enrolled with a TeAHN practice who are experiencing multiple barriers to accessing primary health or Hutt Valley Hospital appointments AND have a genuine transport need and have no other transport option available to them.	Outreach Services Team Leader | TeAHN | ☎ 04 566 5320
Valley Fit	TeAHN's health promotion team provides or facilitates access to exercise programmes for people who need extra support around physical exercise and wellbeing. This programme is available to people enrolled with a TeAHN practice.	Manager Health Promotion | TeAHN | ☎ 04 566 5320
Wellbeing Service (Primary Mental Health)	TeAHN provides primary mental health and addiction services to improve health outcomes for people with mild to moderate mental health needs or with addiction issues. Priority is given to Māori, or Pacific, or Quintile 5 people (who are enrolled with a Hutt Valley general practice) and anyone who is 12-19 years of age. In exceptional circumstances, a referral to the Wellbeing Service may be accepted for other clients, where the referrer has identified a genuine mild to moderate mental health or substance use need that cannot be addressed via other alternatives and capacity in the clinical team allows. Services are delivered in Upper Hutt, Lower Hutt, and Wainuiomata, from some general practice sites and marae.	Wellbeing (Primary Mental) Team Leader | TeAHN | ☎ 04 566 5320

Access and Choice (Integrated Primary Mental Health and Addiction Services)

Service Description

Working within the practice to provide

He Oranga, the Report of the Inquiry into Mental Health and Addiction called for a reorientation of Government's and society's approach to mental health and addiction to one genuinely grounded in wellbeing.

This service aligns with a key theme in *He Ara Oranga* to expand access to, and choice of, primary mental health and addiction responses.

Key Points

- Advocacy for Māori or Pacific of Q5
- And experiencing social and other issues which are impacting on their ability to access General Practice.

Referral

- MedTech outbox document
- Fax to 04 566 5369
- via HealthLink
- Self-refer 04 566 5320.

Health Improvement Practitioner

Health Improvement Practitioners (HIPs) are registered mental health clinicians subject to regulation under the Health Practitioner Competence and Assurance Act who have received phase 1 and phase 2 HIP training delivered by a trainer accredited by Mountain View Consulting. They come from a variety of backgrounds including, nursing, social work, occupational therapy, psychology and psychotherapy.

HIPs are embedded as members of the general practice team and will see anyone whose thoughts, feelings or actions are impacting on their health and wellbeing. They work with individuals (of all ages), whanau, and groups to provide rapid access to evidence based brief interventions – to help people make changes to enhance their health and wellbeing.

In addition to working with people and their whanau HIPs have a key role in building the confidence and capability of the general practice team to meet the needs of people experiencing mental health and/or alcohol and other drug (AOD) concerns. They work with the general practice team to build routine pathways for high impact problems commonly experienced by people in that practice.

HIPs work closely with:

- Health Coaches and NGO Support Workers to provide timely access to natural community supports.
- Local community mental health teams to ensure timely access to advice and services for people who need this level of support.

HIP appointments are in general 30 minutes duration. Around 50 percent of people will choose to be seen just once, but there are no limits to the number of times they can be seen (no pre-prescribed "packages of care") people can return as needed for a same-day or booked appointment.

HIPs are responsible for screening risk during the initial visit and at all visits thereafter. If risk is identified, the HIP will then conduct a brief but thorough risk assessment. They will coordinate care to address the risk with the patient's GP and collaborate with external services as necessary.

HIPs will:

- Actively seek work rather than waiting for "referrals"
- See on average 8-10 people per day
- Write clear and concise notes within the practice management system that comply with established standards
- Be able to demonstrate skills, knowledge and attitudes that ensures culturally safe practice
- Use agreed outcome measurement tools and session rating scales each time they see a person

Health Coaches

Health Coaches are people with relevant lived experience/support work experience who have received training within a recognised Health Coach Training programme in New Zealand and have satisfied all other necessary requirements for working with vulnerable children and adults including requirements in relation to police vetting. Health Coaches are embedded members of the practice team.

The key role of the Health Coach is to partner with people experiencing issues that impact on their health and wellbeing to support them to identify their own priorities, set goals for change and to develop a plan to address those goals through developing self-management skills and linking them to resources and supports. The five key roles of the Health Coaches are:

- Self-management support
- Acting as a bridge between clinician and person/whanau
- Navigation of the health and social services system – including linking to appropriate community supports
- Emotional support
- Providing continuity within a busy general practice team.

The person/whanau will be seen at the General Practice or in a community setting mutually agreed with the health coach.

Eligibility

This service is open to all enrolled patients of a practice where HIPs and Health Coaches are place, regardless of age, ethnicity or income.

Referrals

There is no referral form for this service. HIPs and Health Coaches receive warm handovers from another member of the practice team.

Contacts for Further Information

Access and Choice Team Leader | TeAHN | 04 566 5320

Bowel Screening

Service Description

TeAHN supports the National Bowel Screening Programme (NBSP), with a focus on Māori and Pacific populations. TeAHN manages the payments to practices for consultations for patients with positive Fecal Immunochemical Test (FIT) results from this programme.

Key Points

- 60 – 74 years AND
- Eligible for public funding AND
- Resides in Hutt or Wairarapa DHB
- Claim is for consultation for positive FIT results only

Referral

- BPAC Bowel Screening FIT Positive eReferral

Claiming

- Halcyon claim form

Eligibility

- Aged 60 – 74 years (and not listed on the Bowel Cancer Register)
- Eligible for publicly funded healthcare
- Resident in Hutt Valley DHB, CCDHB or Wairarapa DHB regions

Invitations are posted to patients to take part in the NBSP by the Bowel Screening Pilot Co-ordination Centre. People meeting the eligibility criteria will be automatically sent a FIT every 2 years, on or about their birthday.

The patient will complete the test at home and post the reply-paid envelope provided.

https://www.timetoscreen.nz/bowel-screening/doing-the-bowel-screening-test/

Negative FIT Result:

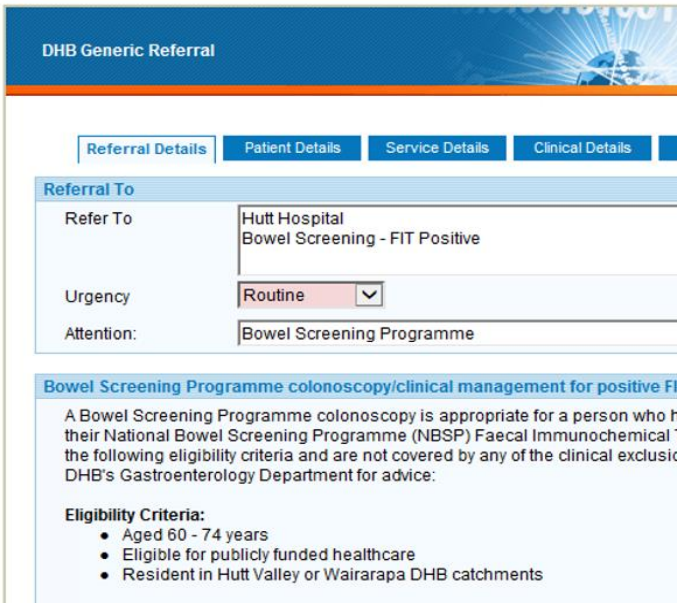
The patient's general practitioner will receive the result for filing. No further action is required.

The NBSP Register will notify the patient and arrange recall in 2 years.

Positive FIT Result:

The patient's general practitioner is responsible for responding to the positive result as follows:

- Inform the patient of the positive result;
- Assess the patient's eligibility for a NBSP funded colonoscopy. The patient must meet the eligibility criteria (given above) AND not be covered by any of the following clinical exclusions:
  - Colonoscopy within the last 5 years
  - Already on a surveillance programme for bowel polyps or bowel cancer
  - Large bowel resection
  - Currently being treated for inflammatory bowel disease
  - Currently experiencing colorectal symptoms
- Consider and discuss management options:
  - Refer to HVDHB for NBSP funded colonoscopy
  - Refer for private colonoscopy if this is the patient's preference
  - Patient declines further investigation
  - Patient is unfit for further investigations



- Notify the HVDHB of the positive FIT result and clinical management decision within **10 working days** using the BPAC Bowel Screening FIT Positive eReferral template.
- The Bowel Screening Programme (BSP) will accept referrals for colonoscopy from General Practitioners or Practice Nurses.

Funding and Payments

GPs are eligible to claim funding for contacting patients receiving a positive result. This payment covers a consultation to discuss their future management. A claim for $69 (incl GST) or $60 (excl GST) can be made once a patient receiving a positive result has been contacted, and/or seen, and the DHB has been notified via the BPAC eReferral form of the positive result and management decision.

How to make a claim

- Complete a Halcyon Bowel Screening claim
- Claims received by the 5th working day of the month will be paid on or before the 25th of the month.

Contacts for Further Information

Clinical Programmes Facilitator or Team Leader Practice Liaison | TeAHN | 04 566 5320

Cardiovascular Risk Assessment

For Māori, Pacific and South-Asian populations screening should begin at **age 30 years for men and 40 years for women**, 15 years earlier than populations without known risk factors.
Individuals with severe mental illness (schizophrenia, major depressive disorder, bipolar disorder, schizoaffective disorder) are a high-risk group and screening from **age 25** years is recommended.

Key Points

- Māori, Pacific and South-Asian
- Starting age 30 for men, age 40 for women
- Sever mental illness start age 25
- Discuss treatment options
- Careful consideration needed for lowering blood pressure and aspirin for high risk patients.

Annual reviews recommended for high-risk individuals

Annual risk management reviews are recommended for all **high-risk individuals** and for **individuals at intermediate risk on pharmacotherapy.**

New clinical high-risk groups

Individuals with Heart Failure, a Glomerular Filtration Rate (e GFR) less than 30 ml/min (chronic kidney disease) and where available, a diagnosis of asymptomatic carotid disease or coronary disease (including coronary artery calcium score greater than 400 or plaque identified on CT angiography) are regarded as high risk for CVD and require intensive risk management.

Lipid management

Statins are the lipid-lowering agent of choice.
For high-risk individuals a LDL-C target of 1.8mmol/L or lower is recommended.
For intermediate-risk individuals the benefits and harms of lipid-lowering drugs should be presented and discussed to allow an individualised informed decision about whether to start treatment. **A target LDL-C reduction of 40% or greater is recommended if drug treatment is commenced.**

Blood Pressure

For high-risk individuals with persistent office BP 130/80mmHg or greater, or an equivalent level from ambulatory or home blood pressure monitoring, drug treatment in addition to lifestyle changes, is strongly recommended.
For intermediate risk individuals with persistent office BP of 140/90mmHg or greater, or an equivalent level from ambulatory or home BP monitoring, the benefits and harms of BP-lowering drugs should be presented and discussed to allow an individualised informed decision about whether drug treatment is commenced.
In all individuals if drug treatment is commenced, a target office BP less than 130/80mmHg is recommended.
Caution is recommended in lowering BP in elderly and comorbid individuals who may be at particular risk of treatment-related harms.

Aspirin

The benefits of the use of aspirin need to be carefully weighed up against the risks of bleeding and, in general, should only be considered in high-risk individuals under the age of 70 for primary CVD prevention alone.
For further detail, please refer to the Cardiovascular Disease Risk Assessment and Management for Primary Care (Ministry of Health, 2018).

Contacts for Further Information

Clinical Programme Facilitator or Team Leader Practice Liaison | TeAHN | 04 566 5320

Cervical Screening

Service Description

TeAHN provides funding to practices to subsidise cervical screening for eligible priority women.

Eligibility

- Aged between 25-69 years requiring regular cervical screening who are either
- Māori, Pacific, or Quintile 5 (or under exceptional circumstances for women whom the practice knows would otherwise not be able to afford a smear).

Funding continues to be available for women 20-24 who have had their first smear prior to the age change on 1 November 2019.

Funding and Payments

$25.56 (incl GST) or $22.23 (excl GST) per cervical smear via Halcyon claim form.

Cervical Screening Training

Funding is available to nurses working in a practice that has a predominantly "high needs" population or where the women do not have access to or choice of a female smear taker. The nurse requires the support and supervision from within the practice and a commitment to completing the training and required number of cervical smears.

Key Points

- 25-69 years old AND
- Māori or
- Pacific or
- Quintile 5 or
- Exceptional circumstances

Referral

- Mana Wahine

Claiming

- Halcyon claim form

Contacts for Further Information

Clinical Programmes Facilitator | TeAHN | 04 566 5320

Community Health Workers Service

Service Description

TeAHN provides support and advocacy for Māori, Pacific or Quintile 5 clients who are experiencing social and other issues which are impacting on their ability to access primary care, and live healthy lives. The team work alongside general practices and a wide range of providers and other organisations to facilitate access to primary health care services, and services delivered by other Government agencies such as Work and Income, Housing New Zealand and MSD Social Housing. The team also work alongside communities assisting and empowering them to address health and social issues.

Eligibility

This service is for patients who are Māori, Pacific or Quintile 5, enrolled with a Te Awakairangi Health Network practice, that are experiencing social and other issues which are impacting on their ability to access General Practice.

Key Points

- Advocacy for Māori, Pacific or Q5
- And experiencing social and other issues which are impacting on their ability to access General Practice.
- Enrolled with a Te Awakairangi Health Network practice

Referral

- MedTech outbox document
- Fax to 04 566 5369
- via HealthLink
- Self-refer 04 566 5320

Referrals

Can be made by:

- MedTech outbox document
- Fax to 04 566 5369
- Sending to TeAHN Community Health Workers Team via HealthLink v2phopcs
- Self-refer by either visiting our office at Level 4, 330 High Street, Lower Hutt or phoning TeAHN on 04 566 5320.

Community Health Workers are assigned to practices, contact details can be found at https://teawakairangihealth.org.nz/service/community-health-workers/

Contacts for Further Information

Outreach Services Team Leader | TeAHN | 04 566 5320

Contraception Access

Service Description

TeAHN provides funding to increase access to contraception for low income women.

Eligibility

Women aged 15-44 years who:

- live in quintile 5 areas; or
- hold a community services card; or
- are at high risk of unplanned pregnancy and poor health and social outcomes (as set out in the background and agreed). An indication of which maybe (but not limited to) women under 25 years of age having rapid repeat pregnancies or women engaged with community alcohol and drug services

Free Oral Contraception, Depo Provera and insertion and removal of funded IUDs and Implants for the target population.
Health practitioners delivering the service must be trained in the quality provision of IUD & Jadelle insertions
Funded long acting reversible contraception include Jadelle, Copper IUD's, Jaydess and Mirena

Key Points

Women aged 15-44 years AND:

- Q5 or CSC or
- high risk.

Referral

- High Street Health Hub
- Naenae Medical Centre
- Queen Street Medical Centre
- Silverstream Health Centre.

Claiming

- Halcyon claim form.

Claiming

Oral Contraceptive and Depo Provera	Amount able to be claimed	
	GST Inclusive	GST exclusive
GP initial Consultation (including 3 month prescription)	$19.00	$16.52
GP Follow up consultations at 3 Months (including 6 month prescription)	$19.00	$16.52
Ongoing 6 month Prescription/Administration of Depo Provera 3 month intervals	$19.00	$16.52

Long Acting Reversible Contraception	Amount able to be claimed	
	GST Inclusive	GST exclusive
GP initial Consultation	$19.00	$16.52
LARC Insertion and Follow up	$131.00	$113.91
GP Initial Consultation	$19.00	$16.52
LARC Removal	$131.00	$113.91

Contacts for Further Information

Clinical Programme Facilitator or Team Leader Practice Liaison | TeAHN | 04 566 5320

Fragility Fractures (Falls Prevention)

Service Description

This programme is to support the management of patients with a fragility fracture who would benefit from an assessment and management plan. One extended consultation is funded, must have GP involvement in some part of the process but can be completed by a nurse.

Eligibility

- Be enrolled with a practice within the CCDHB, HVDHB and WDHB catchment
- Have presented with a fragility fracture within 12 weeks
- Be 50 years of age or over

Claiming

Fax the form to Tū Ora, Compass Health Wellington on

04 801 8715

For eligible patients $115 (including GST) may be claimed – One claim per patient.

Key Points

- Fragility Fracture within 12 weeks
- Over 50 years old
- Enrolled within the CCDHB, HVDHB and WDHB area.

Referral

- In Home Strength and Balance Programme DHB

www.livestronger.org.nz.

Claiming

- MedTech- outbox (FRAC)
- Fax to 04 801 8715 Tu Ora, Compass.

Dexa Scan

People with a recent fragility fracture who also meet the eligible criteria for a funded DEXA scan.

Eligibility

- 50-74 years old who have had a
- Fragility fracture within the last 12 weeks and
- CSC card holder or Quintile 4-5 and
- Moderate risk of future fracture calculated using FRAX / GARVAN tool (see http://3d.healthpathways.org.nz) without a BMD measurement AND one of the following:

Referral

Fill in the MedTech Outbox document DEXA form and fax to Pacific Radiology 04 978 5501.

Contacts for Further Information

Clinical Programme Facilitator or Team Leader Practice Liaison | TeAHN | 04 566 5320

Good Food Programme

Service Description

TeAHN's health promotion team provides hands-on cooking programmes for people who need extra support with cooking and preparing healthy kai. This programme is available to people enrolled with a TeAHN practice.

Eligibility

The programme covers the basics of healthy nutrition and shows people how to prepare favourite dishes and snacks in a healthy way with an emphasis on creating meals on a tight budget. The programme is run throughout the Hutt Valley in collaboration with various community groups such as Marae, Community Houses, Workplaces, Faith led communities, Learning communities and other organisations.

TeAHN provides food, tutors, workbooks and recipe books free of charge to people enrolled in the programme.

Key Points

- Cooking programs
- Preparing Healthy Kai
- Health Nutrition.

Referral

- Outbox document under Healthy Families Coach referral form (HFCREF).

Priority Participants:

- Leaders or community groups who can influence or take responsibility for an improved food environment for their members e.g. Sports clubs, community houses, faith communities
- TeAHN enrolled patients who need extra support around healthy nutrition and cooking.

Contacts for Further Information

Health Promotion Manager | TeAHN | 04 566 5320

Healthy Families Coach Service

Service Description

TeAHN provides a Healthy Families Coach service to Māori or Pasifika clients or low-income families enrolled in a TeAHN practice who have a long-term condition or are trending towards a long-term condition such as diabetes, heart disease or obesity. The service aims to enable positive lifestyle changes for the identified children, whānau, or adults through an individual or whānau centered approach. HFC service is mobile or PHO based depending on the client/s needs. Our exercise and dietitian experts create goals and action plans alongside the client or whānau to achieve improved eating habits and levels of physical activity, and connections that will sustain positive health and wellbeing outcomes.

Key Points

- Māori & Pasifika clients or
- Low income families
- Enrolled in TeAHN practice
- Who have or will have a long term condition

Referral

- Outbox document under Healthy Families Coach referral form (HFCREF)

Eligibility

Children or adults enrolled with a TeAHN practice **who are:**

- Māori or Pacific or low Income (Quintile 5) or exceptional circumstances **and**
- Have a long term condition or are at risk of developing a long term condition which can be managed by a nutrition or physical activity intervention.

What does the service provide?

Intensive one on one healthy lifestyle support for individuals or families for up to six months, including:

- Individualised nutrition and physical activity assessments and support plans
- Regular goal setting and reviews
- One on one walks, swims, gym visits etc. with patients new to exercise to help increase confidence
- Weekly free group exercise session for all patients held in community locations
- Discounted gym and swimming pool memberships
- Self-management support and liaison with other health professionals

Referral

Referrals will be located in the Outbox document under Healthy Families Coach referral form (HFCREF) or the corresponding My Practice document.

GPs or Practice Nurses can make referrals via MedTech or My Practice and be sent to us by fax, post or MedTech outbox through HealthLink address v2phopcs.

Patients can also self-refer by either visiting our office at Level 4, 330 High Street, Lower Hutt or phoning TeAHN on 04 566 5320.

Important: When referring a patient for exercise/lifestyle advice please refer to **only one** of the service options:

- **Healthy Families Coach Service-** If your patient has a long term condition and requires intensive face to face support with motivation, nutrition and exercise.
- **Green Prescription/GRX Plus**- if your patient has pre-diabetes, high blood pressure or lipids, mild mental health, overweight or obesity and requires less intensive support programme or would like to participate in a group programme
- **Active Families/Preschool Active Families**- this programme is your primary option for children needing lifestyle support

Location

HUCHS Pomare and Whai Oranga o Te Iwi Health Centre have a community Dietitian in their practice for ½ day a week. These patients are seen during clinic time at the practice or a home visit can be arranged if needed. For all other practices, the service is delivered either at the TeAHN offices or the patient's choice of venue. This can include their home, community setting or at their General Practice.

Contacts for Referrals or Further Information

Health Promotion Manager | TeAHN | 04 566 5320

Interpreting Service

Service Description

TeAHN manages a contract with Interpreting New Zealand (NZ) for the telephone interpreting service which provides interpreters for approximately 70 languages, to enable patients from non-English speaking backgrounds to communicate in their own language in primary care setting.

Key Points

- All patients enrolled with a TeAHN practice
- Free 24 hour service
- Book via phone, website or email
- Provide necessary information
- Late cancellation or late fees apply
- TeAHN will be invoiced

Patient Eligibility

All patients enrolled with a TeAHN practice requiring translation services in primary care setting

Availability

Interpreting NZ is free and operates a 24 hour service line.

Access

1. **There are three ways to book a telephone interpreter:**
    - **Phone Interpreting NZ:(Note: always phone if it is urgent – less than 24 hours)**
      (04) 384 2849 *or* 0508 INTERPRET (468 377)
    - Book online: https://interpret.org.nz/book-an-interpreter.html
    - Email the details to: request@interpret.org.nz
2. **Provide some critical information** When the Request Coordinators get a request for an interpreter, they will always ask for:
    - The name of the organisation: **Te Awakairangi Health Network**
    - The name of the medical centre
    - The name and contact details of the person requesting the interpreter – the primary contact person
    - The name of the English speaker engaged in the appointment or consultation (often different from the person making the booking)
    - The language required
    - The date and time for the interpreting assignment
    - The name of the non-English speaking patient. This is to ensure that there are no conflict-of-interest issues for the interpreter
    - The purpose of the appointment (the nature of the matter being discussed), so the interpreter can be as well-prepared as possible.

All of this information helps Interpreting NZ find the best interpreter for the job, get in touch with you quickly if there are problems at any time, and provide continuity of service (i.e. give you the same interpreter for a follow-up appointment if needed).

3. **Take a note of the Job number**

   Each interaction has a unique number, which the Request Coordinator will give you. Please take note of the number in case you need to change any details about the appointment or have queries at a later stage.

Cancellation of Telephone Interpreting

If the services of a telephone interpreter are no longer needed, you will need to telephone Interpreting NZ at the earliest opportunity to cancel the interpreter. There could be a cost to TeAHN depending on time eg:

- Where a call is cancelled less than two hours before the booked time, the **first 15 minutes** will be charged or the booked time if that is greater than 15 minutes.
- When a pre-booked call does not begin at the scheduled time, charges will begin form the booked time until the call ends or until Interpreting NZ is notified that the call will not take place.

Please note that cancellation fees take account of the fact that the interpreter will have made advance arrangements and turned down other work to carry out the assignment.

Contacts for Further Information

Outreach Services Team Leader | TeAHN | 04 566 5320

Long Term Conditions Programme

Service Description

The Long-Term Conditions (LTC) programme aims to improve outcomes for people with long term conditions, supporting general practice to expand the clinical focus from one patient at a time to a proactive, population-based approach, especially for chronic care and prevention services. Practices provide LTC care through the implementation of an annual practice plan and supported by an annual allocation of funds. All LTC practice plans must have a component of care for their enrolled population with diabetes and for patients requiring follow up post hospital discharge for a cardiac and/or respiratory related admission.

Key Points

- Patients with a diagnosis of diabetes; **or**
- Enrolled patients requiring a follow up post hospital discharge for a cardiac/respiratory related admission; **or**
- Patient cohorts defined within the agreed individual LTC practice plans

Claiming

- Halcyon claim form

Availability

- All enrolled patients with a diagnosis of diabetes; **or**
- All enrolled patients requiring a follow up post hospital discharge for a cardiac/respiratory related admission; **or**
- Patient cohorts defined within the agreed individual LTC practice plans

Practice Plans

Practices Plans are developed in consultation with General Practice team members and TeAHN. They are developed based on enrolled practice population using patient profiling; patient LTC risk stratification, pharmacy audit data and general PMS data. LTC plans include:

- Funding allocation for LTC Components i.e. plan deliverables
- LTC plan deliverables including activities and services directly relating to the outcome of LTC patient cohorts
- Performance Measures i.e. LTC related System Level Measures

Note: refer to your general practice LTC Practice Plan for more information.

Funding

Funding is agreed in the Practice Plan.

Note: Individual general practice funding amounts will not be shared unless permitted by general practice owners.

Accountability

Both TeAHN and each general practice will have access to all LTC Programme activity via a portal or via manual PMS extracts conducted within general practice. LTC programme activity is determined by individual general practice(s) delivering the LTC Plan activities contained within their individual LTC Practice Plans.

Contacts for Further Information

Clinical Programmes Facilitator | TeAHN | 04 566 5320

Outreach Nurses

Service Description

TeAHN offers complex clinical case management, working with and on behalf of the practice to connect Māori, Pacific or Quintile 5 patients enrolled with a TeAHN practice who are not accessing general practice or primary care to access ongoing support that meets their needs. The nurses work alongside general practice teams to assist them to engage high need patients, providing assistance with health education, advocacy and support at home. The aim is to extend the capacity of the practice to reach, engage and reintegrate high need patients back into regular care arrangements with the practice.

Key Points

- Māori, Pacific or Q5
- Enrolled with Te Awakairangi Health Network practice

Referral

- MedTech outbox documents (OUTRCH)
- Outreach Nursing Service

Availability

This service is for patients who are Māori, Pacific or Quintile 5, enrolled with a Te Awakairangi Health Network practice, who have difficulty accessing General Practice or primary care.

Referral

A referral can be made via MedTech outbox documents and faxing on 04 566 5369, or by simply ringing the Outreach Nursing Team.

Contacts for Referrals or Further information:

Outreach Services Team Leader | TeAHN | 04 566 5320

Palliative Care

Service Description

Te Omanga Hospice (ToH) has partnered with Te Awakairangi Health Network (TeAHN) to provide funding and strengthened support for general practice teams in the Hutt Valley to manage the palliative care needs of their population. This includes funding to enable palliative patients to live well and die well, through the provision of free-for-patient conversation/s to plan care and support at the end of life. Further subsidies are available for the general practice team to deliver care in the last days of life.

Support from Specialist Palliative Care Services/ToH is also available for these patients. Clusters of practices in each neighbourhood (Upper Hutt, Central and Lower Hutt) will be assigned a Palliative Care Facilitator from ToH. These nurses will help to facilitate and coordinate services to support the palliative care needs of the patient and their carer/family/whānau. These roles are now established across the Hutt Valley.

Key Points

- Patient must be enrolled and reside in the Hutt Valley
- Be in the last 6 months of life
- Patients remain in GP-lead care with support from Te Omanga
- Eligible for EoL package

Claiming

- Halcyon claim form

Availability

Patient Eligibility

Patients must reside in the Hutt Valley and be an enrolled and funded patient at a Hutt Valley General Practice.

- To be eligible for PCP funding a patient will be approximately in their last six months of life.

To be eligible for the EoLC funding, patients will have been assessed by the practice to be approximately in their last 30 days of life and requiring more intensive support by the practice

Funding and Payments

Primary Care General Practice teams will be funded to undertake Palliative Care Planning (PCP) conversation/s with eligible patients through Halcyon claiming.

As these patients near the end of life, further funding is then available for Primary Care General Practitioners to subsidise their delivery of care and support in the last days of the patients life - End of Life Care (EoLC).

*Please note that as this provision relies on the Primary Care General Practitioner remaining the Lead Medical Palliative Carer this funding **does not apply** to patients living in a residential care facility, or for patients living at home and are receiving full medical care from the ToH team.*

Funding is available in 2 parts:

1. **Palliative Care Planning Conversation (PCP) A one off payment of $150 (excl GST)**
    - The Palliative Care Facilitator linked to your practice is available to be part of this conversation.
    - This conversation could happen in one extended visit or over several appointments as appropriate.
    - The payment is claimed once the Palliative Care Planning Conversation has been completed.

2. End of Life (EoLC) care is additional payments of $150 – up to max of $300 (excl GST)

- This funding package is available to enable subsidised care for patients during their last 30 days of life.
- Specialist Palliative Care Service/ToH is available for help with after-hours support during this period. This should be discussed/organised in advance with hospice through the Palliative Care Facilitator linked to your practice.

Palliative care Facilitator Contact details:

Upper Hutt - Sue Campbell | 0211934646

Mid Hutt - Erin Pomana | 0211961609

Lower Hutt - Anna Garton | 0211979428

Please note: it is recognised that need and prognosis is difficult to ascertain for palliative patients, therefore funding beyond this $300 EoLC subsidy is available if needed. Special Approval for this is required through the Palliative Care Facilitator/Te Omanga Hospice linked to your practice and is made at their discretion.

Contacts for Referrals or Further Information

Clinical Programme Facilitator | TeAHN | 04 566 5320

Piki (until June 2021)- Youth Mental Health

Service Description

Piki is a Ministry of Health mental health initiative.

Through this initiative TeAHN provides youth focused and cognitive based primary mental health services to enhance the quality of life of our youth by equipping them with tools to overcome adversity and strengthen their wellbeing. This service is available to all residents of the Greater Wellington Region aged 18-25 years.

Services are delivered in Upper Hutt, Lower Hutt, and Wainuiomata, from some general practice sites and marae.

Patient Eligibility

Piki is available to youth aged 18-25 years, living in the Greater Wellington Region.

Key Points

- 18- 25 years old
- Living in Wellington Region
- Delivered in Upper Hutt, Lower Hutt, Wainuiomata and some marae
- Cognitive behavioural based counselling and therapy

Referral

- Outbox document under Wellbeing referral (WBREF)
- Self referral to Piki or TeAHN

Services provided

Generally, around six sessions of brief intervention including assessment, youth focused and cognitive-behavioural based counselling and therapy.

Referral

Wellbeing Service: Practice staff - please use the Wellbeing referral form (WBREF) from outbox documents in your practice management system. Send it to TeAHN via HealthLink to v2phopcs or fax to 04 566 5369.

Self, family and other agency referrals are also accepted by phone, fax, mail or people can call into our office.

Self Referral – through piki.org.nz or by contacting Te Awakairangi Health Network.

Contacts for Referrals or Further Information

Wellbeing Team Leader or Intake Co-ordinator | TeAHN | 04 566 5320

POAC - Primary Care Options for Acute Care

Aim

TeAHN manages funding so that general practice teams can provide free services in the community (for specific conditions and in accordance with the 3DHB Health Pathways) where the aim is to prevent an ED visit, an outpatient visit, or a hospital admission.

Availability

If a member of the General Practice team has a query about managing someone in the general practice who would otherwise be sent to ED/Hospital, they can ring the Clinical Programme Facilitator to see what assistance and funding they may be able to access.

POAC can be used for approved conditions such as:

- Uncomplicated cellulitis where the patient has already trialled high dose oral antibiotic treatment for 48-72 hours and who now requires IV antibiotics
- Suspected lower limb DVT
- Management of confirmed distal DVT
- Renal colic
- Acute asthma
- Migraine/Headache
- Dehydration
- Urinary retention
- Iron infusions

Note: These conditions must be managed under the relevant 3D Health Pathway and will be funded under POAC.

Key Points

Services to treat

- Cellulitis
- DVT
- Renal Colic
- Acute Asthma, Adult & Child
- Migraine/Headache
- Dehydration
- Urinary Retention
- Iron Infusion
- Minor Gyne

Claiming

- Halcyon claim form

Contacts for Further Information

See: 3d.healthpathways.org.nz

Clinical Programme Facilitator | TeAHN | 04 566 5320

POAC- Minor Gynaecology Procedures

Service Description

TeAHN manages funding for the provision of minor gynaecological procedures to patients who meet the criteria and are not able to access services that are covered by other funding streams such as WINZ, ACC or maternity.

Eligibility

- Resident in the Wellington, Hutt Valley or Wairarapa DHB regions – not necessarily an enrolled patient and
- Live in Quintile 5 **or** hold a current Community Services Card and
- Are not able to access services that are covered by other funding streams such as WINZ, ACC or maternity and
- Are eligible for publicly funded health services.

NB: Patients who do not meet the criteria above and where hardship is an issue can be referred to the hospital Gynaecology Department.

Key Points

- Reside in Wellington, Hutt or Wairarapa DHB regions and
- Quintile 5 **or** CSC Card and
- Not able to access services that are covered by other funding streams such as WINZ, ACC or maternity and
- Eligible for publicly funded health services

Claiming

- MedTech- outbox doc (GYNCLA)
- Other users- 3Dhealthpathways

Funded Procedures are:

- **Mirena Insertion for:**
  - Dysmenorrhoea
  - Endometriosis
  - Heavy or irregular menses
- **Pipelle Biopsy for:**
  - Heavy or irregular menses
  - Intermenstrual and/or post coital bleeding
  - Post-menopausal bleeding
- **Ring Pessary for:**
  - Pelvic organ prolapse.

Payment Guide

- The patient must pay for the first GP consultation and for any related prescription charges
- All subsequent consultations are then free to the patient and no co-payment can be charged
- There is no funding available to cover any patients who do not attend a booked appointment
- The cost of all consumables is covered in the specified price apart from the dispensing fee for the Mirena.

Contacts for referrals or further information

See: 3d.healthpathways.org.nz

Clinical Programme Facilitator | TeAHN | 04 566 5320

Podiatry (Community Podiatry)

Service Description

Podiatry sessions for people with diabetes who have moderate to high foot risk disease and require foot care.

Eligibility

Resident of the Hutt Valley, **OR** enrolled through a general practice located in the Hutt Valley and meet the following criteria:

- Have a known diagnosis of diabetes **AND**
- The patient is referred by their GP/PN/RN or HVDHB Podiatry Service to TeAHN **AND**
- **The patient has Moderate or High diabetic foot risk**

*If low foot risk Manage the patient in general practice for foot checks during DAR/LTC appointments

*If active risk/active foot disease refer patient to HVDHB

Key Points

- Diabetes diagnosis AND
- Enrolled **OR** resides in Hutt Valley AND
- Moderate or High diabetic foot risk

*if low foot risk manage in General Practice

*if active foot disease refer to HVDHB Podiatry service

Referral

- MedTech: Outbox – **COMPOD** Community Podiatry
- HVDHB podiatry referral

Approved Provider List

Clinic	Address	Telephone
Access Podiatry (2 sites)	In Queen St Pharmacy, 35 Queen Street, Upper Hutt In Woburn Pharmacy, 66 White Lines East, Lower Hutt	04 527 8931
Avalon Podiatry (2 sites)	841 High St, Lower Hutt Clive's Chemist Wainuiomata, Lower Hutt	04 567 5916
Hutt Foot Clinic	66 Bloomfield Terrace, Lower Hutt	04 566 7586
Petone Foot Clinic	Unit 1, 3 Britannia Street, Petone	04 939 0272
Silverstream Podiatry Clinic	2 Whitemans Road, Upper Hutt	04 528 7650
Upper Hutt Foot Clinic	UH Health Centre, 6 Sinclair Street, Upper Hutt	04 528 8805
Upper Hutt Podiatry	12 Criterion Lane, Upper Hutt	04 527 3052

Payments

The community podiatrist invoices TeAHN for sessions delivered.

For further information on foot risk stratification

Visit: https://www.nzssd.org.nz/special-interest-groups/group/3/diabetic-foot-special-interest-group

- Go to the New Zealand Society for the Study of Diabetes (NZSSD) website
- Go to "Diabetic Foot Special interest group" page
- Scroll half-way down the page to the "Resources" heading
- Follow the PDF link "Updated Foot Screening Referral Pathways 2017"

Contacts for Further Information

Clinical Programme Facilitator or Team Leader Practice Liaison | TeAHN | 04 566 5320

Radiology (Community Radiology)

Service Description

The community radiology programme provides clients referred by primary care with timely access to high quality radiology services, to facilitate a prompt, cost effective and accurate diagnosis of clinical problems and conditions. The service is free to eligible people. TeAHN manages the funding and supports the Clinical Advisory Group (CAG), which provides clinical governance on how this fund is utilised.

Key Points

- Reside in Hutt Valley and
- Patients who hold a CSC or High Use Health card or are Q4-5 and meets the clinical criteria for the investigation.

Referral

- BPAC radiology referral form.

Eligibility

- **Hutt Valley Residents** who meet one or more of the following funding criteria:
- Holds a current Community Service Card or High Use Health card
- Resides in a Quintile 4 or Quintile 5 area
- Meets the clinical criteria for the following investigations, linked to specific pathways on HealthPathways as per the table below:

Investigation	Specific related pathways
1. CT Head (Dementia)	Cognitive Impairment and Dementia
2. Ultrasound DVT (Lower Limb)	DVT
3. Ultrasound Pelvis (Gynaecology)	Dysmenorrhea Heavy or Irregular Menses Intermenstrual or post-coital bleeding Post-menopausal bleeding Ovarian cyst Endometriosis *also must meet CSC/High Use Health card/Q4/Q5 eligibility
4. X-ray Chest	Community Acquired Pneumonia
5. High Risk Breast Screening	Breast Cancer Risk Assessment

Exclusions

The following procedures are excluded from Community Radiology funding:

- Nuclear & MRI scans (other than CT Head scans for Dementia as described above)
- The usual (i.e. not high-risk) breast screening programme
- Accident related investigations (these are covered by ACC)
- CT Sinus
- CT Extremities
- CT and imaging for children - these should be discussed with the Paediatricians
- CT colonoscopy that is outside the clinical guidelines
- Acute or Urgent CT
- Head CT is only funded where this is recommended by the clinical guidelines or part of a localised health pathway – currently only relevant in the Dementia Pathway
- Ultrasound – lower limb arteries

Community Radiology also excludes procedures that are covered under:

- ACC
- Maternity services

Referral

Referrals for funded investigations under this scheme will only be accepted if they are on the **BPAC Radiology eReferral form**. Note: it can be supplied to radiology providers either electronically or in a printed format (if patient selection is preferred).

Patients make their own appointments and can choose their provider (except for CT Head Dementia scans*):

Hutt Hospital Radiology (Hutt Valley Imaging) Hutt Hospital High Street, Lower Hutt Tel: **04 566 6999**; ask for Valley Imaging Appointments	**Pacific Radiology** **Lower Hutt:** Boulcott Hospital, 668 High Street **Upper Hutt:** Health Centre, Queen Street Tel (for both branches): **04 978 5500**	**Valley Ultrasound*** 216 High Street, Lower Hutt Tel: **04 909 3240** *ultrasound services only

*In the case of CT Head scans (Dementia) the GP needs to fax the completed form directly to Hutt Valley Hospital Radiology Department at **(04) 570-9241**. They will contact the patient to arrange the appointment.

Contacts for further information

Clinical Programme Facilitator or Team Leader Practice Liaison| TeAHN | 04 566 5320

Refugee Health

Service Description

TeAHN will directly fund agreed contracted General Practices for support delivered to former refugees enrolled at the practice as part of the annual intakes via Red Cross. This is prospective and applies to new enrolments.

Availability

This funding will apply to former refugees who arrive under the Red Cross refugee settlement scheme and are enrolled at a TeAHN practice.

Funding and Payments

A payment of $350 (GST excl) per person will be made on presentation of an invoice on enrolment of the former refugee families. A further $150 (GST excl) per person will be paid on the one year anniversary of their enrolment.

Key Points

- Former refugees who arrive under the Red Cross refugee settlement scheme
- Enrolled in a TeAHN practice

Claim

- Halcyon claim form

This funding is intended to support the practice to provide subsidised care to the members of the former refugee families as they arrive and settle into life in NZ. The funding will be paid into the practice account and we expect the practice to apply this to the former refugee family's account. The practice may then deduct funds from this account as services are provided to the family members. The practice has the flexibility to apply this differentially across the family to meet their overall needs. The expectation is that the practice provides subsidised care to the family over the course the two year period, with the level of subsidy diminishing in the second year.

Contacts for further information

Team Leader Practice Liaison| TeAHN | 04 566 5320

Respiratory Care (Tu Kotahi Māori Asthma and Research Trust)

Service Description

TeAHN works with Tu Kotahi Māori Asthma and Research Trust, the HVDHB specialist respiratory services and general practices to improve access to services and improved care for patients with established respiratory disease. TeAHN contracts with Tu Kotahi so that TeAHN Māori patients who have babies with bronchiolitis or whanau with asthma / COPD can benefit from receiving respiratory education and support in a group

Patient Eligibility

Patients who are enrolled with TeAHN who have:

- Babies with bronchiolitis
- Whānau with asthma
- Whānau with long term respiratory conditions (COPD).

Referral

Tu Kotahi Māori Asthma and Research Trust Referral form, MedTech Outbox, send to 7-9 Barnes St, Seaview, Lower Hutt. Phone: 04 939 4629. Fax: 04 920 2925

Contacts for further information

Tu Kotahi Māori Asthma and Research Trust | 04 939 4629

Key Points

- Babies with bronchiolitis
- Whānau with asthma
- Whānau with long term respiratory conditions (COPD)
- Enrolled with TeAHN

Referral

- MedTech Outbox
- Other PMS: Tu Kotahi Māori Asthma and Research Trust Referral form

Retinal Screening- Diabetes

Service Description

Compass Health Network manages the contract for Diabetic Retinal Screening with a select group of community-based optometrists throughout the Wellington and Hutt Valley region. Patients on referral from their GP are screened and monitored, and in some cases, referred to specialist services. The objective of the retinal screening programme is to prevent sight-threatening diabetic retinopathy which is largely preventable through regular screening and prompt treatment.

Key Points

- Diabetes diagnosis

Referral

- MedTech- Outbox doc

Accredited and contracted Compass Health Retinal Screening providers are:

Optometrist	Location	Phone No.
Barry and Sargent	Porirua	04 237-8323
Barry and Sargent	Wellington	04 473-7047
Bentley and Sue	Upper Hutt	04 528-8868
Black Gates Meek and Dong	Lower Hutt	04 566-3940
Calver Optometrists	Johnsonville	04 478-4209
Clear Vision Optometrists	Newtown	04 939-0304
Foresight Optometrists	Tawa	04 232-7900
Grylls and Keleher	Kapiti Coast	04 298-4426
McClellan and Grimmer	Wellington	04 473-6275
Stuart Henderson	Wairarapa	06 378-7672

Contacts for Further Information

Clinical Programme Facilitator or Team Leader Practice Liaison | TeAHN | 04 566 5320

Skin Lesions – Primary Care

Service Description

TeAHN manages the skin lesion programme, which provides cost effective, early access for the removal of eligible skin lesions, free of charge to patients with Community Service Cards. This is a service provided through referrals and/or within the general practices.

Key Points

- Eligible skin lesion
- CSC or High Use Health Card, and
- Reside in the Hutt Valley or enrolled in a Hutt Valley PHO

Claiming

- Halcyon claim form

Patient Eligibility

The service can be provided to patients who:

- Have an eligible skin lesion
- Hold a Community Services or High Use Health Card, and
- Reside in the Hutt Valley or enrolled in a Hutt Valley PHO.

An eligible lesion is:

- Any suspicious lesion requiring simple excision and direct closure that the GP believes he/she is competent to remove both completely and to the aesthetic satisfaction of the patient.
- Examples of suspicious lesions are suspected basal cell carcinoma, squamous cell carcinoma or melanoma.
- Simple skin tags, lipomata and sebaceous cysts are not considered suspicious lesions and will not be covered by programme funding.

Approved Providers:

Only approved providers can claim under the service. To gain approval status, GPs must complete the training programme facilitated by TeAHN and delivered in partnership with the Plastics Department, HVDHB.

Claiming:

- Via Halcyon Claim system

Claiming Level	Type of Skin Lesion	Claiming Guide		Can GMS be claimed
		GST Inclusive	GST Exclusive	
Level 1	**Simple lesion** – will involve minimal sutures and approx 30 minutes of your time.	$120.00-160.00	$104.35 - $139.13	No
Level 2	**Complex lesion** – will require deep sutures and anywhere between 40-60 minutes of your time.	$160.00 - $260.00	$139.13 - $226.09	No

Primary Care Skin Lesion claim: to be completed and sent to TeAHN at the post-operative follow-up appointment, after the lesion has been excised and the post histology results have returned from the laboratory. All fields marked in red are compulsory and must be completed.

Contacts for further information

Clinical Programme Facilitator | TeAHN | 04 566 5320

Sore Throat Management (Rheumatic Fever Prevention Programme)

Service Description

TeAHN funds general practices and local pharmacies to provide rapid response services for assessment and treatment of children and young people with sore throats, specifically Māori and Pacific aged 4 to 19 years or those aged 4 to 19 years with a family history of rheumatic fever. TeAHN works with the Well Homes service (a multi-agency partnership helping whanau with housing problems and connecting them to health and social services) to increase referrals from general practices.

Availability

Free service available to people at **High Risk** of developing rheumatic fever.

- Māori and Pacific aged 4 to 19 years who normally live in the Hutt Valley and are enrolled in general practice in the Hutt Valley
- Anyone else aged 4 to 19 years with a family history of rheumatic fever who is living in the Hutt Valley
- Low socioeconomic areas of the Hutt Valley or are living in crowded circumstances.

The risk factors are:

- Tonsillar swelling (with or without exudate)
- Swollen cervical lymph nodes
- A fever with a temperature of at least 38°c
- No cough
- No runny nose.

Key Points

- High risk or Rheumatic Fever AND
- Māori, Pacific aged 4 to 19 years who normally live the Hutt Valley and are enrolled in a general practice in the Hutt Valley
- Anyone else aged 4 to 19 years with a family history of rheumatic fever who is living in the Hutt Valley
- Low socioeconomic areas of the Hutt Valley or are living in crowded circumstances.

Claiming

- Only available for Eligible providers via Halcyon claim form.

Service Providers

Pharmacists at several Hutt Valley pharmacies, including Lower Hutt After Hours Urgent Pharmacy will provide a free consultation and antibiotic treatment to those meeting the high risk criteria. No appointment is required at a pharmacy clinic. Also available at some General Practices in the Hutt Valley. GP visits will require an appointment. These visits are free for children under 14, but there may be a charge for children and young adults aged 14-19 years.

A list of Service Providers is available on the TeAHN website
https://teawakairangihealth.org.nz/service/preventing-rheumatic-fever-hutt-valley-free-sore-throat-clinics/

Provider Eligibility

This service and funding are only available to approved providers. If your practice has a High Risk population and would like to provide this service please contact us.

Funding and Payments

Sore Throat Assessment and/or Treatment Funding	
GP and / or Nurse assessment (including throat swab) and/or treatment	$40.25 (incl GST) or $35.00 (excl GST) per assessment (where a throat swab has been administered) followed by treatment if required (where antibiotics have been provided).
Pharmacist assessment and/or treatment	$28.75 (incl GST) or $25.00 (excl GST) per assessment (No throat swab is required) followed by treatment if required (where antibiotics have been provided).

Contacts for further information

Team Leader Practice Liaisons | TeAHN | 04 566 5320

Transport Service

Service Description

TeAHN provides free, short-term transport support for Māori, Pacific or Quintile 5 patients (and others only in exceptional circumstances), enrolled with a TeAHN practice who are experiencing multiple barriers to accessing primary health or Hutt Valley Hospital appointments AND have a genuine transport need and have no other transport option available to them.

Availability

The Transport Service is available Monday to Friday between 8.00 am and 5.30 pm.

Key Points

- Māori, Pacific or Quintile 5
- Enrolled with a TeAHN practice
- No other transport options available.

Referral

- MedTech outbox under "TRANS"
- Provided by WFA.

Patient Eligibility

All patients referred must meet the following criteria:

- Are experiencing multiple barriers to accessing primary health or Hutt Valley Hospital appointments AND
- Have a genuine transport need and have no other transport option available to them AND
- Be enrolled with a TeAHN Practice (any Hutt Valley practice except Ropata Medical Centre) AND
- Be Māori or Pacific Ethnicity OR Quintile 5[1] OR have exceptional circumstances (see below).

Exceptional Circumstances

- Where a patient does not meet the criteria above, a referral to the transport service may still be permissible where the referrer has identified a genuine need.
- If the referrer is unsure of a patient's 'genuine need', then please refer to:
    - Community Health Manager - for advice and support on financial and social issues *or*
    - Clinical Services Manager - for advice and support on clinical issues.

Referral Process

Before arranging transport ensure that there are no other transport options available to the patient, i.e. through family or friends, other community providers, Work and Income Disability Allowance (for medical transport costs), and Total Mobility Card (50% off the total fare, up to a maximum of $40.00 per trip).

The referral form is in the MedTech Outbox document under "TRANS". This form will prepopulate with the practice's identifying code as well as the practice address and the patient details.

Before printing off the document and faxing to the number on the form, please ensure the following patient information is included:

- **Ethnicity** and
- **Quintile -** go to F3, open the "enrolment funding tab". On the right hand side of the page you will see information including Quintile, to add to your referral.

Patients should be told before their first pick-up that the transport is provided by WFA and informed that a Patient Transfer Vehicle with WFA logo will pick them up.

If you have a patient who does not meet the criteria but is a special case, please contact the Community Health Manager.

Contacts for further information

Outreach Services Team Leader | TeAHN | 04 566 5320

[1] Ministry of Health criteria for use of Services to Improve Access (SIA) funding

Valley Fit (Te Awa Active) Programme

Service Description

TeAHN's health promotion team provides or facilitates access to exercise programmes for people who need extra support around physical exercise and wellbeing. This programme is available to people enrolled with a TeAHN practice.

Locations

Locations vary throughout the Hutt Valley. Contact the Lead Healthy Family Coach for more information about upcoming programmes.

Classes are run by TeAHN Healthy Families Coaches and are attended by people of all shapes, sizes, ages and ethnicities.

Key Points

- 18- 65 years old
- Support for physical exercise and wellbeing
- Enrolled in TeAHN practice.

Referral

- MedTech referral to the HFC under "HFCCREF".

Patient eligibility

TeAHN enrolled patients aged 18 – 65 years who need extra support around exercise.

It is preferable that if a patient is interested in attending that a referral is made to the HFC service via MedTech outbox document under **"HFCCREF".** Under reason for referral please indicate that they are interested in Valley Fit gym class etc.

Contacts for Referrals or Further Information

Health Promotion Team Leader | TeAHN | 04 566 5320

Wellbeing Service (Primary Mental Health)

Service Description

TeAHN provides primary mental health and addiction services to improve health outcomes for people with mild to moderate mental health needs or with addiction issues. Priority is given to Māori, or Pacific, or Quintile 5 people (who are enrolled with a Hutt Valley general practice) and anyone who is 12-19 years of age. Young adults aged 20-24 who have barriers to accessing an alternative appropriate service are generally accepted. In exceptional circumstances, a referral to the Wellbeing Service may be accepted for other clients, where the referrer has identified a genuine mild to moderate mental health or substance use need that cannot be addressed via other alternatives and capacity in the clinical team allows. Services are delivered in Upper Hutt, Lower Hutt, and Wainuiomata, from some general practice sites and marae.

Key Points

- Mild to moderate mental health needs or addiction issues
- Māori, Pacific or quintile 5 priority
- 12- 19 years old (20- 24 year olds also accepted)
- Enrolled with Hutt Valley GP

Referral

- Via MedTech use Wellbeing referral for (WBREF) from outbox
- Self, family and other agency referrals accepted to TeAHN or Vibe

Patient Eligibility

Adolescents and adults aged 12 years or older with a mild to moderate mental health or substance use concerns who are likely to benefit from a brief intervention. Adults must be enrolled with a Hutt Valley GP; young people aged 12-19 do not have to be enrolled to be eligible for this service.

If other suitable funded services (e.g. ACC, student counselling, employee assistance programme counselling) are available, these may be recommended first depending on the referred person's circumstances and needs.

Priority Groups

- Māori or Pacific, or
- Quintile 5, or
- 12-19 years of age.

Exceptional Circumstances

- In exceptional circumstances, a referral to the Wellbeing Service may be possible for other Community Services Card holders, where the referrer has identified a genuine mild to moderate mental health or substance use need that cannot be addressed via other alternatives
- If you are unsure of a person's level of need or alternative option, please contact the Wellbeing Service Manager or intake coordinator for advice
- "Exceptional circumstance" referrals can be accepted at the discretion of the Wellbeing team only when it has the capacity to do so. At other times, they will be declined.

Exclusions

- Children under 12 years of age
- Current clients of a secondary mental health or addictions service or those awaiting an assessment by a secondary mental health or addictions service.

Access

Qualifying Patients of all Hutt Valley Practices: Refer to TeAHN's Wellbeing Service. We accept referrals from practice staff, other agencies and self-referrals. Our base is in Lower Hutt with outreach clinics at various locations across the Hutt Valley. Home visits can be arranged when necessary. Patients at Hutt Union and Community Health Service also have access to a limited counselling service at HUCHS Pomare.

Young people who use Vibe: Can choose to use its primary mental health services if preferred. The young person must book a Vibe nurse or GP appointment first. For young people at a high school or alternative education

setting with a Vibe health service, access can be facilitated through Vibe's school nurse or doctor if preferred. Vibe counsellors see clients at Vibe's Lower Hutt and Upper Hutt clinics.

Services provided

Up to six sessions of brief intervention including assessment, counselling, and a range of psychological therapies. Groups are offered from time to time.

The Wellbeing team will also:

- Liaise with the General Practice team regarding the progress of the referred person
- Provide information, resources, support and advocacy around mental illness and substance use
- Refer to or connect people with other health and social services and community groups
- Work closely with other TeAHN services e.g. Health Promotion, Community Health Workers and Outreach teams, to address client needs
- Support practices to help their patients. We can advise about other services and referral options, and resources to use with patients. Please phone us if we can be of help.

Referral

Wellbeing Service: Practice staff - please use the Wellbeing referral form (WBREF) from outbox documents in your practice management system. Send it to TeAHN via HealthLink to v2phopcs or fax to 04 566 5369.

Self, family and other agency referrals are also accepted by phone, fax, mail or people can call into our office.

Vibe: If young people aged 12-19 years choose to use the primary mental health service at Vibe, they will need to contact Vibe and book an initial appointment with a Vibe nurse.

Service Availability:

Most services are available Monday to Friday (except public holidays) 8:30am-5.00pm.

Vibe:	5 Daly Street Lower Hutt, Ph: 04 566 0525 | Fax: 04 586 2054
	68-70 Ward Street Upper Hutt, Ph: 04 528 6261
Wellbeing Service:	Level 4, 330 High Street, Lower Hutt, Ph: 04 566 5320 | Fax 04 566 5369 Postal Address: P O Box 44-125 Lower Hutt 5040

Wellbeing outreach clinic locations

- Upper Hutt – Queen Street Medical Centre, Queen Street, Upper Hutt
- Wainuiomata - Whai Oranga O Te Iwi Health Centre, 7 The Strand, Wainuiomata
- Stokes Valley - Koraunui Marae clinic rooms at Tui Glen School, 126 Stokes Valley Road.
- Hutt Union Community Health Services, Petone and Pomare

These venues are current as at 1 August 2017. Clients from any practice can attend sessions at these locations.

Contacts for referrals or further information

Wellbeing Team Leader or Intake Co-ordinator | TeAHN | 04 566 5320.