RAPHS
A Year in Review
1 July 2017 to 30 June 2018

Rotorua Area Primary Health Services Ltd

Website: www.raphs.org.nz

Together, we make it better

ROTORUA AREA RAPHS Primary Health Services

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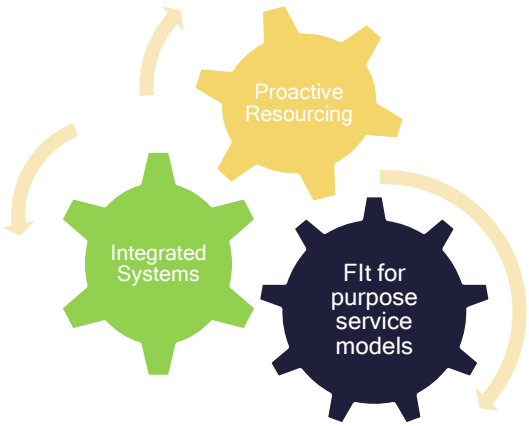
THE RAPHS SERVICE MODEL

To improve the health and equity of outcomes for our community, RAPHS enables, facilitates and supports the connection of an integrated network of service providers to deliver community-based health services in response to the needs of patients and their whanau.

The RAPHS vision statement *Together, we make it better* prioritises the importance of a collaborative partnership approach to improve health service delivery and outcomes. This partnership is community, patient, provider, PHO and funder.

Strategy

Through integration of all PHO systems encompassing service models, resourcing methodologies and information systems; we deliver primary care capacity and capability building, workforce development, quality assurance, accreditation support, and provider business support in an efficient & consistent way to support delivery of fit-for purpose services.



Multidisciplinary Collaborations to improve:

1. Equity and Quality
2. Patient & Provider Experience
3. Efficiency & Accountability

Key PHO Support to Providers:

Service Support:

- Build clinical workforce capacity
- Enable pro-active care coordination
- Enable acute care response

Integration Support:

- Provide systems and infrastructure
- Share information
- Support health navigation
- User support

Provider Support:

- Service efficiency
- Accreditation and CQI
- Practice Management support

Funding Support:

- Results-based accountability
- Direct to provider contracts
- Funded patient co-payments

LINC Model of Care

Alignment with the Healthcare Home

The healthcare home is an international concept with many PHOs in New Zealand adopting aspects of this philosophy as the basis of supporting ongoing evolution and improvement of service delivery models. At its heart, the healthcare home is patient-centered care delivered by an integrated, comprehensive and accessible team focused on delivery of safe an effective services to meet patient needs, with levels of service targeted to increasing levels of health need.

RAPHS delivers the healthcare home through the LINC Model of Care.
(LINC = Lakes Integrated Network Care)

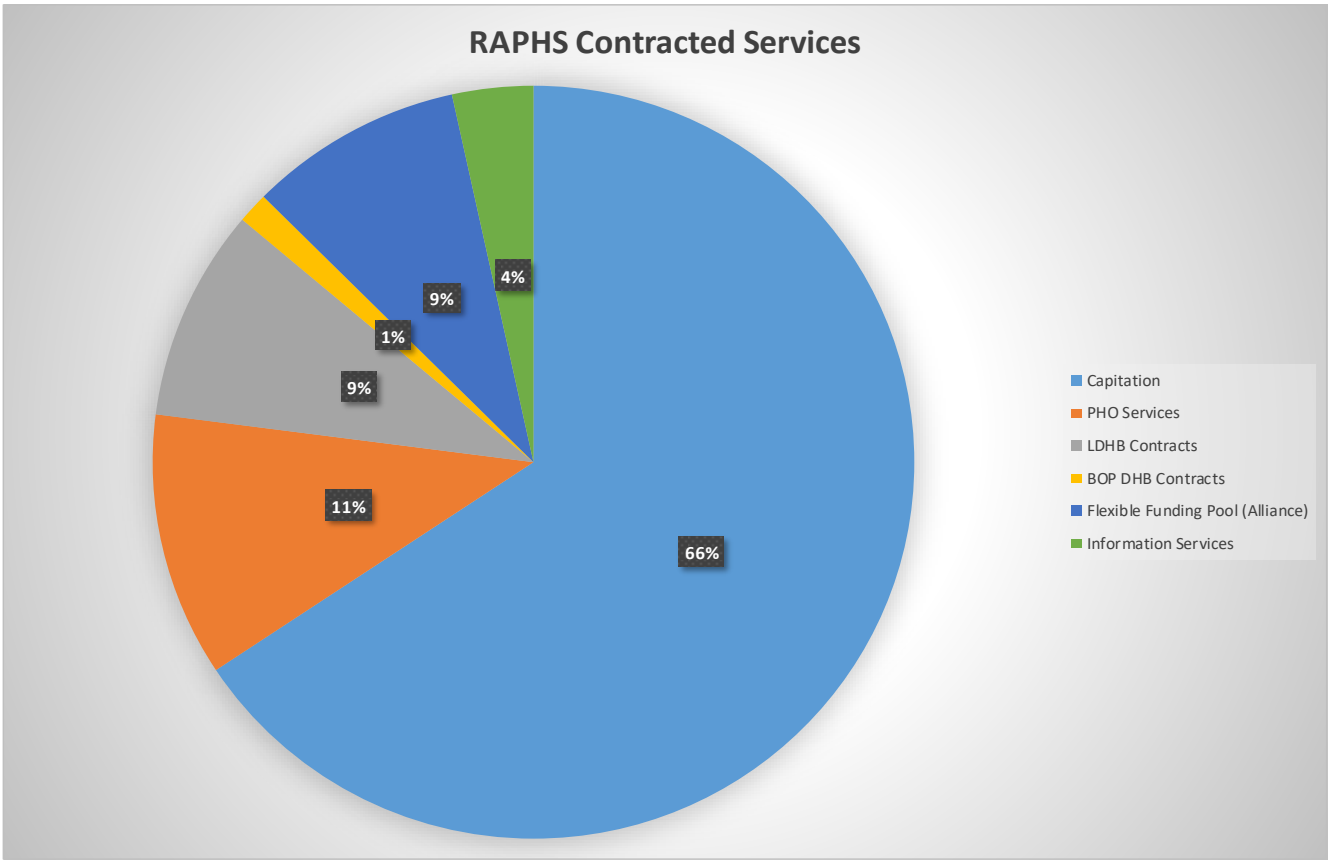
- LINC puts the patient at the center of care and enables the coordination of care from an enrolling general practice through a wide network of connected service providers
- Smart IT tools and support systems coordinated and delivered by RAPHS connect and integrate this provider network
- Responsive-services are able to identify and target service delivery proactively

MOH Healthcare Home Definition[1]	LINC element
The practice needs to be a nice place to visit There should be a calm reception area where staff can focus completely on patient needs	Accreditation and provider support for Members
Easier access and more choice **Patients** have online access to book appointments, contact their GP or nurse, and view lab results and other clinical information. This saves them the time and hassle of travel. Patients can also phone or make appointments in the usual way and may be able to speak directly to a GP	Patient Portal Support
Access to care when it's urgently needed If a patient phones a Health Care Home practice, they can get an appointment on the same day if it is clinically necessary. They may be able to speak directly to a GP about their care before making an appointment	Drop in clinics Coordinated after-hours access via LPC
More Services Health Care Home practices are expanding services so that patients can get additional urgent care (such as intravenous antibiotics and management of deep vein blood clots) and in this way avoid having to make unnecessary trips to the emergency department for such care.	Packages of care, with integrated funding support
Better management of ongoing health conditions Healthcare home practices will make it easier for the many patients who have ongoing health conditions to plan and manage their health care, and maintain a high quality of life. Practices will work with patients to set goals for their health and wellbeing, and work with them regularly to achieve these goals. Health Care Home practices make available the time patients need to manage conditions in partnership	LINC Care planning and care coordination Extended Care Support Team
Better service at hospital or after hours Hospital and after-hours staff will be able to see patient's health information, which they can use to provide better and more personalised care	PatientWise

1. **Ministry of Health. 2018. Top Tips for Improving Your Acute Demand Management. Wellington: Ministry of Health.**

CONTRACT SUMMARY

RAPHS contracts with external funders (public and private) to deliver health services on their behalf. Contracts specify accountabilities, deliverables and volumes. An integrated approach to contracting is essential for efficiency and is inherent to the LINC model of service delivery.

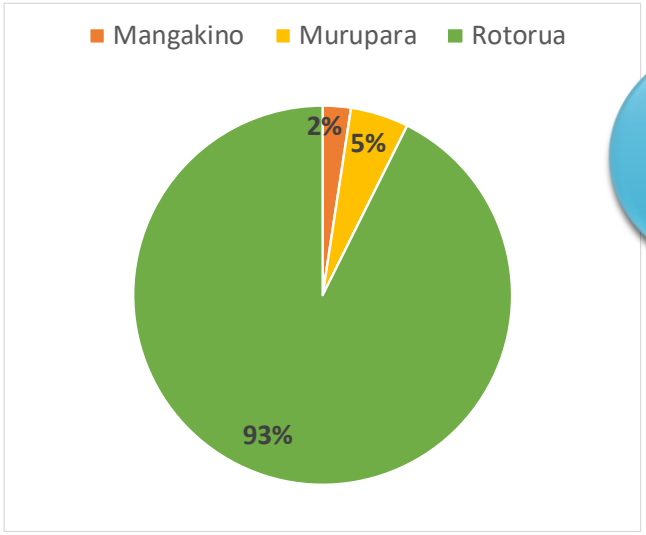


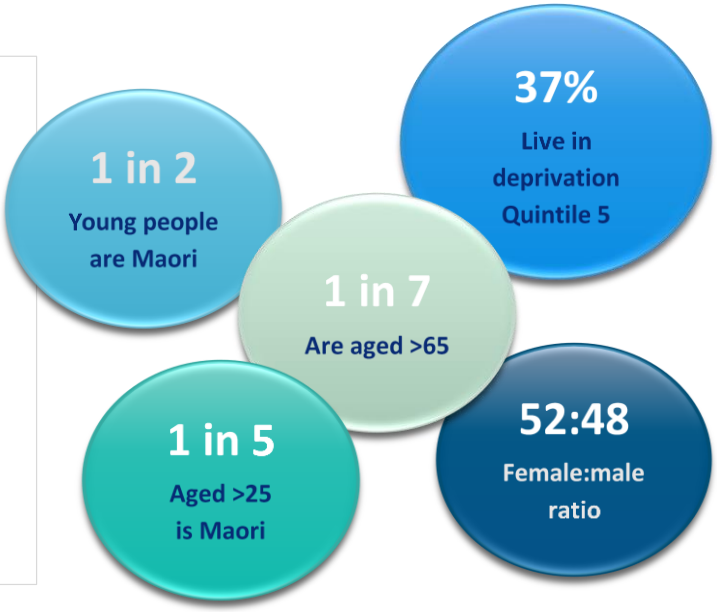
Service Contracts: PHO Services Agreement; Capitation; After Hours (LPC) under 13; LDHB Mkino Rural Services; LDHB Mkino Rural Sustainability; BHDB Murupara Rural; BDHB Murupara A/Hrs; BoP Long Term Conditions; PHO Services (CarePlus); LDHB Diabetes Management Services; BoP Long Term Conditions; PHO Services (Murupara SIA); LDHB Breast and Cervical; LDHB CASH; LDHB Medicines Use Review, LDHB POAC; LDHB Retinal Screening; LDHB Palliative Care; LDHB Diabetes - Insulin Initiations; LDHB FTE to Support Clinical Outcomes; Cervical Packages of Care; Clinical Psychologist Services; CVDRA Support packages of care; Maternal Packages of Care Antenatal; Integrated Nursing Service; Clinical Pharmacy; Green Prescription; Youth Health; Hosted Services and ICT Support.

Details of volumes delivered see page 8.

OUR COMMUNITY

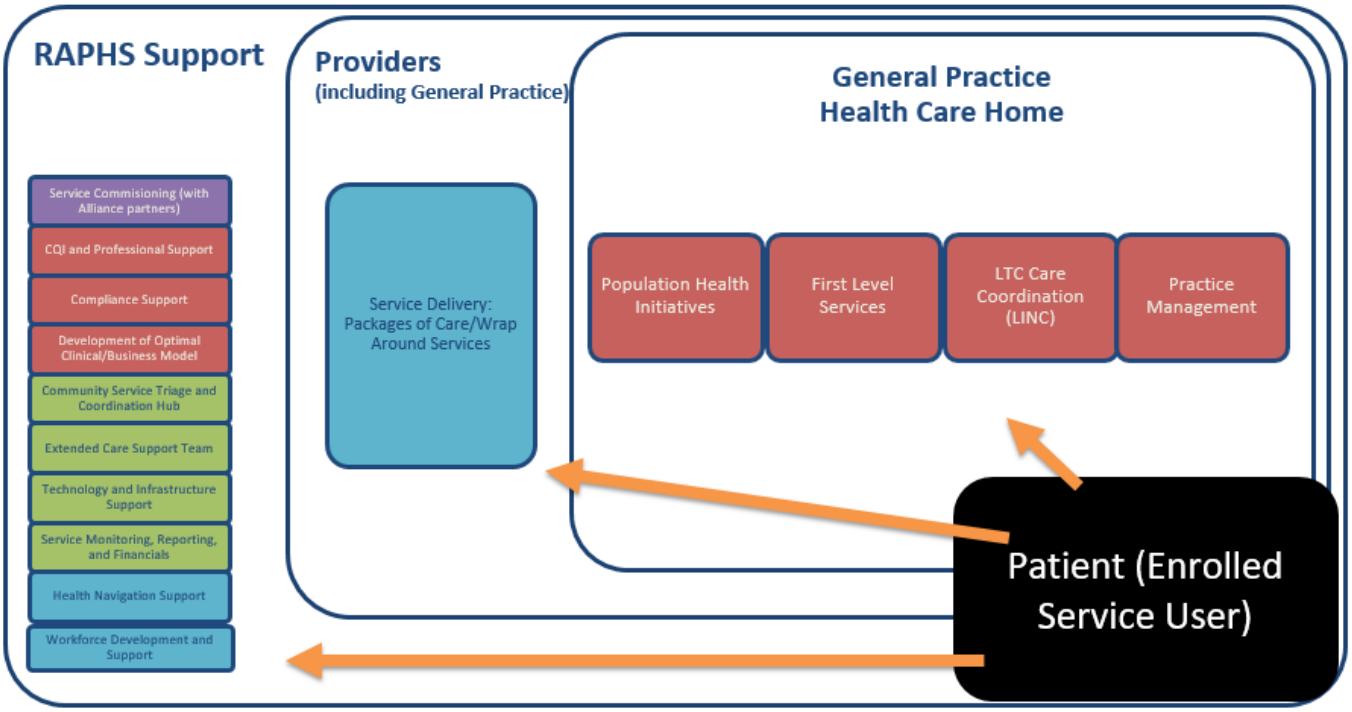
RAPHS delivers primary care services to nearly 73,000 people enrolled in a RAPHS member general practice in Rotorua, Mangakino and Murupara. Further services are delivered across the Lakes District to people enrolled in all other practices, including Afterhours services in Rotorua, Retinal Screening services across Rotorua and Taupo.



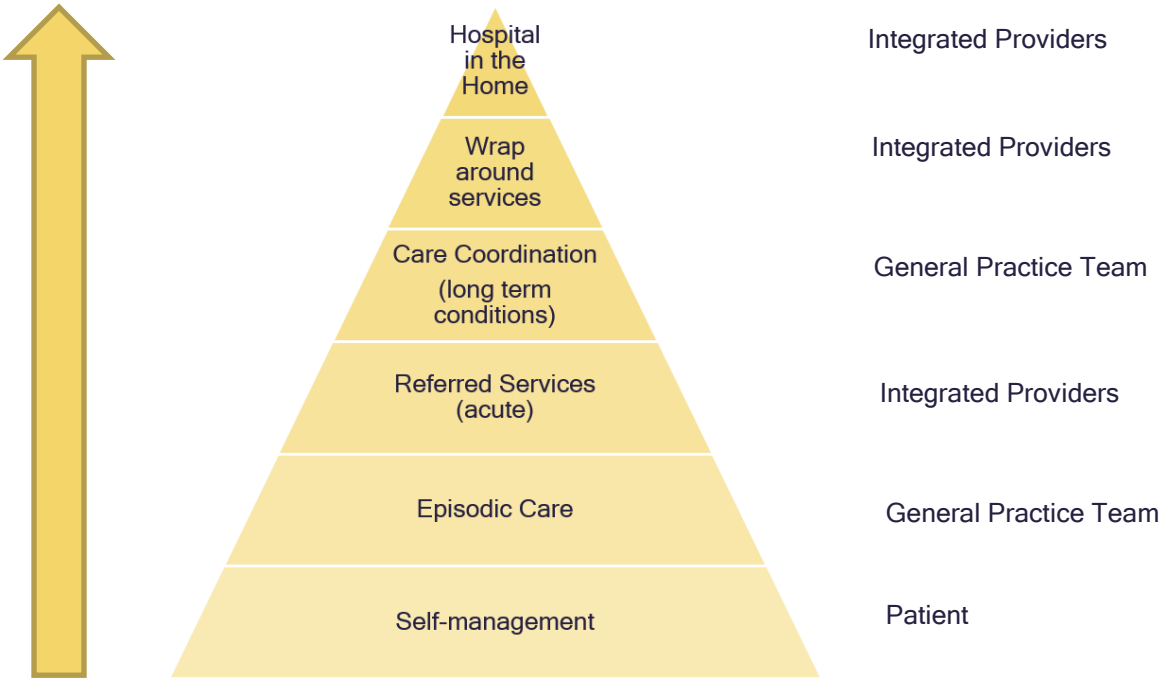


A MULTIDISCIPLINARY TEAM IN ACTION

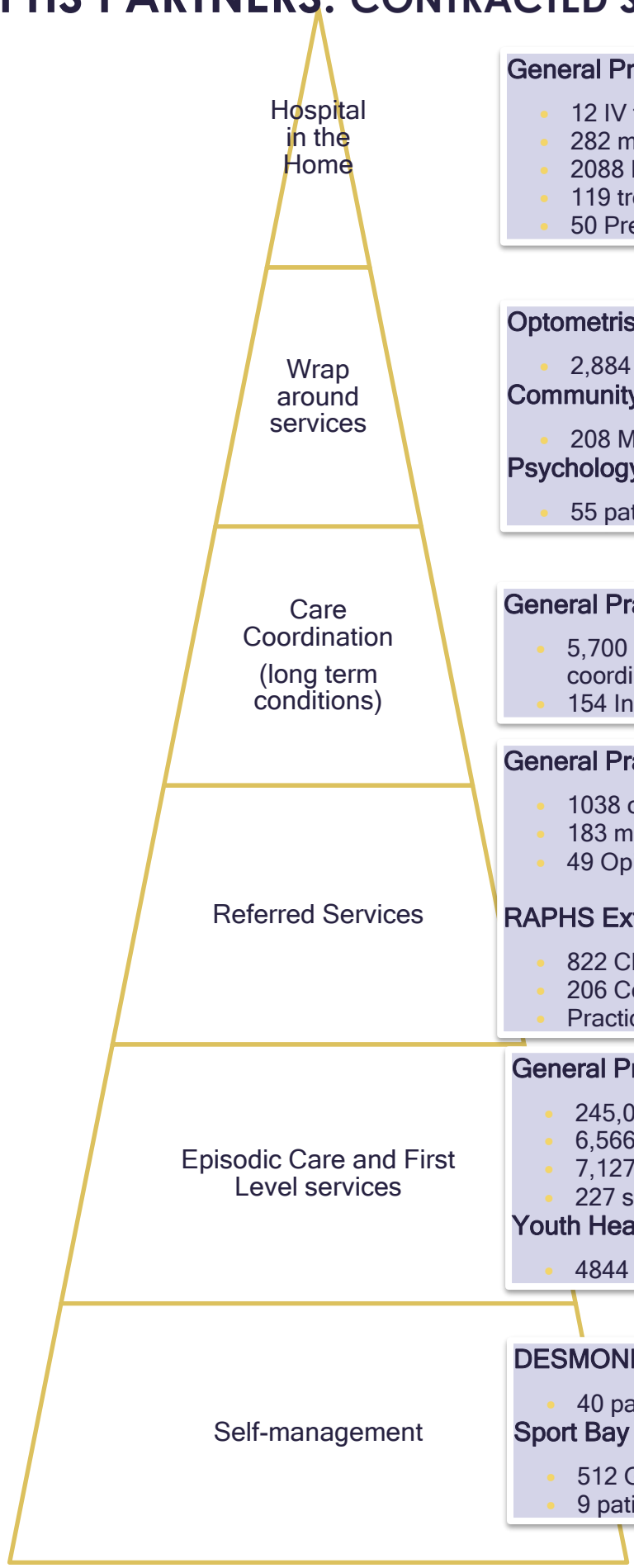
An Integrated Team



LINC: Coordinated Levels of Care



RAPHS PARTNERS: CONTRACTED SERVICE DELIVERY FY 17-18



General Practice & LPC:

- 12 IV treatment of dehydration
- 282 management of DVT
- 2088 Palliative care episodes of care
- 119 treatment of renal colic visits
- 50 Prevention or admission packages of care

Optometrists:

- 2,884 Retinal Screens (Rotorua & Taupo)

Community Pharmacy:

- 208 Medicines Use Review

Psychology:

- 55 patients for packages of care

General Practice

- 5,700 patients enrolled in long term conditions care coordination
- 154 Insulin initiation consults

General Practice

- 1038 contraception and sexual health services
- 183 maternal packages of care
- 49 Opioid Substitution Therapy (methadone)

RAPHS Extended Care Support Team

- 822 Clinical Pharmacy episodes of care
- 206 Community Nursing Support patients
- Practice education support

General Practice & LPC:

- 245,076 patient consults
- 6,566 cervical screens
- 7,127 CVD risk assessments
- 227 sore throat

Youth Health

- 4844 consults (partial funding by RAPHS)

DESMOND:

- 40 patients with newly diagnosed diabetes since Dec 17

Sport Bay of Plenty:

- 512 Green Prescription referrals
- 9 patients Pre-Diabetes course

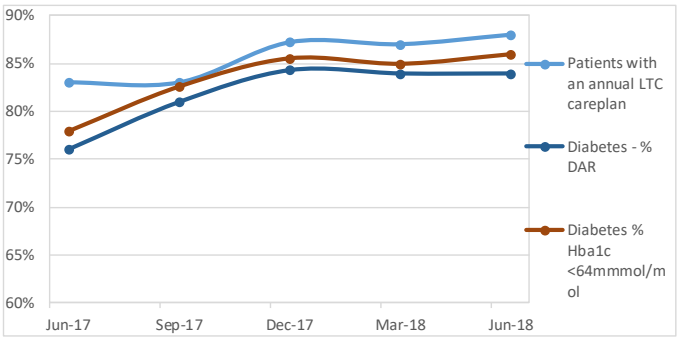
IMPACT OF SERVICE DELIVERY:

IS ANYONE BETTER OFF?

RAPHS Quality Plan Performance

Measures	Jun-17	Sep-17	Dec-17	Mar-18	Jun-18	Target Achieved	YTD Movement	Tracking vs Jun-17	TARGET
Patients with an annual LTC careplan	83%	83%	87%	87%	88%	!	▲	▲	90%
CVDRA - total eligible patients	90%	91%	91%	91%	92%	✓	▲	▲	90%
CVDRA - Maori males 35-44 years	66%	70%	70%	72%	74%	!	▲	▲	90%
Smoking cessation - Health Target (total population)	90%	89%	91%	89%	91%	✓	▲	▲	90%
Smoking cessation - Health Target (Maori)	87%	87%	90%	87%	88%	!	◀▶	▲	90%
Smoking cessation- trained staff	100%	100%	100%	100%	100%	✓	◀▶	◀▶	90%
Diabetes - % DAR	76%	81%	84%	84%	84%	✓	▲	▲	80%
Diabetes % Hba1c <64mmmol/mol	78%	83%	86%	85%	86%	✓	▲	▲	80%
Level 700/800 Diabetes Education - 1 Nurse trained	100%	100%	100%	100%	100%	✓	◀▶	◀▶	100%
Cervical smears (total population)	72%	74%	74%	76%	77%	!	▲	▲	80%
Cervical smears (Maori)	66%	68%	70%	70%	71%	!	▲	▲	80%

Diabetes Management

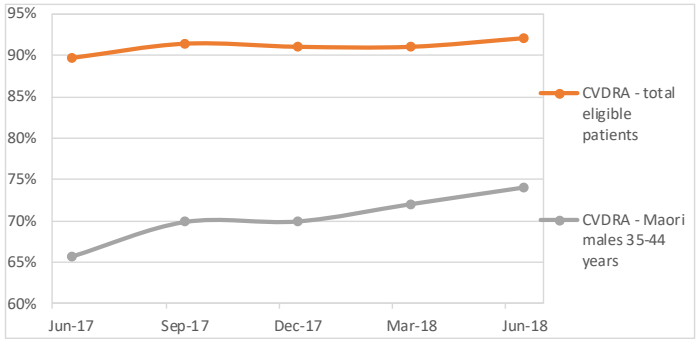


8% increase in diabetes annual review

5% increase in patients with a LINC care plan

8% decrease in patents with elevated blood glucose

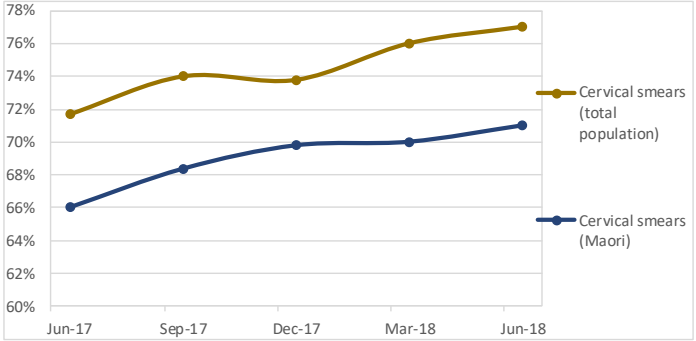
Cardiovascular Risk Assessment



CVD risk assessment exceeds national target

6% increase in equity for Maori Males

Cervical Cancer Screening



5% increase cervical cancer screening

Equal increase for Maori women

DATA SHARING

MILESTONES IN ENABLING INTEGRATED SERVICES

2008

Wide Area Network established (WAN)
Secure Network between practices, Active Directory for user identity established with secure email between member practices and Lakes DHB. Member practices opted in and can opt out at anytime

Migration of practice PMS application to secure RAPHS Cloud system

EnrolWise – Validation of patient enrolment forms, and establishment of Practice enrolment form repository

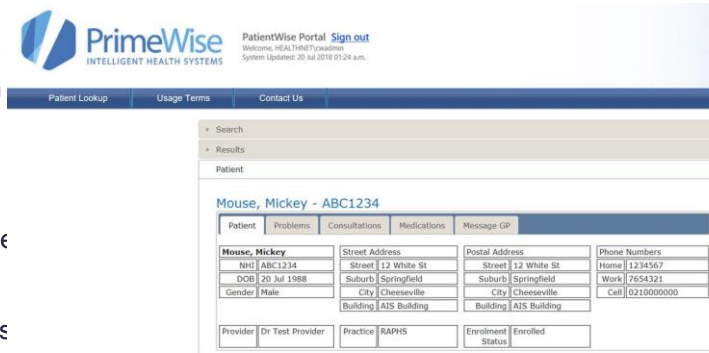
2010

Development and deployment of **PrimeWise** as RAPHS organisation integration tool, secure Intranet for publication of information to member practices

2011

Practice agreement obtained for sharing of demographic information and secure messaging to enrolled GP
Version one developed and implemented in LakesDHB – Patient demographic information and secure message to GP available to ED staff.

LINC Model of Care – Project approval October 2012. Launch July 2013.

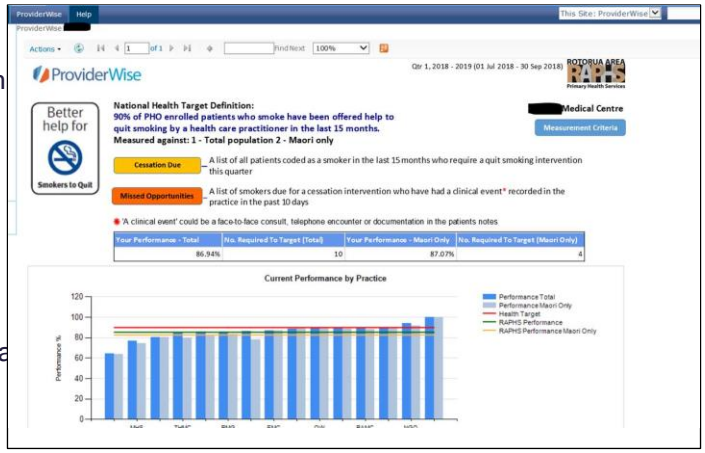


2012

PatientWise: Practice agreement for sharing of clinical information through, Clinical Governance, Practice Owners, Privacy Impact assessment completed and reviewed by Office of the Privacy Commissioner, big tick
Version two developed and deployed to Rotorua Hospital – Patient demographic information, problem codes, Medications Clinical encounters, and secure message to GP. PatientWise Audit Policy, Break the Glass Policy, User schedules and security matrix implemented

2013

RAPHS becomes a PHO October 2013



Korowai Aroha and Mangakino Health Services practices join RAPHS network

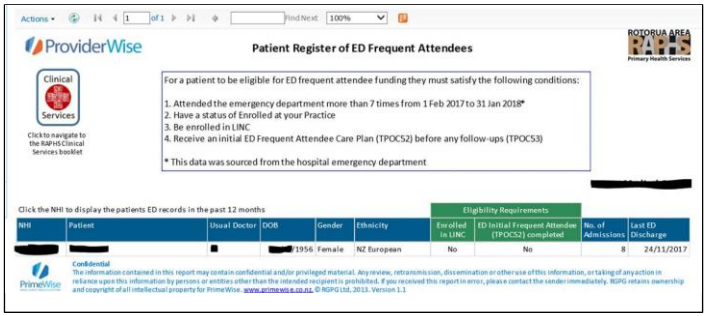
Midland Regional e-referrals implemented

2014

LINC Register and Patient Intensity list/calculated score implemented to **ProviderWise**

Three Lakes Clinic joins RAPHS
Expansion in user roles for **PatientWise** to authorised Rotorua **2016** Hospital staff, Pharmacy, Outpatients, Children's Team, Hospital Midwifes, Physiology services

Patient Portals - development of practice toolkit including guidelines, identification of Privacy Risks
Discharge Summaries BPA completed on receipt and **2017** distribution of LakesDHB Hospital Discharge lists
Cervical Screening Register developed, including data from national collections
GP Unknown – Initiated Scope for project



2018

Tiaho Medical Centre joins RAPHS

Development and deployment of LakesDHB Frequent flyers List to general practice via ProviderWise

FUTURE DEVELOPMENT

The Agreed Team Rotorua Alliance Work Plan for FY 18-19 Includes:

- GP Unknown Project: Maori, youth and quintile 5 patients are disproportionately represented in the current 'unknown GP' patient cohort presenting to ED. Connecting these patients with primary care services will support better access to care and support in the community, enabling access to subsidised services and care programmes supporting better patient outcomes.
- Transfer of Stable Mental Health Patient to Primary Care: The aim of this project is to support stable mental health patients back to primary care with the aim of providing community-based care provision for patients with a long-term mental illness, integrated with social support services and specialist care.
- Acute Demand Presentations: This programme of work will align and be monitored closely through the System Level Measures, particularly, 0-4 ASH Rates, Amenable Mortality and Acute Bed Days. This will include a number of activities including the development and implementation of new models of care and clinical pathways to manage response to acute presentations.
- Data Sharing: Agreement has been reached to advance a number of opportunities for data sharing to improve planning and improve clinical care for patients. Facilitating data sharing is a key enabler of service integration and improvement.
- Management of Long-Term Conditions and Risk Stratification: There is a need to define models of care and clinical pathways to support proactive care coordination for people with long term conditions (usual care). This will require a coordinated and collaborative management in primary health care from a multidisciplinary team.
- System Level Measures Framework: The SLMF is a focus for collaborative activity in 2018-19. A new SLMF plan has been developed that will require RAPHS to develop new capability and capacity to support activity to improve:
    - 0-4 ASH
    - Amenable mortality
    - Acute Bed days
    - Patient Experience
    - Youth Health
    - Smoke Free households

AUDITED FINANCIAL SUMMARY

Statement of Comprehensive Revenue Expense				
for the year ended 30 June 2018				
		2018		2017
Revenue from Non Exchange Transactions				
PHO Contracts		12,314,078		12,292,540
Total Revenue from Non Exchange Transactions		12,314,078		12,292,540
Revenue from Exchange Transactions				
PHO Contracts		3,950,434		3,749,253
DHB Contracts		1,963,379		1,909,407
Other Income		1,882,373		1,771,857
Total Revenue from Exchange Transactions		7,796,186		7,430,517
Total Revenue		20,110,264		19,723,057
Expenses				
Clinical Services		749,875		797,498
Information Services		1,460,671		1,355,152
Operations/Management		1,310,042		1,230,336
Provider Payments		16,388,483		16,045,532
Audit Fees		7,500		5,750
Depreciation and Amortisation		63,695		59,616
Total Expenses		19,980,266		19,493,884
Surplus (Deficit) before Finance Activities		129,998		229,172
Investment income		29,295		10,483
Operating Surplus (Deficit)		159,293		239,656
Other Gains (losses)				
Gain (Loss) on Sale of Assets		- 14,453		- 2,205
Surplus (Deficit) for the Year		**144,840**		**237,451**
Other Comprehensive Revenue & Expenses for the year Before Tax				
Income Tax Expense		46,384		64,993
Other Comprehensive Revenue & Expenses for the year After Tax		98,456		172,458