Long Term Conditions – Mental Health

Practice Information

Last updated: Jun 2022

West Coast Health
Community Wellbeing Services

General Information

All patients with a serious long-term mental health condition are at greater risk of poorer health outcomes and higher mortality than the rest of the population. Completing this section for these patients helps you and the patient identify where further clinical and self-management interventions may decrease that risk.

Please use the Halcyon Web Portal Form: LTC Mental Health to claim funding for qualifying individuals.

Programme Information

This programme provides for a holistic clinical review of all eligible patients within your practice who have a serious long-term mental health condition. A serious long-term mental health condition includes any or all of the following diagnoses: major depression (ongoing – e.g. greater than two years), schizophrenia disorder, bi-polar disorder, psychotic disorder

Programme Objectives

- Opportunity to integrate Community Mental Health (CMH) patients with the general practice through the WCPHO LTC programme;
- An opportunity to have an in-depth appointment to ensure optimal clinical management, to discuss clinical and mental health issues, lifestyle factors, how to manage them, and discuss any pharmaceutical management;
- To ensure patient's physical and mental health needs are addressed in a timely way;
- A funded annual review, and/or quarterly visits depending on which level of care they are enrolled on;
- A care plan to encourage the patient's participation in self-management of their own health and conditions;
- A relapse plan for recognising triggers, for early intervention to prevent exacerbations and/or hospitalisation;
- Link patients into healthy lifestyle interventions – either PHO based or provided within the wider community. The aim of this is to support patients to achieve any or all of the following: prevention of diabetes, CVD, COPD or progression and complications from existing co-morbidities, improving lipid levels, blood pressure and BMI, and to increase physical activity, smoking cessation and flu vaccination;
- An opportunity for referral to nutrition and exercise programmes to support lifestyle self-management.

- Funded time to provide a comprehensive annual review and quarterly follow-up for those patients with long-term mental health conditions;
- Regular opportunities to support patients to maintain good health and prevent exacerbations of their mental health condition and/or hospitalisations;
- Provision of a structured electronic programme allowing for proactive and evidenced based management of the patient's respiratory health;
- An opportunity to reduce any access, or treatment inequalities that exist between Māori and non-Māori patients.

Eligibility Criteria

A confirmed diagnosis of a serious long-term mental health condition e.g.: major depression (ongoing – e.g. greater than two years), schizophrenia disorder, bi-polar disorder, psychotic disorder

Exclusion Criteria

This programme is not for those patients within your practice who have mild to moderate mental health issues (e.g. anxiety, stress, episodic depression), but the principles may guide your care for those patients also.

Programme Process

- All eligible patients can have a one-off initial review completed;
- Annual reviews must be a minimum of 48 weeks apart;
- Invite patients who qualify to join the programme. Notify any CMH patient's case manager/support worker for assistance with attendance as needed. Obtain patient consent from CMH clients for case manager to attend as needed;
- If applicable, provide each patient and/or their CMH case manager/support worker with a laboratory form for any necessary tests, prior to their appointment at the practice, enabling the blood results to be reviewed at the appointment;
- At each review the LTC/MH review form will assist you in providing evidence-based care for your patient;
- Ensure annual/quarterly recalls are set. Check and ensure the patient is on recall for any screening required. Notify any CMH client's case manager for assistance with completing these;
- Provide a care plan if the patient does not already have one, including a relapse plan identifying triggers and necessary interventions where applicable, or add to/update a current plan;

- Consider referring patient to appropriate support services, PHO lifestyle programmes, or in the community as available;
- Consider follow-up requirements and check health literacy comprehension with the patient and/or their Carer/support worker;
- Ensure communication with case manager/support worker is completed highlighting outcomes and any follow-up that is needed.

Level 1 vs Level 2

- Level 1: Enrol if the care plan includes annual review only. (1 funded appointment per year)
- Level 2: Enrol if the care plan requires quarterly appointments. (4 funded appointments per year)

Payment

Type of Review	$ Funded	Appointment Time	Frequency of Review	Level 1 Eligible?	Level 2 Eligible?
Initial	$120	1.5hr	Once (for enrolment)	Yes	Yes
Annual	$80	1hr	Yearly	Yes	Yes
Follow-Up	$40	30min	Quarterly	No	Yes