Long Term Conditions Programme

Practice Information

Last updated: Mar 2025

West Coast Health
Community Wellbeing Services

General Information

The programme is designed to enable excellent accessibility to Primary Care for high priority groups living with a Long-Term Condition in our community.

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

Programme Information

- Patients can only be enrolled once per year.
- Limited number of people can be enrolled per practice.
    - The current number of allocations available in your practice is visible on Halcyon.
- A detailed Planned Package of Care is **required**.
- Specific Condition Review forms completed annually.
- Funded one-time payment per enrolment.

Programme Objectives

- Provide flexible funding to help with access to primary care.
- Give clinicians the ability to establish with patients and whānau the level of care needed to meet their health needs.
- Enable comprehensive review of the patient's condition, ensuring clinical management is optimal and in partnership with the patient to explore self-management strategies that will increase likelihood of changes in behavioural risk factors.
- Enable whanaungatanga/relationship building.
- Provide an opportunity to link patients into healthy lifestyle interventions- either PHO based or within the wider community.
- Provide an opportunity to link patients with social and community supports.
- Provide an opportunity to reduce any treatment inequalities that exist between Māori/Pacifica and non-Māori/non-Pacifica.

Questions or Feedback?
Please contact the West Coast Health Clinical Quality Team

Top Floor,
163 Mackay Street
Greymouth, 7805
Phone: +64 3 768 6182

QualityTeam@westcoasthealth.nz

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Eligibility Criteria

Patients must satisfy both **Criteria A** and **Criteria B** and **Criteria C** for eligibility in this Programme.

Criteria A: Be a member of one of the following Groups:

1. Māori Ethnicity
2. Pacific Ethnicity
3. CSC Holder
4. Live in Quintile 5
5. New Diagnosis

Criteria B: Have one of the following Diagnoses:

1. Cardiovascular Disease (CVD)
2. Diabetes
3. COPD
4. Asthma
5. Gout

Criteria C: Have one of the following:

1. Clinical Need
2. Psychosocial Need

Exclusion Criteria

Patients who do not have an official diagnosis of a long-term condition. For example: persons with pre-diabetes, hypertension without CVD event, hyperlipidaemia without CVD event, etc.

Exception Criteria

Exceptions to the eligibility criteria will be made on a case-by-case basis.

A person eligible for an exception must satisfy Criteria C **and** either Criteria A OR Criteria B.

If they do not satisfy Criteria B, they must have a long-term chronic condition requiring significant cost to the patient with obvious need.

Example Exception: Māori individual diagnosed with Bronchiectasis requiring high clinical needs – This person qualifies with Criteria C and Criteria A and they have a long term chronic condition requiring frequent clinic visits.

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Exception Enrolments must be approved by the Clinical Quality Team at West Coast Health. To inquire about an exception, please email qualityteam@westcoasthealth.nz.

Exception Enrolments cannot exceed more than 10% of your enrolled LTC patient numbers.

Programme Process

1. Patient arrives for appointment.
2. Clinician identifies patient both qualifies and needs extra funding to help them manage their chronic condition.
3. Clinician informs patient they will be enrolling the patient in the Long-Term Conditions programme and as such, they will be receiving extra funding. Together the patient and clinician form a care plan on how this funding will be used to better the patient's health (*please see "Example Planned Package of Care" for more information)*.
4. The clinician opens the LTC Programme Registration form and enters in the mutually agreed upon "Planned Package of Care" in the appropriate section and enrols patient.
5. Either at this appointment or at the next appointment, the corresponding LTC Review form is completed for this patient.

Payment

$300 per enrolment.

Planned Package of Care - Explained

The Planned Package of Care is the evidence of how the $300 of funding will be used to better the health of this patient.

The items and instances listed in this section should roughly total $300+.

Free services should NOT be listed in the planned package of care as this does not require funding. (i.e. Public Podiatry, Retinal Screening, etc.)

Avoid vague timeframe terms such as: "frequent", "regular", "routine", etc. Instead **use specific timeframes**, such as: "quarterly", "monthly", "every two weeks", "3 times per year", etc.

Example Planned Package of Care:

1. Patient A – enrolled in LTC Diabetes
    a. "Patient has worsening DM II, now requiring insulin
        i. Funded Initial weekly GP/RN consults for Insulin titration

ii. Funded quarterly GP visits once stabilised
iii. cover pharmacy fees co-pay (the $5 per prescription)

2. Patient B - enrolled in LTC CVD for hx of MI
    a. "Learning and communication difficulties
        i. Funded extended appointments quarterly and PRN with GP"
3. Patient C:
    a. “Needing medication titration for better control of Gout
        i. Funded quarterly and PRN visits with GP
        ii. Funded nurse visits monthly
        iii. Funded additional care as it may come up ie pharmacy courier fees with med changes”
4. Patient D – LTC COPD
    a. Funded Pneumonia Vaccine. Any leftover funds to be used for quarterly GP/RN appointments.

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Summary Table

Eligibility Criteria	Diabetes	CVD	COPD	Asthma	Gout
High Priority groups • Māori • Pacifica • CSC • Quintile 5 • New Diagnosis	**Meets diagnostic criteria for diabetes.** (NZSSD recommendations: Link to guidelines	**Diagnosed cardiovascular disease** Angina, MI, PCI, CABG, TIA, Ischaemic stroke, PVD, CHF	**Confirmed diagnosis of Chronic Obstructive Pulmonary Disease:** Spirometry showing FEV_1/FVC <70% and FEV_1<80% (post bronchodilator) Link to guidelines	**Meets diagnostic criteria for asthma** (NZ Asthma and Respiratory guidelines) Link to guidelines	**Meets diagnostic criteria for gout.** Gout guide for Health professionals See Community HealthPathways Gout
	New diagnosis or assessed to need additional clinically or psychosocial support.				
Clinical care	In person review of clinical management by GP team according to national guidelines				
Practice self-management support	Care Plan developed or updated, smoking cessation (Coast Quit) if required. Funded Planned Package of Care developed and discussed with patient. Action plans (e.g. COPD, Asthma) given with patient education				
PHO/Community support	Referral to Poutini Waiora, community support groups, green prescription (PASS), dietitians, pharmacist support, CNSs, HIPs or health coaches.				
Registration	Web Portal LTC registration of equity priority group and condition(s)				
Clinical forms	Diabetes review form (this includes CVD)	CVD review form	COPD review form	LTC Other Review Form	
	If diabetes and CVD just use diabetes review form (*CVD review included*)				

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