Pinnacle
Midlands Health Network

INTEGRATED CARE FOR PEOPLE WITH LONG TERM MENTAL ILLNESS: TRANSITIONING FROM SECONDARY CARE TO PRIMARY CARE

What is it?
This is a new, integrated care service funded by Waikato District Health Board. It enables general practices in the Waikato region to provide 12 months of free care for patients discharged from Waikato Mental Health and Addiction Services.

The service, facilitated by Waikato District Health Board's Integrated Care Coordination Team (ICCT), focuses on collaboration between the patient, their GP and mental health providers, to support the transition from secondary to primary care. The goal of the transition is to remove barriers for these patients to access primary care, and to assist the patient to reach a stage where they are able to self-fund their primary care.

What will it achieve?
Many secondary care patients report cost and unfamiliarity as barriers preventing them from accessing primary health care and remain in their specialist's care when transitioning to primary care would be more suitable. This programme aims to remove these barriers to improve the physical health outcomes of this group.

The integrated care service will ensure specialist resources in secondary care are used appropriately and will build capacity and resource within primary care. Ultimately, stable patients with enduring mental health needs should be able to be managed in primary care with the right support.

With this programme, patients will have their health care needs met closer to home and gain access to a broad range of community health services.

Who is eligible?
Selection of patients for this programme will be carried out by the Integrated Care Coordination Team. Patients are eligible if they have been in specialist mental health care for more than two years and are considered to require additional support to transition to a primary care provider. It is also required that:

- They are enrolled, or willing to enrol, with a general practice in Waikato
- They have given their consent to transition to primary care
- They understand and accept this support is time limited and after a period of time they will be expected to pay their GP co-payments, or they are eligible to access a disability allowance through Work and Income New Zealand (WINZ) after the initial 12 months
- It is clinically safe to manage their care within primary care
- The primary care team agrees to take responsibility for the patient's care and be a consistent point of contact for them
- The patient is supported by a key support worker and/or ICCT during their transition

How will it work?

- Clinician/specialist assesses patient as ready for transfer and discusses options for GP care
- Patient is registered with GP prior to transfer
- Clinician writes transfer of care letter to GP with clinical handover notes to inform the development of a care plan
- Patient and key worker meet with GP for extended consultation and develop and agree on care plan
- Patient and key worker continue to meet with GP as required
- A review of care takes place between GP, patient and key worker
- GP can discuss any issues or concerns with ICCT
- GP may wish to contact ICCT to discuss adjusting treatment or whether re-referral is appropriate
- Patient transfers to primary care and is supported to apply for a disability allowance until they reach a stage where they can self-fund their care.

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Integrated Care for people with long term mental illness (IC)