CASE STUDY SERIES:
ENHANCED CAPITATION


Riccarton Clinic, located on Yaldhurst Road, is a member of the Christchurch Primary Health Organisation.

## BACKGROUND

In September 2016, the way Care Plus funds were distributed to General Practice teams changed. The aim was to reduce administration and ensure general practice teams had the flexibility to provide services that matched the needs of their population, particularly those patients with complex health and/or social needs.

Under the new scheme, Enhanced Capitation, General Practice teams were encouraged to come up with their own innovative ways to apply the funding, with the only expectation being that it enhances the quality and coordination of care provided to these patients.

In this series of case studies we look at the ways some practices across Canterbury are using the funds innovatively to enhance the care provided to their enrolled population, particularly those with complex needs.

## HIGHLIGHTS - Riccarton Clinic

Enhanced Capitation funds have primarily been used to retain the expertise of the clinic's care coordinator role.

The funds have also been used to engage supplementary services, such as social services, which provides a holistic approach to supporting regular patients.

OUTCOME: A decrease in the number of patients repeatedly presenting to Christchurch Hospital's emergency department and the clinic itself.

OUTCOME: By helping patients with complex needs better manage their condition, other patients benefit from more readily available appointments.

## Identification

It was an obvious choice for the Riccarton Clinic to use the new-found flexibility to fund a Care Coordinator role.

Mark Darvill, General Manager, said: "We found that having RN Tracey Udell in the Care Coordinator role was really helpful for our patients. Tracey has already invested a lot of work into defining our higher-needs patients and deciding the best ways of working with them."

The flexibility in funds allowed Tracey to work even more proactively. As well as identifying regular attendees to Christchurch Hospital Emergency Department, they went a step further and identified the clinic's own regular attendees, then correlated this data with patients having multi-morbidities.

"Although pulling the historical data from MedTech was fairly labour-intensive, the results were very interesting and so it was an extremely worthwhile endeavour.

"We looked at patient consultations with all GPs in a 12-month period. This showed a range of zero visits for one patient to 27 visits for another."

Having carried out this work, the practice realised they could go a step further by using the data they had to predict who was likely to become a regular attendee.

"We can anticipate that patients with co-morbidities will require more complex care and patients with multi-morbidities are vulnerable and likely to need more support to manage illnesses.

For example we could have 76 patients with heart failure. If 13 of those have one other condition and six of them have two other conditions, that's likely to mean the support they'll need to manage their conditions is more intensive. We are able to use the funding to focus on those patients," Mark continued.

## Care coordination

This is where the care coordinator role comes into its own, with Tracey using HealthOne to see who is involved in a patient's care and get a feel of their experiences so far.

"I'll make contact with the patient and they're usually aware that they're a high user of health services and are quite responsive.

"I start by explaining what I do and give some structure to our conversation by using our screening tool. This includes asking about falls, diet, family support and even power of attorney and wills.

"Then I'll ask if I can share the information with other teams who might be able to provide some support to any aspects of the patient's life which could lead to an improvement in their health.

"I'll talk to other specialist nurses and formalise that by getting an acute plan (part of the shared care plan suite) set up for the patient."

Most of Tracey's work is carried out over the phone because working collaboratively with Nurse Maude and Older Person's Health means she can instigate home intervention with relevant services if appropriate.

Once this information has been shared with patients, Tracey will begin to make referrals for them, including acute situations where patients are too unwell to come to the clinic but well enough that they don't need to go to hospital. Tracey also notifies the GPs that the patient has a shared care plan in place.

## Wider benefits

Mark highlights that by helping patients manage conditions better, it means improved access for the clinic's other patients.

"The benefit isn't necessarily just for patients with complex needs. By helping our patients manage their conditions better the knock-on impact is that they are using fewer appointments, which means that we have more appointments available for other patients.

"Some General Practice teams might be struggling with capacity and looking to close up their lists, but managing patients differently could help solve this problem."

For more information email Mark Darvill, General Manager, at MarkDarvill@riccartonclinic.co.nz