Porirua Union and Community Health Services (PUCHS)

Interview with Ioana Viliamu-Amusia (Clinical Coordinator) and Brian Betty GP

Summary

This case study describes how Porirua Union and Community Health Service (PUCHS) changed their model of care to provide better care to their patients.

Background

PUCHS is a not for profit, incorporated society committed to providing quality primary health services that are affordable, accessible, and appropriate for all members. PUCHS is a partner in Well Health Trust PHO and a member of Healthcare Aotearoa. All GPs are salaried. Charges for adults are kept to $10 for a GP visit and no charge for visits to other health care team members.

Key clinical staff - Ioana Viliamu-Amusia (Clinical Coordinator), Brian Betty GP, Ma'u Pauta Practice Nurse champion (Diabetes).

Population – Maori, Pacific, new migrants, refugees. 92% of population are in quintile 5. Many of the workers often have 2-3 jobs. Young population.

Reasons for change of model of care

Five years ago, the practice could have as many as 20 people queuing up in the morning without an appointment including people requiring urgent Work and Income medical certificates. In addition, staff were answering up to 80 phone calls every morning, meaning work was reactive with poor continuity of care.

What the practice did

Every 6 months the whole clinical team meets to review the services. As part of this review they identify changes and suggest improvements. All of these ideas are discussed and the top five ideas are selected and tested. There are interim review meetings and the ideas are either adopted or abandoned. Most of the five ideas generated every six months are implemented.

Clinical meetings are held every Monday. This started as an informal session but now meetings are much more structured with an agenda including diabetes and general medicine case conferences.

Both patients and staff get better outcomes and this keeps people motivated.

Practice quality improvement and change initiatives

Big focus on relationship building, providing quality coordinated care, prevention, and whole of family/whānau approach.

Model of Care - developing a description based on Sir Mason Durie's Te Whare Tapa Whā model.

Extended surgery times - 8am start one day per week with a GP and nurse on duty and phones open for triage. Late close at 7pm one day per week, with GP and 2 nurse led clinics.

Nurse telephone triage reduced number of phone calls from 80 to 50 each day. Triage also reduced patient 'walk ins' from up to 20 each morning to about 5.

Community education - discussed with the community about the importance of ringing for an appointment. In the practice, staff talk to people who walk in with non-urgent issues or issues that can be better planned for, about how the patients could manage these by planning and making an appointment. Encourage patients to regularly updates of personal contact details due to the large numbers of mobile/transient families.

Work and Income medical certificates - this was major cause of 'walk ins' Set up an arrangement with Work and Income to fax documents to them. Also talked to community about how renewals needed to be planned to avoid crises.

Low cost access practice - repeat prescriptions and visits to staff other than the GP are free. There is a $10 charge for seeing the GP.

People without diabetes are also able to see onsite podiatrist for small fee.

Administration has systems set up for debt management and regular payments. Patients are encouraged to talk to administration about these.

PHO has some flexible funds available that the nurses can use to pay for things like blister packs, repeat prescriptions and one off social needs.

Diabetes Clinic - (includes pre-diabetes) runs twice a week. This is nurse led with 20-minute appointments but appointments can take up to 40 minutes if necessary. The dietitian, podiatrist and clinical pharmacist are on site and every patient with diabetes is offered appointments to see these clinicians. If there is time these clinicians are also available to see patitents in the clinic, who don't have booked appointments. The GP also sees the patients. Everybody who attends diabetes clinic is given information about SME groups.

Self-Management Education - broadly follow the Stanford model but use the 'My Life My Journey' local DSME programme. People pick and choose which sessions they are going to attend with some attending all of the sessions.

Recently the practice ran a Panel session where the clinical pharmacist, dietitian, and CCDHB CNS in renal and diabetes, were all on the panel. This was very popular and people asked a lot of questions and gave good feedback. Panel lasted 1.5 hours, and people were invited through clinic advertising, diabetes clinics, phone calls. Transport was offered. All family members invited, including youth.

PMS - updating Medtech with Evolution. Use the BPAC common form as the care plan – not very good, would like an electronic care plan that everyone can access and is easy to find.

Wider healthcare team members - Community Health Workers, Cross Cultural worker (refugee support) and Navigators - work with the Navigators from the PHO, use them a lot. CHWs help with SME, transport etc. Thinking about upskilling them to be life coaches as practice sees this as a gap. All PUCHS nurses are encouraged to upskill in renal diseases as it affects their community greatly.

Features of Success

- Leadership – very supportive manager and GP, Proactive Senior Administrator.
- Staff are passionate about what they do.
- Staff cultural profile matches that of the patients.
- Staff encouraged to train others – someone who is skilled at insulin initiation will teach other staff how to do it.
- Nurses are encouraged to participate in training and ongoing education.
- Each nurse is a champion of a particular area e.g. diabetes and mentors others in their particular area. Nurses are encouraged to participate in projects, research and training in their particular area.
- Team approach – each nurse works with the same GP or GPs if they are part time which helps with continuity of care.
- Nurse GP team meets to discuss issues.
- Whole of practice team meets 2-3 times per year.
- Supportive Governance group.
- Community and cross-cultural workers key to social community supports.
- IPIFs displayed on whiteboard in common staff area.
- Have built really good relationships - involved in community advocacy such as ‘The Living Wage’.
- Half day offsite clinic with a GP and Nurse at a Local Marae.
- Focus on prevention and work through the youth clinic (HYPE: Healthy Young People Energised). Encourage strong relationships between the practice and enrolled youth and through youth participation, Youth Committee, encourage family and friends. Onsite Youth Social Worker also.
- The practice is a teaching practice training GP registrars, midwives and nurses and this has made a difference by encouraging staff to think about how things could be done differently.
- All staff are salaried including GPs. Efforts are always made to ensure that GPs have ownership of the clinical process and buy in to the change process.

Acknowledgements

Oct 2016: Thank you to Ioana, Bryan and team for so willing sharing their experiences and learnings.