GPSC
General Practice Services Committee

A key component in evaluating the success and benefits of patient medical homes involves collecting stories of health care change from doctors, patients, and allied care providers. These stories take readers on a journey toward understanding how patient medical homes are improving care around the province.

Change snapshot: How team-based care improved access for patients.

Listen to an audio version of this story here.

Accessible Upstream Care Supporting Patient Health

I have been working as a primary health care nurse at a health care cooperative for the past year. I work in a three doctor clinic in Christina Lake. We are supported by one social worker during her time amongst 4-5 clinics in the area.

The most significant change I've noticed since the patient medical home started is that patients are seen more quickly. There is increased access. People who would have otherwise gone to the Emergency Department now have more opportunities to see a care provider, whether that be a doctor or a primary health care nurse or social worker. Patient health is also improving, because patients are not only seen more quickly but they have more time with a health care provider. They may see a nurse, doctor, and social worker. This is helping us to pick up more mental health issues- for example, a woman coming for a well woman exam may be asked how she's feeling and this may lead to a conversation about depression and anxiety that would not have been diagnosed if I hadn't had the time to talk with her.

Our health care team is more balanced and holistic now. The MOA takes all calls and does a telephone triage. Even if the doctors are booking two to three weeks in advance and are unavailable, I can see them as a nurse to do an assessment and make a plan, so the doctor can have a shorter visit and write a prescription if needed for example. These patients would previously have been turned away, as it was hard to get someone in with appointments booked every 10-15 minutes.

The Emergency Department is always there-it's the meat and potatoes of the community and does a great job of providing care. Primary health care allows us to focus on prevention and wellness before possible disaster strikes in the form of a heart attack, stroke, COPD exacerbation or suicide. It is significant to me to be working upstream rather putting out fires. This is truly why I went into nursing. I enjoy helping people prevent disease, promote health, and coach patients to be stronger and better able to cope in their daily lives, so they can have a better quality of life. We work across ages and conditions within a diverse population; anyone on the verge of turning a corner where there is a point of no return- someone about to get diabetes, who might want to commit suicide tomorrow- we can make a huge impact in these people's lives.

This health care coop was created to support the patient medical home. We do assessments on all patients and refer them to the social worker if needed. The social worker has been a phenomenal addition to our health care team. Someone who requires one hour of time to navigate long-term disability and mental health forms or challenges, which would have been by the doctor, can now see the doctor and the social worker spends 30-60 minutes doing a thorough assessment and working on complicated paperwork for the patient if needed, for example. The patient is supported in a more timely fashion and is getting better outcomes.

The patient medical home is long overdue in BC, and I am seeing fantastic results. Not only are the numbers looking good but patients are appreciating the care. They see us working together providing the right care and the right place, and they walk out of here feeling heard often. As soon as you're heard, the healing starts. If primary care prevention continues to be funded, we will continue to reap the benefits of healthier communities.