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 FP networking led to identifying key care needs for a population of seniors.*

Listen to an audio version of this story here.

Concepts Insufficient for Real Change in Physician Experience

I have previously been on the board of my division and was a member of the Patient Medical Home (PMH) steering committee. I had done previous work around access, considerations around seniors' care, and EMR data integration, the three biggest areas we felt needed to have PMH working groups for. I became the lead for our working group on seniors' care. We wanted to obtain an understanding of what the community thought was needed regarding seniors' care. We knew that alcohol use disorder was a much-neglected area but didn't have the data to back this up. We also knew the extent of need for assisted living and dementia care. We met as a group of interested physicians, and invited community care nurses, seniors' groups from the communities and NPs working with seniors in the community to talk together about what we saw as needs in the community.

We identified three main issues for seniors: alcohol use disorder among adults including seniors, dementia, and residential care. We found that a lack of access to data was a barrier to action. Many physicians recognized the importance of home detox, but there was no appetite at the health authority level without solid data. They indicated that they felt that the volume of people impacted by this issue is low, while physicians felt that it was higher than it presented. We tried to do a survey of patients with addictions issues, either drug or alcohol-related, who visited the ED, but this proved to be challenging given the current diagnostic coding for ED visits. We also asked the health authority about doing a chart review, however the availability of staff to carry out the review was not identified. It's very hard to get people into alcohol detox programs, because narcotics are so imminently deadly that funding for addictions has been directed to substance use, leaving alcohol detox funding underfunded as it doesn't have the same urgency.

One area that turned out to be hugely identified deficit was dementia care. We talked about respite for patients, respite for caregivers, caregiver burnout, and improving community resources. In the end, Shared Care was also working with dementia care and we were able to access funding to continue the work through a different shared care program.

PMH is still misunderstood as a concept. I found it frustrating that despite several meetings, emails, info packets PMH remains poorly understood. We tried but I don't believe we achieved a good understanding within our community or among our physicians. In our community, we've always had 5 or 6 clinics, some referring between clinics based on expertise. This practice is in itself a group of PMHs but we never got to the point of expanding or improving each PMH or the network.

I didn't experience any significant change as part of PMH. I am most hopeful that the dementia work will carry on with funding from Shared Care. We deal with dementia all the time in the hospital, so it should be a good fit with geriatric psychiatrists as well. For the seniors' home detox, I am hopeful that they may do something smaller scale at the local Community Health Centre, where no partnership is required with

the health authority, if they can fill their NP position and gather data. If that proceeds, we would likely be involved again in the future.

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* *Note that this was not identified as a significant change.*