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 a blended compensation model supports full-service family practice and team-based care.

Listen to an audio version of this story here.

Marching to a New Drummer: Funding Better Patient Care

Three years ago, GPs were leaving full service family practice in our community and we were at a grave risk of not being able to deliver primary care to a significant part of our population. The Division of Family Practice was the driving force in addressing the crisis, and we called on assistance from the Deputy Minister of Health and our local MLA. Since then, we've shifted to a blended compensation model that combines fee for service with population-based funding, introduced interprofessional teams, and improved our ability to recruit and retain physicians.

The fee for service model worked best for physicians whose focus was on particular services such as emergency, obstetrics or OR assists. However, the office overhead burden of fee for service didn't serve physicians well who work in family practice combined with other duties such as working in the hospital. This meant that it was difficult to recruit and retain physicians to work in clinics. Also, as physicians were unable to bill for services if they were provided by allied health professionals there was limited impetus to provide team-based care in the office setting.

Over the past two years of prototyping this blended funding model, we have been able to integrate interprofessional teams into clinical practice and retain several graduating residents who were offered the opportunity to access the blended funding model as a preferential way of joining the community. During the process we met with the Health Authority to work on an integrated team presence in clinics, and it was really powerful to have all the players in the same room at the same time. Practices do well to help patients with their problems "here and now" but fall short of helping patients look ahead to "if and when", which is where an integrated team can best help a patient to improve their health and create a better patient experience.

We still have some challenges; we found that some allied health care professionals enjoy their specializations such as wound care, mental health or community health nursing, and may not wish to become generalists serving in the primary care system. As a result, our teams are still scattered and only working one half-day per week, which is not adequate to building a team atmosphere.

This model has been very successful in my clinic of 7 physicians, and other clinics will be transitioning to this model in the summer of 2018. In our clinic a trial to invite high needs patients to meet with myself as their GP, a Resident in our clinic, a nurse to talk about other supports available, and a pharmacist from the local pharmacy to advise on medications was initiated. As a team, we looked for gaps in care, especially related to polypharmacy and its adverse effects, and had detailed conversations with input from the patient and team. It was a lengthy process- we invited 5 patients, starting at 1pm, and didn't finish until quarter to 6. With the involvement of the team and an ongoing role of the clinical pharmacist, the patients were able to reduce polypharmacy and utilize other health care supports in the community.

The introduction of the blended funding model has been the most significant change in our community. Where fee for service funding didn't support physicians to work office practice, and deterred physicians from incorporating allied health professionals into their workflow, the new model supports family practice physicians and creates a greater appetite to work with patients in a different way to ensure that their health care needs are met.

The crisis is what drove the change. If we were stable, I suspect we'd still be marching to the previous drummer from the 1970s that told us that physicians must be all-knowing and all- doing. It would have been very hard to make the transition to a new funding model without that critical impetus. We realized that if we didn't change, the future of primary care in our community looked bleak indeed. After 40 years in practice, I'm delighted that things have changed with this new funding model, and we can now start to see better health outcomes for patients. We want to move beyond "here and now" to include "if and when" to the patient experience.