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 the PMH increased patient access and improved patient care.

Listen to an audio version of this story here.

Patient Medical Home Model of Collaborative, Quality Health Care

There are two aspects to my work on a proof of concept primary medical home in this region: as a semi-retired physician working in this community for about 28 years and wanting to provide access to higher quality service, and as a physician leader looking forward to supporting health care in the region. We now have a patient medical home in our clinic. We have been operating for about a year now, employing three full time nursing positions (with one position split between two people), and one social worker, spread out among communities in the region. In these communities, we have a close-knit group of 10 physicians and 1 NP working in 5 clinics, and all physicians also work in the hospital.

Bringing allied health professionals into individual practices has had a wide variety of impacts. For example, it has improved our ability to urgently see patients, which has in turn resulted in less urgent care in the emergency room; and increased access to mental health counselling through a social worker, especially for mild and moderate cases, which has taken some of the load of the mental health office. In general, the patient medical home approach has improved the wellbeing of patients in the region.

In the past, I would have had to supply all the care for each patient. For example, if I identified a patient with mental health issues, I would have had to make time to provide counselling, generally a 30-minute appointment. Those with acute needs would have required several sessions or a referral to the mental health office. Now I can refer to the social worker who can do the counselling. In addition, we can now do "lumps and bumps" work such as caring for skin lesions with the assistance of the nurses, which would have previously been done at the hospital. We can now take patients on a walk-in basis, because the nurses can triage and do a lot of the preliminary work, allowing us to spend 5 minutes with a patient for urgent matters.

The most significant change is both professional and personal. On a professional basis, this model enables me to see more patients in a given time, which has shortened the wait list for patients to be seen. On a more personal basis, I feel that we are supplying better care for patients. Nurses are spending more time, especially with complex patients, providing counselling regarding many time consuming and repetitive issues such as cholesterol and diet, which frees up my time to see more acute cases.

I was the board chair of the Kootenay Boundary Division of family practice during this transition, working in coordination with the Health Authority within our Collaborative Services Committee. I was motivated by the opportunity to deliver improved health care services to the people of our region and to support physicians on the ground. We've been discussing this for several years now, looking at provincial policy papers, and working toward a patient medical home and primary care network model, and this was our first opportunity to do something on the ground. When we first started working together, we didn't have any idea what we would do--we looked at lots of alternatives, including physiotherapists, dietitians, social workers, and nurses. We created a cooperative so that we would have less restrictions over employment, but this also meant developing job descriptions and contracts that had to approved at the provincial level.

It's been a big change for the community, and we continue to meet regularly to find ways to work more effectively. Our Health Authority has been very supportive, and we wouldn't have been able to accomplish this without the financial and human resources of the Division of Family Practice.

We experienced a number of challenges and learned a number of things that will be useful to others doing similar work across the province. First, this was a much more expensive process than we had anticipated, because of the amount of planning required. This included contributions of time from the Health Authority, division and physicians. It's key to have physicians involved in planning, but they cannot realistically close their practice and come to meetings as often as they need to take place, sometimes for a full day at a time. We need to find a better way to ask physicians for their advice. We also lacked solid guidance and information from the Ministry regarding funding and governance in our initial work prior to being given an assurance of a defined amount of money that we could work with. It was very difficult to make specific plans until we knew exactly what the financial resources would be. Another challenge has been in the area of information sharing--while we are working to restructure in relation to Health Authority personnel, we have run up against different policies such as PIPA and FOIPPA which have prevented us from sharing information electronically using our EMRs. The majority of physicians moved to the same EMR as part of the restructuring, which has been hugely beneficial in allowing us to share patient files, but the Health Authority still faxes information, including in the areas of public health and home care nursing, causing us to use paper and fax workarounds that are time consuming and inefficient. We'd like to see a patient-centred medical record.

Despite the challenges of setting up the patient medical home, our patients and physicians are very happy. The integrated primary and community care program was well-accepted and successful in our community, and the new model builds on this.