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 the PMH model increases provider capacity, care quality, timeliness, and access.

Listen to an audio version of this story here.

Team Approach to Improving Patient Care

We first partnered with our local health authority in 2007 to create an integrated health network. At first, the network consisted of two GP offices with a shared nurse and dietician. We worked with the health authority to design and build a new clinic to house all the GPs health authority staff, which grew to include a medical office assistant and social worker in addition to the nurse and dietitian. We opened the new clinic in 2011. The most significant change at that time was transitioning from a classic GP style of practice to team-based care. This new model increased our capacity to see more patients, and improved the quality of care that patients received, in terms of timeliness and access to other care providers with specialized knowledge. This included the nurse doing new insulin starts, insulin titration, and helping remote specialists perform teleconference visits, the social worker supporting access to financial and other resources, and the dietician doing a variety of disease specific education including weight loss support. Team-based care also gave us other ways to deliver care, including group medical visits for mental health and chronic disease management. Even when the visits did not include a GP, and were not billable, we could enrol patients in a group that met weekly or monthly with Health Authority staff.

We've been constantly refining our model, and have been ramping up since the patient medical home and primary care network announcements over the past few years. There is an ongoing process with the Health Authority, and we have a primary health services working group hosted by the municipality that includes the Health Authority, local Division of Family Practice, local GPs, local community health groups, and the mayor. We are working towards the next iteration of what the model should look like and how to fund it.

The community has been supportive of the process, and developing this model has been a great way to get everyone together to talk about the needs and wants of the community. As a result of this kind of community dialogue, we successfully influenced a local medical imaging provider to improve their hours and upgrade their equipment.

In our clinic, the doctors do case finding, and any patient identified as needing service from the integrated health network for health or wellness will be referred. Some are direct referrals to a specific allied health professional, and others are general referrals, to be assessed by a team leader within the integrated health network. In the beginning, we were not as busy, and referrals were seen more quickly. Now, it takes 2-4 weeks for an initial assessment or to see an allied health professional. We are following a large roster of patients plus unattached patients in the community. Prior to 2007, there was no access to these services. A dietitian would have been impossible to see unless there was a very specialized need, access to a social worker was limited to a cases involving the Ministry of Child and Family Development (MCFD), and the diabetes education centre would have been the only place to receive counselling for diabetes on a one-off basis.

With this model, I don’t have to do it all- I can delegate a lot of tasks I would have previously done myself, mainly around teaching on topics such as diabetes. Patients benefit from more time with a clinician for chronic disease management, mental health and substance use issues.

We have 9 GPs (8 FTEs), as well as a dietitian (0.8 FTE), registered nurse (1 FTE), and a social worker (0.8 FTE). We employ 9 medical office assistants and an office manager. The Health Authority also has their own medical office assistant (0.8 FTE). We share overhead expenses with the Health Authority (lease, utilities). We also share a single Electronic Medical Record (Med Access).

Ideally, we’d like to see a more fully integrated team approach, with a panel of patients registered with a team, rather than individual patients being moved along different parts of the system through referrals. For example, a diabetic patient could have a single visit to meet all of their needs. A nurse could be responsible for identifying overdue testing, recalls and assessments and identifying other clinical team members, a social worker could ensure the patient could afford any required medications and identify issues, and physician could come in at the end. This would give our staff a greater ability to take initiative for investigations, to prepare lab requisitions, and adjust medications within certain parameters. In an ideal model we could develop protocols together for what fits into the scope of practice of each team member and have the allied health professionals operate with a much greater degree of autonomy.