



*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 innovation allows nurses spend extra time with patients to help support the GP.**

[Listen to an audio version of this story here.](#)

### **Time and a Team Approach**

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I joined this medical clinic six months ago as part of the new Nurse in Practice initiative. The practice consists of three family practice doctors who work part time and I work full-time. The focus of my practice is to ensure patients having the best health care and outcomes possible. We realized that patients were coming into the office with several different concerns, but given the time constraints of the appointments, the patients will triage their problems to fit into the limited time they have with their physician. As a result, they may have had important health issues that were not being discussed. The most significant change I've experienced is that as part of the clinic team, as the clinic nurse, I have the ability to spend extra time with patients, so they can express their various health concerns and I can summarize them so that the doctor can decide on the appropriate course of action.

I have been in nursing since 1984 and have worked in many areas, including medical, surgical, and community. I'm certified in orthopedics, neurology, critical care and gerontology, and have been a nursing instructor for Okanagan college and UBC Okanagan. Prior to working in this clinic, I was the Manger of pre-surgery optimization for orthopedics within the Interior Health Authority. Most recently I had been working as an Integrated Primary and Community Care (IPCC) nurse. My experience has been an advantage for me in helping patients in my current role, and it has been a wonderful opportunity to apply all the information I've acquired in my career. As I went through the interview process for this job and got to know the doctors in the clinics and I became intrigued with their visions for collaborative care in the office. I felt that a nurse joining family practice would be a much better way of providing my skills and expertise to a patient population over the IPCC program and create capacity for the doctor to see those who need that level of expertise.

Under the model of a nurse in the office I would be accessible to the patients within the practice. Working directly with the doctors allows the family practice team to create areas of focus where my interventions can make a positive change for patients. The team has the ability to go through the patient panel and identify medical issues or individual patients that need closer monitoring and or education. Some of our areas of focus include dietary, osteoarthritis, and healthy heart. I see patients one on one, I do presentations for groups of 12-14, and meet with small groups of 3-4 people who can then support each other. The dietary group is held twice per month, and the other presentations are every 3 months. Patients are thrilled that we're not just looking at medication to solve their problems- we are stepping back and looking at root causes and working to engage them in lifestyle changes.

I now have a much closer relationship with the doctors, where before when I was based in the Health Authority we had a detached relationship. Doctors often wouldn't have space in their office for Health Authority employees to see patients at their office. Previously, most of our communication was through paper. They didn't know me, my experience, or what I was telling patients. Now I know the doctors and I can be respectful of their practice; I can adapt what I say and how I say it to reflect the individual practice



of each doctor. Patients now see me as a team member of this practice, where as in my role as IPCC they were confused as to how I work with their doctor and would see me as being from a different branch of the system.

The Elderly baby boomers, who are our main demographic, want to be healthy, happy, independent, and living in their own homes. They recognize that the system may not be able to take care of them. They are looking to health care to help them stay healthy. The internet is a good resource, but information can be overwhelming and highly contradictory. For example: One patient phoned me after having seen an ad on TV suggesting that he take an aspirin every day for heart health and stroke prevention, but we found that he was already on a blood thinner. The doctor said that it was exciting that he felt he could call me to ask about this, as he may not have every brought it up with her. Adding aspirin to a blood thinner may not have been a good idea for him.

Our team is providing patient-centered care, encouraging the patient to connecting to extended community resources that support health living rather than focusing on health care management. I am thrilled to be working with a fabulous supportive team.