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 nurse in practice and a GP work more closely to better understand the GP's care approach.

Listen to an audio version of this story here.

Whole Person Approach; from Incident to Ongoing Connection

As part of the patient medical home initiative, I've worked as an RN with a team in a private practice with five complex care patients to do a comprehensive review of polypharmacy. The doctor booked appointments with patients where polypharmacy was identified as a potential issue, and we met with the patient as a team: the doctor, a pharmacist, a student doctor and myself.

We met with each patient for a one-hour appointment, explained our roles, and the doctor explained the concerns regarding the patient's treatment. Each of us would speak about the issues from the perspective of our discipline, and we talked as a team the steps we would follow to improve the overall treatment. My role in the meetings was small, but outside the meetings it was huge. I was the person who followed up with patients and connected the people in the team. During the initial meeting, the team discussed the options with patients and they completed the forms, for example, regarding whether they'd like to be resuscitated if they are unconscious and cannot respond. This can be a scary process for patients and the options can be hard to understand. Many of the patients did not want to discuss the forms at all.

Of the five patients we saw in the initial meeting, I worked with four over the past three and a half months to work through the proposed changes. The patients would phone me, sometimes for one hour three times per week, to discuss a problem and ask me to work with the doctor to see what he proposed, and to make impromptu appointments to see him if necessary. I visited the patients' homes as well, visiting one patient working on palliative paperwork three times and speaking with him on the phone at least once each week. I saw another of the patients who was working on her Medical Orders for Scope of Treatment (MOST) form twice in her home and she came to see me in the office twice. For a patient changing her medication, I visited her home once and talked with her on the phone. The fourth patient has talked to me twice over the phone, and I will do an assessment to ensure that her home is safe. The fifth patient is working with their family to go through the suggested changes.

We've already seen changes: one patient has been making fewer emergency department visits to deal with end-stage COPD, running out of anxiety medication, and pneumonia due to insufficient or ineffective use of puffers. This coordinated process also reduced the amount of phoning around that patients had to do to follow up on various appointments, more than one of which would likely have been lost in translation.

After meeting with me and having the opportunity to ask questions and think through the options, two of the three patients who had signed the MOST forms revised their selections and made less aggressive decisions related to do not resuscitate orders. In the past, the physician would have sent a referral to a pharmacist to do a medication review, made a referral to home nursing for follow up with medication and

home care, and the physician would have discussed the MOST forms and had the patients sign the forms in a seven-minute visit. The patients feel a lot more confident in their decisions now.

Normally my job scope is to deal with frail seniors and support them with chronic disease management. Now the focus is on end of life and the long-term health effects of being on short-term drugs for a long time, and supporting patients with their advanced care planning.

It's been an extremely positive experience for me as a nurse, and patients have been receptive to having me as part of their care. They felt they could call me and I could follow up with the doctor. I felt that the patients trusted me, and this made me feel good and valued. However, it's added a tremendous additional workload to my already full scope, as I had a full patient load and working with these five patients added an extra day a week.

The most significant change I've experienced is that I am in closer contact with the physician in the clinic and I know how he operates and care for his patients. I work with nine physicians, and each one has a different approach and process for caring for patients. I feel that this project has helped me better support the physician I worked with as a team, which is a shift from the requests I receive from other physicians to help patients in their home and make referrals to other services in Northern Health such as occupational therapy, respiratory services, dietitians, and home nursing care. In this initiative, I feel supported and valued by the doctor and the pharmacist, and I provide excellent support to patients. Working in community allows me to see patients as a whole person and help them through life, not just an incident.