The Patient and Physician Experience in the Patient's Medical Home

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PATIENT'S MEDICAL HOME

This document aims to highlight the benefits of the Patient's Medical Home (PMH) vision by presenting the experiences of a fictional patient and physician.[1]

Scenario:

A 21-year-old male recently moved back to his parents' home after being laid off from work. After struggling to find employment, the patient's mood deteriorated. He was drinking more often and his motivation and interest in outside activities had steadily waned. The patient felt depressed and was drinking to cope with the stress of unemployment. He scheduled an appointment with a new family physician, submitting a series of intake forms.

The patient's experience in a non-PMH practice

A month later, the clinic secretary called to arrange an appointment. The family physician had multiple availabilities in three weeks and an opening at 8:30 a.m. that week because of a cancellation. The clinic did not offer evening appointments. The patient settled for the morning appointment even though he did not have access to a car, instead taking public transit.

Following intake questions on his personal and medical history, the patient explained the reason for his visit. The physician diagnosed him with depression and alcohol use disorder, deciding to treat the depressive symptoms first. She wrote a prescription for an anti-depressant medication and advised him to seek a counsellor, which he could find by browsing the available pamphlets.

The family physician told the patient that if he had questions about his medication, he could speak to his pharmacist. The patient booked another appointment in four weeks time.

The patient left feeling frustrated and unheard. He felt the appointment was rushed and he still had questions about his diagnosis and treatment.

The patient's experience in a PMH

A week after the patient submitted his intake forms, the clinic secretary called back and offered him a range of appointments including same-day spots. The clinic was also open on evenings and there was an appointment available in two days. As the patient had access to a car after hours, he opted for the evening appointment.

That evening, the patient was introduced to the doctor and a nurse. The physician explained that the clinic team worked together so in the future the patient may see other team members. With his consent, his medical information would be shared with other health care professionals to ensure coordination of care. The doctor added she had already reviewed his history with the nurse, which she had accessed using an EMR. However, to fill in some gaps, the doctor and nurse asked further questions. After listening to the patient, the physician diagnosed him with depression and alcohol use disorder and told him she wanted to treat his depressive symptoms first with a combination of anti-depressant medication and counselling. The nurse added there were peer support groups available.

Before leaving, the physician wrote a prescription and assured the patient she could arrange to have him meet the clinical

[1] Although the scenarios presented here is entirely fictional, they were informed by the knowledge and expertise of several consultants including family physicians, patient representatives, and allied health professionals.

pharmacist at his next visit. The family physician left, leaving the nurse to finish drafting the patient's management plan. Together they reviewed the available options for concurrent disorders counselling and selected a provider with the relevant expertise and who had an established relationship with the doctor's practice. The nurse also encouraged the patient to make positive lifestyle changes.

For the first time in weeks, the patient felt in control of his health and that he had support and a clear plan to follow.

The physician's experience in a non-PMH practice

The clinic secretary – the only administrative worker on staff – received intake forms for a new patient. The secretary assumed the patient would need to wait at least three weeks for an appointment because the family physician was the only staff member available to treat patients. The physician also performed administrative and managerial duties. A cancellation allowed the patient to come three days later.

That morning, the family physician arrived early and noticed she was seeing a new patient. She hadn't had time to review his file and when she asked the secretary about his medical history, the secretary said it hadn't been entered into their system due to software incompatibility.

The family physician spent a considerable amount of time taking the patient's history before addressing the reason for his visit. The patient described what the physician believed were symptoms of clinical depression and alcohol use disorder. Although she wanted to spend more time discussing the proposed treatment plan, she was now behind schedule so she wrote a prescription for an anti-depressant and advised the patient to browse the pamphlets in the waiting room to find a counsellor.

As the physician hurried to her next appointment, she noted she would need to complete her charting on the patient's visit later, adding it to an already considerable backlog of administrative tasks.

The physician's experience in a PMH

The clinic secretary – one of several staff members who shared administrative duties – received intake forms from a new patient. Later that week, the secretary called the patient and suggested a few appointment times. The clinic had an open scheduling system that reserved time each day for same-day appointments as well as evening spots, which the patient booked for two days time.

On appointment day, the family physician and nurse held their daily huddle to review files and prepare for appointments. They discussed the patient's history, which had been proactively uploaded to the clinic electronic medical record, as well as any potential causes of concern. They decided they would both meet with the patient before the nurse, who was knowledgeable about mental health resources in the community, would help him select a counsellor and complete his action plan.

At the appointment, the family physician explained the team-based treatment model. She said they had already reviewed the patient's history, but asked additional questions for a more complete assessment. The family physician explained she believed he was suffering from depression and alcohol use disorder, and it would be best to treat his depressive symptoms first with a combination of an anti-depressant and counselling. The nurse added there were peer support groups in the community.

Before leaving, the physician wrote the patient a prescription and assured him she could arrange to have him meet with the clinical pharmacist to discuss the medication at his next visit. Knowing the nurse would find the patient an appropriate counsellor and draft a suitable action plan for him, the family physician left to see her final patient of the evening, feeling this patient has been well equipped to begin their treatment plan.

At the monthly quality improvement meeting, the nurse suggested the team review the clinic's practices for the treatment of patients with concurrent disorders. The pair led the review, stressing the importance of appropriate communication techniques, inclusivity, and the avoidance of stigmatization.

Concluding remarks

These fictional scenarios demonstrate how the differences between a PMH and a traditional practice produce different experiences for both patients and physicians. The fictional, yet realistic, scenarios presented here illustrate how the team-based PMH model is more conducive to the provision of higher quality care when compared to the traditional model of primary care. Please visit **https://patientsmedicalhome.ca** for more information including supporting evidence, successful examples, and additional resources.