



PATIENT'S MEDICAL HOME

IMPLEMENTATION KIT

Newfoundland and Labrador College of Family Physicians



THE COLLEGE OF
FAMILY PHYSICIANS
OF CANADA



LE COLLÈGE DES
MÉDECINS DE FAMILLE
DU CANADA



Centre for Effective Practice

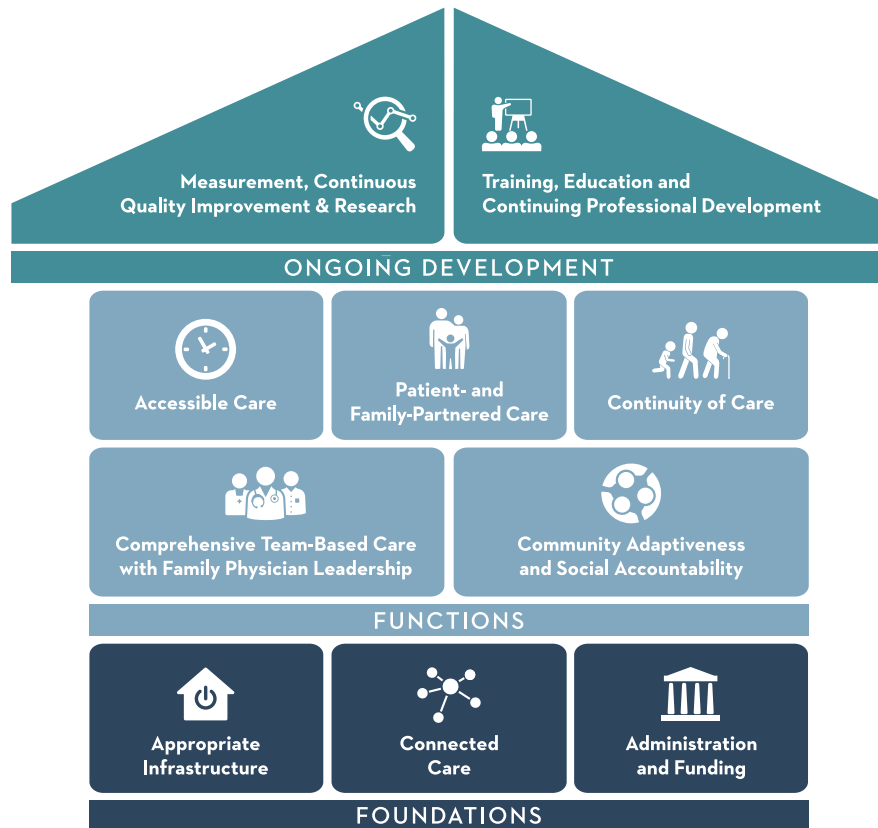
NEWFOUNDLAND AND
LABRADOR COLLEGE OF
FAMILY PHYSICIANS



LE COLLÈGE DES MÉDECINS
DE FAMILLE DE TERRE-
NEUVE-ET-LABRADOR

A CHAPTER OF THE COLLEGE OF FAMILY PHYSICIANS OF CANADA
UNE SECTION DU COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA

The **Patient's Medical Home (PMH)** is a vision developed by the **College of Family Physicians of Canada (CFPC)** to support family physicians and their teams in providing coordinated, comprehensive, accessible care to their patients. While many family doctors provide comprehensive care regardless of their practice design, the PMH vision can help enhance care through its 10 key pillars:



This PMH Implementation Kit is a collaboration between the CFPC and the **Newfoundland and Labrador College of Family Physicians**. It helps Canadian family physicians further align their practice with this vision by providing a few manageable changes to introduce. The kit is organized around a number of actions you can take right now:

- 🔗 Understand your patient population and their needs
- 🔗 Start quality improvement (QI) projects to enhance your care and your practice
- 🔗 Ensure providers and patients have clear lines of communication

- 🔗 Establish clear roles and responsibilities when caring for patients with interprofessional colleagues as a team

If you are starting from scratch and have decided you want to implement the PMH principles in your practice, the information provided in this kit will help you.

Note: The resources provided in this kit do not represent an exhaustive list. Resources are hosted by external organizations and, as such, the accuracy and accessibility of their links are not guaranteed.

UNDERSTAND YOUR PATIENT POPULATION AND THEIR NEEDS

Knowing the breakdown of your patient population (e.g., age, social determinants of health), what health concerns are most relevant to each patient group, and what supports they need will help to inform your practice organization, including more tailored patient programming and services.

Learn more about your patient panel and find opportunities to enhance your knowledge of your patients' health needs:

- 🔗 Ask your team's electronic medical record (EMR) lead to generate reports on patient demographics and disease prevalence. The data can show trends in your patient population (e.g., age groups, common health conditions) and guide future programming or hiring. Review the data periodically (e.g., quarterly or yearly) to see how your patient panel is changing.
 - ▶ If you are not yet using an EMR, connect with [eDOCSNL](#) to learn more and get started
 - ▶ If practice level data are not available through your EMR, access other resources, such as [Newfoundland & Labrador Public Health](#) and the [Canadian Chronic Disease Surveillance System](#), for more data relevant to your region on chronic disease, socioeconomic status, and health usage
- 🔗 Add and use screening tools to obtain more detailed information about your patients' health and access to services. Tools are available through the following organizations to enhance patient screening:
 - ▶ [Poverty: A Clinical Tool for Primary Care Providers](#): a primary care tool for screening and supporting patients' living situation and socioeconomic concerns as part of their overall health
 - ▶ [Building on Existing Tools to Improve Chronic Disease Prevention and Screening in Primary Care](#): evidence-based recommendations for chronic disease prevention and screening including an algorithm for targets and care pathways adjusted for diabetic and non-diabetic patients
 - ▶ [Alberta Screening and Prevention](#): standardized population screening interventions with recommended screening intervals and evidence-based practice points

Learn more about how your patients feel about their care and health needs:

- ❁ Create an anonymous comment box for your waiting room—and an anonymous form for your practice website, if applicable—and place it in a location that patients can easily find, and set up a process to regularly review what is submitted
- ❁ Develop and execute a plan to survey patients; use examples provided by the [Canadian Institute for Health Information](#) and [Health Quality Ontario](#)

START QI PROJECTS TO ENHANCE YOUR CARE AND YOUR PRACTICE

Any initiatives you and your colleagues implement that are aimed at improving care, office efficiencies or workflows, effectiveness, patient safety and experience, or clinical outcomes, and that link learning to action, are considered QI. Any QI effort helps build a PMH where continuous practice improvement is a priority and an everyday occurrence.

Take on QI projects that are manageable in scope and size for your practice:

- ❁ Identify and celebrate QI activities that your practice may already be undertaking as a starting point for future quality initiatives (e.g., changing office hours to address patient accessibility, reducing the use of bundled tests)
- ❁ Use a QI methodology to identify, plan, measure, and test changes within your practice. The Institute for Healthcare Improvement's [Model for Improvement](#) is a well-tested and widely-used model that employs plan-do-study-act cycles for testing changes and can work well for primary care.
 - ▶ Examples of how to use this model for QI are available from the [Agency for Healthcare Research and Quality](#) (which outlines how to identify and test changes in patient feedback surveys), and from [NHS Education for Scotland](#) (which outlines the adaptation of a patient self-management goal sheet)

Find ideas:

- ❁ Establish and monitor metrics, such as [Third Next Available Appointment](#), as a tool for evaluating patient access and measuring efforts to reduce backlog or optimize scheduling

☸ Incorporate evidence-based QI recommendations for family practice from [Choosing Wisely Canada](#) into your practice

☸ Use step-by-step QI guides from [Health Quality Ontario, Toward Optimized Practice](#), or the [American Medical Association](#), which contain QI tools, resources, and examples

Integrate patient-centredness in your QI projects or engage patients to improve quality:

☸ Incorporate patient-centred principles into your practice using resources from the [Canadian Foundation for Healthcare Improvement](#) and the

[Canadian Patient Safety Institute](#) to guide work with patient advocates or persons with lived experience

ENSURE PROVIDERS AND PATIENTS HAVE CLEAR LINES OF COMMUNICATION

Communication between physicians, patients, and other health care providers is central to providing comprehensive and continuous care. It can also provide opportunities to learn and share knowledge with other family physicians and interprofessional providers, both on specific clinical topics, as well as on successes or challenges experienced in practice QI.

Learn from other physicians about their experiences providing primary care:

☸ Use the Newfoundland and Labrador [eConsult](#) program, BASE™ (Building Access to Specialists), a secure web-based platform, to quickly consult with other specialists; it is available from the Newfoundland and Labrador Medical Association

☸ Connect with family physicians in your province to share knowledge and learn about other interprofessional practices; Canada Health Infoway's [Clinician Peer Networks](#) provide opportunities to connect on different clinical topics and practice needs

Communicate more effectively with your patients:

☸ Investigate and adopt communication supports like a website or online appointment booking for your patients. Setting up an electronic communication system like e-booking gives you

the opportunity to communicate information about your practice's services that patients might not otherwise know (e.g., new programs or providers, changes in office hours).

🔗 Canada Health Infoway provides resources to guide [e-booking](#) adoption, maintenance, and privacy concerns

▶ The Canadian Medical Association (CMA) recommends that your practice website includes contact information, staff introductions, appointment policies, and patient intake processes. The CMA [Starting Your Practice on the Right Foot](#) guide contains a full list of recommended information.

ESTABLISH CLEAR ROLES AND RESPONSIBILITIES WHEN CARING FOR PATIENTS WITH INTERPROFESSIONAL COLLEAGUES AS A TEAM

Practising effectively in an interprofessional team enhances collaborative, patient-centred care by providing patients with access to providers who are qualified to deal with a variety of health needs. Roles and responsibilities within your practice may vary within your team members' professions and experience. Ensuring that these roles are clear can help your team maximize their professional skill set and improve provider or team experience.

Practise more effectively in your interprofessional team:

🔗 Establish clear roles and a clear scope of practice for each provider on your team through open dialogue so that each provider on your team knows, and feels confident in, their role and the roles of other team members. You can obtain American Medical Association Physician's Recognition Award CME credits with your team through [MedScape](#) (a Medscape account is required) to build competency in establishing these roles.

▶ Additional resources are available through [Improving Primary Care](#), including an assessment of your current interprofessional care and strategies to improve teams (e.g., working to optimize scope of practice, professional development opportunities, making time for meetings)

- ❁ Create and regularly review policies in your practice to ensure that they are effective and appropriate for your unique circumstances; the Association of Family Health Teams of Ontario provides [a manual](#)

that offers template solutions around a variety of practice issues (e.g., governance, risk and safety, human resources)

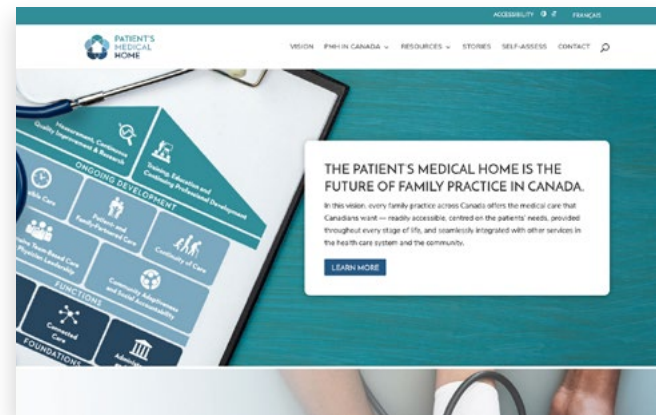
Lead your team more effectively and build your management and leadership skills:

- ❁ Training courses on management and leadership are available from the CMA's [Joule](#); management resources are also available through the [Canadian Health Leadership Network](#)

Leverage resources from other jurisdictions to support continued work on the PMH vision:

Access additional resources about the PMH:

- ❁ [CFPC Patient's Medical Home](#)
- ❁ [Toward Optimized Practice Patient's Medical Home](#)
- ❁ [Ontario College of Family Physicians Patient's Medical Home](#)



RESOURCES

Following is a summary list of the websites and online publications referred to in this document.

Online Publication/Resource	Website
Agency for Healthcare Research and Quality: Health Literacy Universal Precautions Toolkit	www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/healthlittoolkit2-tool2b.html
American Medical Association: Physician's Recognition Award	www.medscape.org/viewarticle/857825_authors
American Medical Association: STEPS Forward™ QI using plan-do-study-act	www.stepsforward.org/modules/pdsa-quality-improvement
Association of Family Health Teams of Ontario: <i>Sample Policies for Primary Care Teams and Practices</i>	www.afhto.ca/provincial-policies-and-procedures-manual-nov2018
Building on Existing Tools to Improve Chronic Disease Prevention and Screening in Primary Care	www.better-program.ca/home
Canada Health Infoway: Clinician Peer Networks	www.infoway-inforoute.ca/en/communities/clinical-peer-network/182-our-partners/clinicians-and-the-health-care-community/clinical-engagement-strategy/12-clinician-peer-network
Canada Health Infoway: e-Booking resources	www.infoway-inforoute.ca/en/solutions/access-health/access-to-services/e-booking

Online Publication/Resource	Website
Canadian Chronic Disease Surveillance System	open.canada.ca/data/en/dataset/9525c8c0-554a-461b-a763-f1657acb9c9d
Canadian Foundation for Healthcare Improvement: Patient engagement resource hub	www.cfhi-fcass.ca/WhatWeDo/PatientEngagement/PatientEngagementResourceHub.aspx
Canadian Health Leadership Network	chl.net.ca/tools-resources/leadership-bytes
Canadian Institute for Health Information: <i>Measuring Patient Experiences in Primary Health Care</i>	www.cihi.ca/en/info_phc_patient_en.pdf
Canadian Medical Association: Joule	joule.cma.ca
Canadian Medical Association: <i>Starting Your Practice on the Right Foot</i>	www.cma.ca/Assets/assets-library/document/en/practice-management-and-wellness/PS-11-00322_PMC_Module_12-e.pdf
Canadian Patient Safety Institute: Patient engagement resources	www.patientsafetyinstitute.ca/en/toolsResources/Patient-Engagement-Resources/Pages/default.aspx
Choosing Wisely Canada	choosingwiselycanada.org/family-medicine
College of Family Physicians of Canada	www.cfpc.ca
eDOCSNL	edocsnl.ca
Health Quality Ontario: <i>Primary Care Patient Experience Survey</i>	www.hqontario.ca/Portals/o/documents/qi/primary-care/primary-care-patient-experience-survey-support-guide-en.pdf
Health Quality Ontario: <i>Quality Improvement Guide</i>	www.hqontario.ca/portals/o/Documents/qi/qi-quality-improve-guide-2012-en.pdf
Improving Primary Care	www.improvingprimarycare.org/team
Institute for Healthcare Improvement: Model for Improvement	www.ihl.org/resources/Pages/HowtoImprove/default.aspx
Newfoundland and Labrador Building Access to Specialists through eConsultation (NL BASE)	www.nlma.nl.ca/Physicians/eConsult
Newfoundland and Labrador College of Family Physicians	nl.cfpc.ca
Newfoundland and Labrador Public Health	www.health.gov.nl.ca/health/publichealth
NHS Education for Scotland: Patient self-management goal sheet	www.nes.scot.nhs.uk/media/3604285/always_events_-_pdsa_examples.pdf
Patient's Medical Home	patientsmedicalhome.ca
Poverty: A Clinical Tool for Primary Care Providers	www.cfpc.ca/Poverty_Tools
Third Next Available Appointment	www.safetynetmedicalhome.org/sites/default/files/Third-Next-Appointment.pdf
Toward Optimized Practice: Alberta Screening and Prevention	www.topalbertadoctors.org/asap
Toward Optimized Practice: <i>Quality Improvement Guide</i>	www.topalbertadoctors.org/file/quality-improvement-guide.pdf
Vega CP, Bernard A. <i>Establishing Roles and Responsibilities for Interprofessional Care Team Members</i> . New York, NY: Medscape; 2016.	www.medscape.org/viewarticle/857825_authors