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FAMILY PHYSICIANS
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DU CANADA



A VISION FOR CANADA

Family Practice The Patient's Medical Home

SEPTEMBER 2011

Acknowledgements



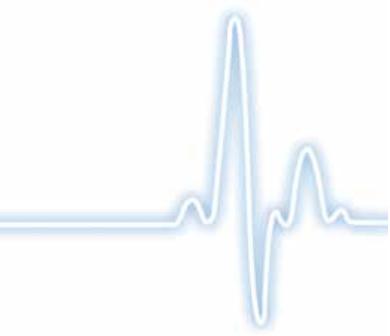
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Executive Summary

The history of health care in Canada is linked to the vital role played by family practice and our nation's family physicians. As we deliberate the future of our health care system it is essential that we contemplate the place that will be assumed by family physicians and their practices. The vision of family practices serving as Patients' Medical Homes is intended for the consideration of all who are concerned about the health of Canadians and the health care provided for them. This includes not only family physicians, nurses, and the health professionals and staff who work with them in their practices but also a broad range of other stakeholders in governments, medical schools, and other health care organizations whose responsibilities and commitments intersect with those delivering family practice services. Most important, this vision is intended for the people of Canada, over 30 million of whom are currently cared for by family physicians in urban and rural family practices throughout the nation, as well as the four to five million who do not yet have family physicians.^{2,3}

In October 2009, the College of Family Physicians of Canada (CFPC) presented its discussion paper *Patient-Centred Primary Care in Canada: Bring it on Home*.³ It described the pillars of a model of family practice focused on meeting patient needs.*

Feedback from a broad cross-section of stakeholders including family physicians, other health professionals and their associations, governments, and the public provided important perspectives that are now incorporated into this vision paper describing family practices throughout Canada serving as Patients' Medical Homes.

*A personal family physician for each patient, team-based care, timely access to appointments in the practice and for referrals, comprehensive continuous care, electronic records, system supports, ongoing evaluation, and quality improvement programs.

A Vision for Canada

While there are some shared elements with other international medical home models, this is a made-in-Canada vision—one that embraces Canadian values of equity, fairness, and access to care for all people. It builds upon the strengths our nation has long embraced in family practice and primary care. It hopes to add to several initiatives that have already begun across Canada, such as Alberta's Primary Care Networks, which have embraced "the concept of the patient-centred medical home as a strong starting point"^{4(p26)}; Ontario's Family Health Teams, which Rosser notes are already achieving significantly positive outcomes for 2.5 to 3 million people in Ontario and are probably the "largest experiment of the patient-centred medical home anywhere in North America"⁵; and Quebec's Family Medicine Groups, which have been found to have a "positive impact on the accessibility, coordination, and comprehensiveness of care and patient knowledge."^{6(p265)}

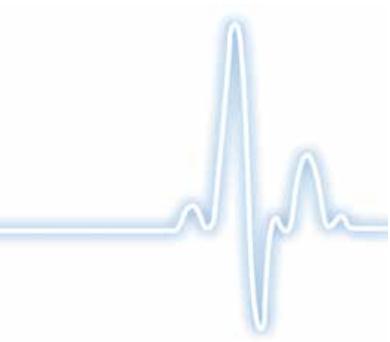
To achieve the objectives and goals of a patient-centred health care system anchored by family practices serving as Patient's Medical Homes in all communities throughout the country, it is imperative that we sustain and enhance the support for primary care and family practice that has been initiated across Canada over the last decade.

Unfortunately, recent studies have indicated that compared with people in other developed nations, Canadians today are less satisfied with their access to and quality of care⁷ and there are now worse health outcomes in Canada for several significant medical conditions.⁸ The vision of the Patient's Medical Home is to see the levels of satisfaction and the health outcomes of Canada's population once again ranked among the world's best.

A VISION FOR CANADA



Family
Practice
The Patient's
Medical Home



Family Practice: The Patient's Medical Home – Definition

The Patient's Medical Home (PMH) is a family practice defined by its patients as the place they feel most comfortable—most at home—to present and discuss their personal and family health and medical concerns. It is the central hub for the timely provision and coordination of a comprehensive menu of health and medical services patients need. It is where patients, their families, and their personal caregivers are listened to and respected as active participants in both the decision making and the provision of their ongoing care. It is the home base for the continuous interaction between patients and their personal family physicians, who are the most responsible providers (MRPs) of their medical care. It is where a team or network of caregivers, including nurses, physician assistants, and other health professionals—located in the same physical site or linked virtually from different practice sites throughout the local or extended community—work together with the patient's personal family physician to provide and coordinate a comprehensive range of medical and health care services required by each person. It is where patient–doctor, patient–nurse, and other therapeutic relationships are developed and strengthened over time, enabling the best possible health outcomes for each person, the practice population, and the community being served.



Family Practice: The Patient's Medical Home – Objectives and Goals

OBJECTIVES

1. Every person in Canada will have the opportunity to be part of a family practice that serves as a Patient's Medical Home for themselves and their families.
2. Patients' Medical Homes will produce the best possible health outcomes for the patients, the practice populations, and the communities they serve.
3. Patients' Medical Homes will reinforce the importance of the Four Principles of Family Medicine for both family physicians and their patients.[†]

GOALS

- Goal 1:** A Patient's Medical Home will be patient centred.
- Goal 2:** A Patient's Medical Home will ensure that every patient has a personal family physician who will be the most responsible provider (MRP) of his or her medical care.
- Goal 3:** A Patient's Medical Home will offer its patients a broad scope of services carried out by teams or networks of providers, including each patient's personal family physician working together with peer physicians, nurses, and others.
- Goal 4:** A Patient's Medical Home will ensure i) timely access to appointments in the practice and ii) advocacy for and coordination of timely appointments with other health and medical services needed outside the practice.
- Goal 5:** A Patient's Medical Home will provide each of its patients with a comprehensive scope of family practice services that also meets population and public health needs.
- Goal 6:** A Patient's Medical Home will provide continuity of care, relationships, and information for its patients.
- Goal 7:** A Patient's Medical Home will maintain electronic medical records (EMRs) for its patients.
- Goal 8:** Patients' Medical Homes will serve as ideal sites for training medical students, family medicine residents, and those in other health professions, as well as for carrying out family practice and primary care research.
- Goal 9:** A Patient's Medical Home will carry out ongoing evaluation of the effectiveness of its services as part of its commitment to continuous quality improvement (CQI).
- Goal 10:** Patients' Medical Homes will be strongly supported i) internally, through governance and management structures defined by each practice and ii) externally by all stakeholders, including governments, the public, and other medical and health professions and their organizations across Canada.

[†]The Four Principles of Family Medicine: the patient–doctor relationship is central, the family physician is a skilled clinician, the family physician serves as resource to his or her practice population, and family medicine is community-based.

Summary of Recommendations

GOAL 1

A Patient's Medical Home will be patient centred.

RECOMMENDATIONS

- 1.1: Care and caregivers in a Patient's Medical Home must be person-focused and provide services that are responsive to patients' feelings, preferences, and expectations.
- 1.2: Patients, their families, and their personal caregivers should be listened to and respected as active participants in their care decisions and their ongoing care.
- 1.3: Patients should have access to their medical records as agreed upon by each person and his or her family physician and team.
- 1.4: Self-managed care should be encouraged and supported as part of the care plans for each patient.
- 1.5: Strategies that encourage user-friendly access to information and care for patients beyond traditional office visits (eg, email communication) should be incorporated into the Patient's Medical Home.
- 1.6: Patient participation and feedback (eg, patient advisory councils) should be included as part of the ongoing planning and evaluation of services provided in the Patient's Medical Home.

GOAL 2

A Patient's Medical Home will ensure that every patient has a personal family physician who will be the most responsible provider (MRP) of his or her medical care.

RECOMMENDATIONS

- 2.1: By 2015, 95% of the people in each community throughout Canada should have a personal family physician.
- 2.2: By 2020, every person in Canada should have a personal family physician.
- 2.3: By 2022, every person in Canada should have a personal family physician whose practice serves as a Patient's Medical Home.
- 2.4: Each patient in a Patient's Medical Home should be registered to the practice of his or her personal family physician.

GOAL 3

A Patient’s Medical Home will offer its patients a broad scope of services carried out by teams or networks of providers, including each patient’s personal family physician working together with peer physicians, nurses, and others.

RECOMMENDATIONS

- 3.1: A Patient’s Medical Home may include one or more family physicians, each with his or her own panel of patients.
- 3.2: Family physicians with special interests or skills, along with other medical specialists, should be part of a Patient’s Medical Home team or network, collaborating with the patient’s personal family physician to provide timely access to a broad range of primary care and consulting services.
- 3.3: On-site, shared-care models to support timely medical consultations and continuity of care should be encouraged and supported as part of each Patient’s Medical Home.
- 3.4: The composition of the teams or networks of health professionals and providers in Patients’ Medical Homes may vary from one practice and community to another.
- 3.5: The location of each of the members of a Patient’s Medical Home’s team should be flexible, based on community needs and realities; team members may be on-site in the same facility or may function as part of physical or virtual networks located throughout local, nearby, or—for many rural and remote practices—distant communities.
- 3.6: The personal family physician and nurse should form the core of most Patient’s Medical Home teams or networks, with the roles of others such as physician assistants, pharmacists, psychologists, social workers, physio- and occupational therapists, and dietitians to be encouraged and supported as needed.
- 3.7: Physicians, nurses, and other members of the Patient’s Medical Home team should each be encouraged and supported to develop and sustain ongoing professional relationships with patients; each caregiver should be presented to each patient as a member of his or her personal medical home team.
- 3.8: Nurses and other health professionals who provide services as part of a Patient’s Medical Home team should do so within their professional scopes of practice and personally acquired competencies. Their roles in providing both episodic and ongoing care should support and complement—but not replace—those of the family physician.
- 3.9: The roles and responsibilities of the team members of each Patient’s Medical Home should be clearly defined. The leadership and support roles assigned to the different team members for the clinical, governance, and administrative/management responsibilities required in a Patient’s Medical Home will vary from service to service and practice to practice, and thus should be determined within each setting.
- 3.10: Health system support, including appropriate funding, should be available to support all members of the health professional team in each Patient’s Medical Home.
- 3.11: Each health provider/professional team member must have appropriate liability protection.
- 3.12: Ongoing research to evaluate the effectiveness of teams in family practice/primary care should be carried out in Patients’ Medical Homes.

GOAL 4

A Patient’s Medical Home will ensure i) timely access to appointments in the practice and ii) advocacy for and coordination of timely appointments with other health and medical services needed outside the practice.

RECOMMENDATIONS

- 4.1: A Patient’s Medical Home should ensure access for patients to medical advice and the provision of or direction to needed care 24 hours a day, 7 days a week, 365 days a year.
- 4.2: Patient’s Medical Home practices should adopt advanced access or same-day scheduling strategies to ensure timely appointments with the patient’s personal family physician or other appropriate members of the team.
- 4.3: When the patient’s personal family physician is unavailable, appointments should be made with another physician, nurse, or other qualified health professional member of the Patient’s Medical Home team.
- 4.4: Patients should have the opportunity to participate with their family physicians and Patient’s Medical Home teams in planning and evaluating the effectiveness of the practice’s appointment booking system to ensure timely access to and adequate time allotment for appointments.
- 4.5: Panel size for a Patient’s Medical Home and its providers should be appropriate to ensure timely access to appointments and safe, high-quality care for each patient and the practice population being served.
- 4.6: Panel size should take into consideration the needs of the community, the workload of the health care providers, and the safety of the patients.
- 4.7: Defined links should be established between the Patient’s Medical Home and other medical specialists and medical care services in the local or nearest community to ensure timely appointments for patients being referred for investigations, treatments, and other consultations.

GOAL 5

A Patient’s Medical Home will provide each of its patients with a comprehensive scope of family practice services that also meets population and public health needs.

RECOMMENDATIONS

- 5.1: In a Patient’s Medical Home, the patient’s personal family physician should work collaboratively with the other team members to provide a comprehensive range of services for people of all ages, including the management of undifferentiated illness and complex medical presentations.
- 5.2: A Patient’s Medical Home should meet the public health needs of the patients and population it serves.
- 5.3: Patients’ Medical Homes should prioritize the delivery of evidence-based care for illness and injury prevention and health promotion, reinforcing these at each patient visit.

- 5.4: The health care system should support Patients' Medical Homes to ensure their key role in the management and coordination of care for patients with chronic diseases, including mental illness.
- 5.5: Patients' Medical Homes should address the health needs of both the individuals and populations they serve, incorporating the effects that social determinants such as poverty, job loss, culture, gender, and homelessness have on health.

GOAL 6

A Patient's Medical Home will provide continuity of care, relationships, and information for its patients.

RECOMMENDATIONS

- 6.1: Care for each person in a Patient's Medical Home should be provided continuously over time.
- 6.2: Patient's Medical Homes should foster continuity of relationships between patients and each of their caregivers.
- 6.3: Patient's Medical Home teams should ensure continuity of the care being provided for their patients in different settings, including the family practice office, hospitals, long-term care and other community-based institutions, and the patient's residence.
- 6.4: A Patient's Medical Home should advocate on behalf of its patients to help ensure continuity of their care throughout the health care system.
- 6.5: A Patient's Medical Home should serve as the hub that ensures coordination and continuity of the information related to all the medical care services their patients receive throughout the medical community.

GOAL 7

A Patient's Medical Home will maintain electronic medical records (EMRs) for its patients.

RECOMMENDATIONS

- 7.1: By 2022 all family physicians in Canada should be using EMRs in their practices.
- 7.2: System supports, including funding to support the transition from paper records, must be in place to enable every Patient's Medical Home to introduce and maintain EMRs.
- 7.3: EMR products for use in Patients' Medical Homes should be identified and approved by a centralized process that includes family physicians and other health professionals. Each practice should be allowed to select its EMR product and service providers from a list of provincially, territorially, or regionally approved vendors.
- 7.4: EMRs approved for family practice/Patients' Medical Homes must include appropriate standards for recording and following patient care in a primary care setting; e-prescribing capacity; incorporated clinical decision support programs; e-referral and consultation tools; advanced-access e-scheduling programs; and systems that support teaching, research, evaluation, and continuous quality improvement in the practice.

- 7.5: EMR and electronic health record systems must be interconnected, user-friendly, and interoperable.
- 7.6: There should be a pan-Canadian electronic health care communication and information infrastructure that ensures secure access to medical records and privacy and confidentiality of communications for all citizens and their medical and health care providers.

GOAL 8

Patients' Medical Homes will serve as ideal sites for training medical students, family medicine residents, and those in other health professions, as well as for carrying out family practice and primary care research.

RECOMMENDATIONS

- 8.1: Patients' Medical Homes should be identified and supported by medical and other health profession schools as prime locations for the experiential training of their students and residents.
- 8.2: Patients' Medical Homes should teach and model their core defining elements including patient-centred care, teams/networks, EMRs, timely access to appointments, comprehensive continuing care, management of undifferentiated and complex problems, coordination of care, practice-based research, and continuous quality improvement.
- 8.3: Patients' Medical Homes should provide a training environment for family medicine residents that models and enables residents to achieve the objectives of the Triple C Competency-based Family Medicine Curriculum, the Four Principles of Family Medicine, and the CanMEDS—Family Medicine (CanMEDS-FM) Roles.
- 8.4: Patients' Medical Homes should be identified as optimal sites for training experiences for residents in all medical specialties.
- 8.5: Sufficient system funding and resources must be provided to ensure that teaching faculty and facility requirements will be met by every Patient's Medical Home teaching site.
- 8.6: Patients' Medical Homes should encourage and support their physicians, other health professionals, students, and residents to participate in research carried out in their practice settings.
- 8.7: Patients' Medical Homes should function as ideal sites for community-based research focused on patient health outcomes and the effectiveness of care and services.
- 8.8: Competitions for research grants relevant to primary care and family practice such as the Canadian Institutes of Health Research's Strategy for Patient-Oriented Research should be strongly supported.
- 8.9: Family physicians and other health professionals in Patient's Medical Home practices should be encouraged and supported to compete aggressively for research grants to study the effectiveness of the services they provide.

[#]Comprehensive, focused on continuity of education and patient care, centred in family medicine.

GOAL 9

A Patient's Medical Home will carry out ongoing evaluation of the effectiveness of its services as part of its commitment to continuous quality improvement (CQI).

RECOMMENDATIONS

- 9.1: Patients' Medical Homes should establish CQI programs that evaluate the quality and cost effectiveness of the services they provide and the satisfaction of their patients and providers.
- 9.2: Indicators should be defined to help guide the CQI activity of Patients' Medical Homes, based on the objectives, goals, and recommendations in this document, and other published quality indicators for family practice.
- 9.3 To ensure relevance for the populations being cared for in primary care/family practice settings, clinical practice guidelines and performance indicators must be applicable to patients with comorbidities and complex medical presentations.
- 9.4: All members of the health professional team, as well as trainees and patients, should participate in the CQI activity carried out in each Patient's Medical Home.
- 9.5: Annual national multi-stakeholder forums should be held to monitor and evaluate the effectiveness of Patient's Medical Home initiatives across Canada.

GOAL 10

Patients' Medical Homes will be strongly supported i) internally, through governance and management structures defined by each practice and ii) externally by all stakeholders, including governments, the public, and other medical and health professions and their organizations across Canada.

RECOMMENDATIONS

- 10.1: Governance, administrative, and management roles and responsibilities should be clearly defined and supported in each Patient's Medical Home.
- 10.2: The individuals responsible for assuming and carrying out the governance, administrative, and management roles and responsibilities will vary from one Patient's Medical Home to another and should be determined by the stakeholders involved in each practice.
- 10.3: Leadership development programs should be offered for those assuming the governance, administrative, and management roles in each Patient's Medical Home.
- 10.4: Sufficient system funding must be available to support Patients' Medical Homes, including the clinical, teaching, research, and administrative roles of all members of Patient's Medical Home teams.
- 10.5: Blended payment models should be introduced in every province/territory as a preferred option for remunerating family physicians in practices functioning as Patients' Medical Homes.

- 10.6: Research evaluating the impact and effectiveness of different physician payment models on access to care, patient health outcomes, and patient and provider satisfaction should be ongoing.
- 10.7: Governments, the public, family physicians, and other medical and health professions and their organizations, should support and participate in establishing and sustaining Patients' Medical Homes across Canada.
- 10.8: Future federal/provincial/territorial health care funding agreements must include clear accountability provisions with a requirement that each jurisdiction eligible to receive funds must meet explicitly defined targets, including those related to primary care and comprehensive family practice.
- 10.9: Future federal/provincial/territorial agreements must include commitments to primary care/family practice/Patient's Medical Home priorities including illness and injury prevention, population health, EMRs, home care, and pharmacare.
- 10.10: The current federal/provincial/territorial Health Accord, which expires in 2014, must be extended for at least another decade.



Introduction



For millions across Canada, primary care is centred in and synonymous with family practice. Consistent with the findings of Green et al, the majority of all the health and medical care services for our population is provided in primary care/family practice settings.⁹ For decades, Canada's family physicians in solo or group practices located in large cities, mid-sized towns, and small rural communities have provided exemplary primary care for their patients, contributing significantly to our nation's excellent health outcomes and international recognition of our health care system as one of the best in the world. Recently, however, this reputation has been slipping with reports of increased rates of infant mortality, and morbidity and mortality related to diabetes and musculoskeletal diseases.⁸ Further, international comparisons place Canada well below world leaders in same-day access to physicians, use of electronic medical records (EMRs), avoidable hospitalizations, and ability to access after-hours care. The Commonwealth Fund Report indicates that Canada lags behind other selected countries in the Organization for Economic Cooperation and Development (OECD), except the United States, in each of the categories used to define a high-performance health system, including quality, access, efficiency, and equity.¹⁰

Studies have shown how important it is for patients to have access to family physicians in order to achieve the best possible health outcomes,^{11(p1495),12,13} yet access to these services has been compromised over the past decade. To reverse these trends, Canada must ensure that increased and sustained support for primary care and family practice is a national priority. A healthy primary care system leads to a healthy society.¹⁴

Most family physicians and family practices across Canada serve their patients well and provide a broad scope of services. However, compared with populations in six other nations, Canadians report lower levels of satisfaction with overall access to and the quality of our nation's primary care services.⁷ There has also been some media attention on patient opinion regarding frustration with finding a family physician and the decreased time spent with patients at each visit.^{7,15} Yet public surveys find that Canadians feel more positive about health care quality, service, and access when they have personal family physicians.¹⁶

The recent downturns in quality outcomes and patient satisfaction are cause for concern. Why they have been occurring has been the subject of numerous editorials and opinion pieces over the past decade, with most linking them to our system's struggle to adapt to a rising number of challenges. These challenges include a growing population of older Canadians; the increasing complexity of many patients' medical problems and the consequent increased time needed for medical visits; significant shifts from institutional to community-

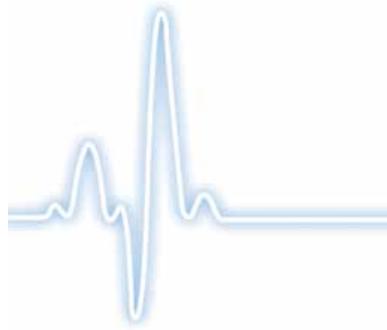
and home-based care without the human resources, appropriate facilities, or funding to support this transition; the lack of system support for the incorporation of electronic medical and health records; and the escalating costs for advanced technologies and pharmaceuticals. Superimposed on these factors are two critically important realities: i) significant shortfalls in the number of health professionals—including pronounced shortages of family physicians—which have impacted almost every community across Canada and ii) perceptions about the sustainability of our highly valued single-payer, publicly-funded system, and uncertainties regarding future federal government funding once the current Health Accord ends in 2014. Further, we must come to grips with the system's focus on specialized and facility-based services despite a lack of adequate support in the primary and community-based sectors. In *Crossing the Quality Chasm*, Berwick states that our system's struggle is not due to a lack of goodwill, but rather to fundamental shortcomings in the way care is organized.¹⁷

If Canada is to regain its reputation for producing quality health outcomes for its population, there must be changes introduced to ensure timely access to high-quality primary care/family practice services; adequate numbers of family physicians, nurses, and other health professionals; and sustainable funding and other resource supports for primary care/family practice. The collaborative commitments of all levels of government will be essential to the future of our system. As stated by Roy Romanow in his landmark final report of the Commission on the Future of Health Care in Canada, "While provinces and territories have the primary responsibility for the delivery of health care, the federal government also has important responsibilities... in providing a stable base of funding."^{18(p47)} Fortunately, over the past few years, our federal and provincial governments have supported the introduction of many innovative primary care and family practice initiatives aimed at improving access for patients (see Appendix A).

There is ample justification for sustaining and augmenting support for family practice. International research provides clear evidence of the correlation of access to effective family practices with better population health outcomes.^{11,12} A strong and high-performing primary health care system in which family physicians play an essential role has the potential to deliver better health care for the population as a whole and for groups with specific health care needs, such as those with mental illness and other chronic diseases.^{10,19} Both the traditional family practices that have cared for Canadians for many years and those that are part of newer primary care initiatives contribute significantly to delivering quality care to our population. However, assessing the effectiveness of a practice (solo or large group, inner city, or rural) and determining whether it is truly meeting the needs of the people it is serving requires clearly defined practice models to which all can refer.



Understanding the Patient's Medical Home



Enter the concept of the Patient's Medical Home (PMH)¹: the patient-centred family practice identified by its patients as the place that serves as the home base or central hub for the timely provision and coordination of all their health and medical care needs. While some physicians have indicated that they believe their practices may already incorporate the core elements of a PMH, without a standardized model to refer to, these assessments may or may not be valid. Some might discover that their patients can identify areas needing further attention. Achieving the objectives of the PMH requires family physicians and other health professionals to work in partnership. One of the challenges is that to date, there has not been a model available to describe what all patient-centred family practices, regardless of location, should be aspiring to achieve.

The PMH provides an opportunity to fill this void. It is presented as a vision to which every practice can aspire. It can serve as a frame of reference for every patient of a family practice and for every family physician, nurse, and other team member involved in a practice. It can be the resource team members use for ongoing practice assessment and quality improvement initiatives. The PMH can help other stakeholders, including government planners, policy-makers, and funders better understand what defines an effective patient-centred family practice. It can serve as a guide for the establishment of optimal teaching environments for family medicine, nursing, and other health professions; as a foundation for ongoing practice-based research; and as an inspiration for every practice focused on delivering the best possible care for its patients. By involving patients in all stages of the development, evaluation, and continuous quality improvement activities of the practice, the PMH can contribute significantly to furthering the goals of transformation to a patient-centred health care system.²⁰

WHAT THE PATIENT'S MEDICAL HOME IS NOT

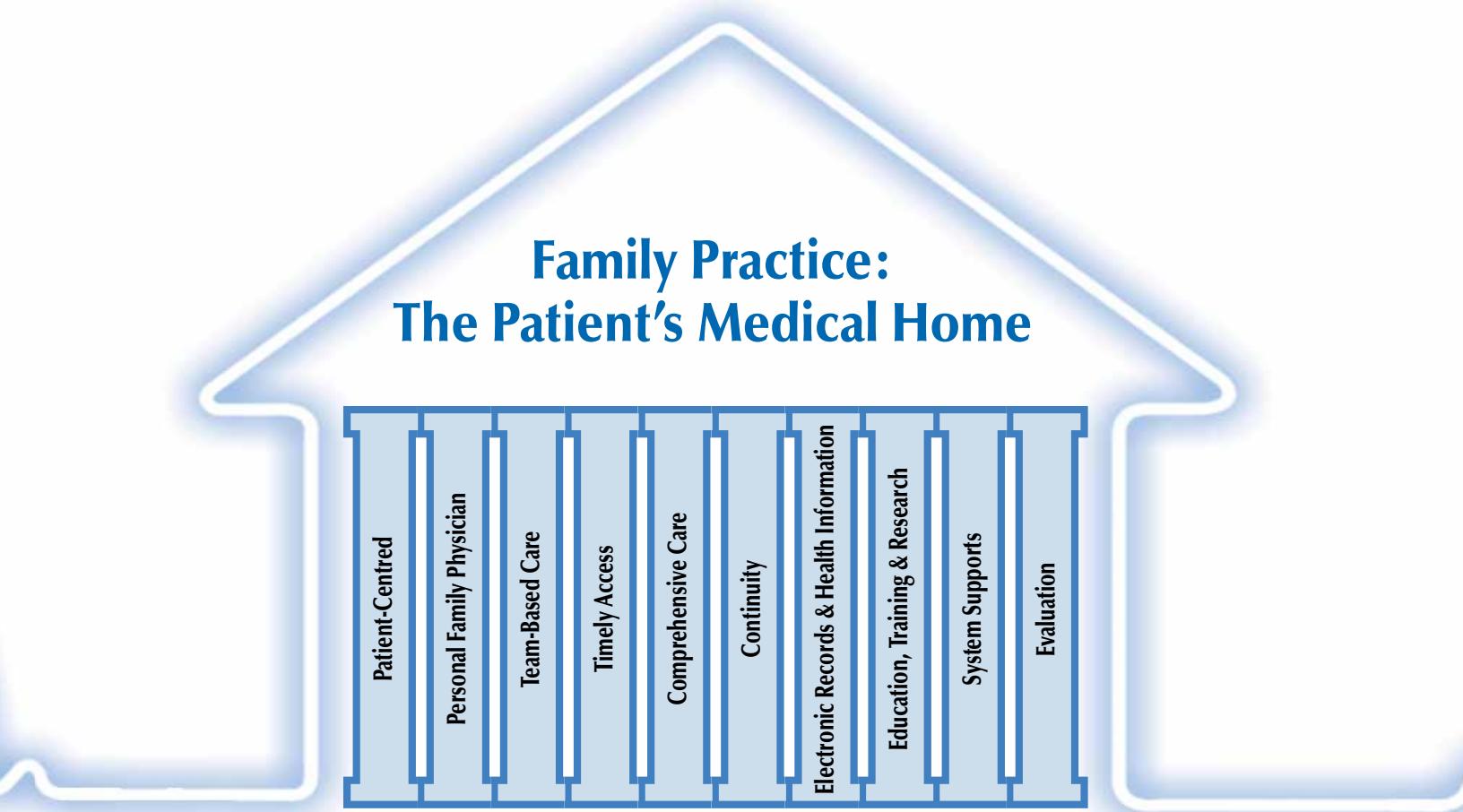
While it is important to understand what the PMH is intended to be, it is also important to know what is not intended; this is not a one-size-fits-all solution. Solo practices in rural or remote settings, or large, group practices serving inner-city populations can become PMHs by incorporating strategies that match the realities of each setting. While every patient must have a personal family physician identified in the practice regardless of its location, how the links to and relationships with other health professionals are established will vary. The vision for the PMH also does not suggest that current practices be relocated or re-engineered, or that significant financial investments be made by physicians or other health professionals. While

the objectives and core elements that define a PMH can and should be used to evaluate the progress or improvement of a practice in meeting the needs of its patients, they are not intended to suggest that practices that do not achieve these indicators should face disciplinary actions or other penalties. In the same vein, although financial incentives to recognize practices that meet and maintain the objectives of a PMH are encouraged, those who have not embraced this model should not face financial penalties.

This vision, while strongly advocating interprofessional teams and networks and enhanced support for the roles and responsibilities of other health professionals including nurses, nurse practitioners, physician assistants, and others, is not intended to address the important roles played or challenges faced in many different settings by colleagues in these professions. This is a vision focused on family practice and on ensuring that it will appropriately evolve in order to better meet the growing and changing needs of our population. It assumes that the feedback from Canadians, which consistently indicates how highly having personal family physicians and family practices for themselves and their families is valued, is valid and is not about to change.[§] It recommends and welcomes augmented collaborative and complementary roles for other health professionals who work with family physicians in family practice settings, but does not address alternative primary care models in which patients do not have personal family physicians. It is also important to note that this is not a plan intended to undermine or change the progressive initiatives involving the role of family practice and family physicians currently underway across Canada (several of which are already embracing and incorporating the medical home concept); rather, it is meant to build upon and strengthen them. Family Health Teams in Ontario, Primary Care Networks in Alberta, Family Medicine Groups in Quebec, chronic disease management programs and primary care divisions in British Columbia, and many other innovative projects in other provinces and territories (see Appendix A) can and should remain on the paths they are following. Each of the family practices in these projects could aspire to be PMHs. The more health care initiatives that meet the PMH objectives, the more likely it is that the overall goals of creating a patient-centred health care system throughout Canada will be realized.

[§]According to the College of Family Physicians of Canada (CFPC), 88% of Canadians say that having a family physician allows them to feel much more confident in their ability to access appropriate and timely care.

Framework of the Patient's Medical Home: The Pillars



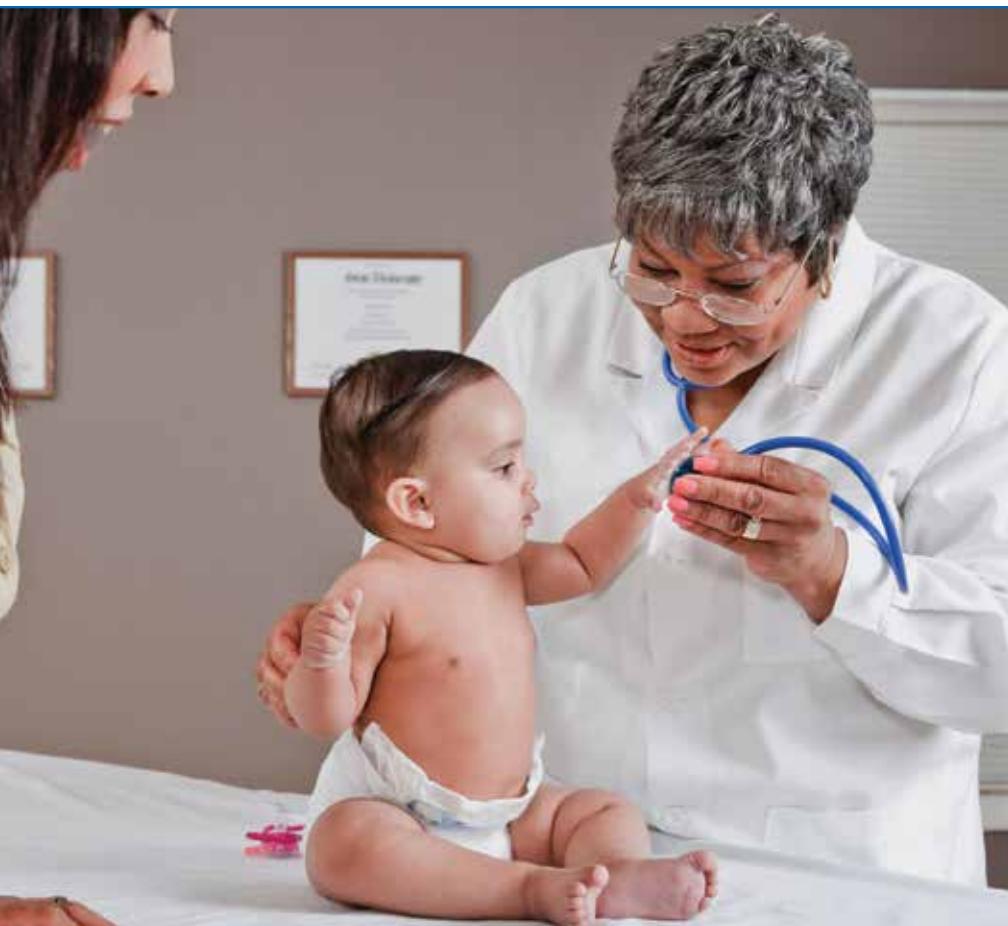
Patient-Centred Approach

GOAL 1

A Patient's Medical Home will be patient centred.

Patient-centred care is a pillar of the PMH. McWhinney describes patient-centred care as the provider “enter[ing] the patient’s world, to see the illness through the patient’s eyes ... [It] is closely congruent with and responsive to patients’ wants, needs and preferences.”²¹ In its *Charter for Patient-Centred Care*, the Canadian Medical Association (CMA) states that patient-centred care is “the essential principle... that health care services are provided in a manner that works best for patients. Health care providers partner with patients and their families to identify and satisfy the range of needs and preferences.”^{20(p14)}

In *Quality of Healthcare in Canada: A Chartbook*, the Canadian Health Services Research Foundation defines patient-centredness as being responsive to patient attitudes, preferences, and experiences.^{22(p14)} In a practice that serves as a PMH, care is person-focused rather than disease-focused and the needs of each person and family are paramount. Achieving patient-centredness requires the establishment of ongoing, trusting relationships between patients, their family physician, and other health professionals.



A range of user-friendly options for accessing information and care should be available to patients in each PMH. These might include email and other electronic communication, home visits, same-day scheduling, group visits, self-care, patient education, assessment, treatment sessions offered in community settings, and patient access to medical records. Patient surveys and opportunities for patients to participate in planning and evaluating the effectiveness of the practices' services should be encouraged, including patient feedback about access to and

adequate time for appointments. To strengthen a patient-centred approach, some practices may consider developing patients' advisory councils as part of their continuous quality improvement (CQI) processes.

PMHs should facilitate and support patient self-management. Support for self-care has been shown to be most effective when it is consistently available from all team members of a practice.²³ Family physicians, nurses, and other team members should always consider recommendations for care from the patient's perspective. They should work collaboratively with patients and their personal caregivers to develop realistic action plans and teach problem-solving skills. Self-care is particularly important for those with chronic diseases. Some have shown that it may be helpful for a practice to host group visits for patients with chronic diseases.²⁴ The goal of self-managed care should be to build confidence in patients and their personal care givers to help them deal more effectively with their illnesses and improve their health outcomes.

RECOMMENDATIONS

- 1.1: Care and caregivers in a Patient's Medical Home must be person-focused and provide services that are responsive to patients' feelings, preferences, and expectations.
- 1.2: Patients, their families, and their personal caregivers should be listened to and respected as active participants in their care decisions and their ongoing care.
- 1.3: Patients should have access to their medical records as agreed upon by each person and his or her family physician and team.
- 1.4: Self-managed care should be encouraged and supported as part of the care plans for each patient.
- 1.5: Strategies that encourage user-friendly access to information and care for patients beyond traditional office visits (eg, email communication) should be incorporated into the Patient's Medical Home.
- 1.6: Patient participation and feedback (eg, patient advisory councils) should be included as part of the ongoing planning and evaluation of services provided in the Patient's Medical Home.

Personal Family Physician

GOAL 2

A Patient's Medical Home will ensure that every patient has a personal family physician who will be the most responsible provider (MRP) of his or her medical care.



More than 30 million Canadians currently have personal family physicians. Canadians have always turned to their family physicians to be their first and ongoing medical contacts for any health-related concerns—to diagnose their problems, advise them regarding the need for investigations and treatments, provide care whenever possible, and arrange referrals when necessary. Because they come to know and

understand one another over time, patients trust their family physicians to play a key role in administering and coordinating their care, whether provided by the family physician directly or by other health professionals through referral.

Family physicians play important roles in our health care and medical education systems as clinicians, teachers, researchers, and administrators. While they are significant contributors to the delivery of primary care services, their education and training as physicians enables them to provide care for patients in many settings, including more complex secondary and tertiary care settings in emergency departments and on hospital wards. In many instances, particularly where other specialists are not readily available, it is family physicians with special interests and added skills who provide many of the consultations requested by their medical colleagues for the patients they are serving. Family physicians are also a resource for medical consultations or advice for other health professionals such as nurses or physiotherapists, who attend to patients in hospital clinics or community-based occupational health or school programs, where they play key front-line roles. These responsibilities all require the expertise of family physicians, but they do not define the most valued and valuable role that family physicians play in the care of patients and the population as a whole—the role that gives real meaning to their title as family physicians.

It is as the “personal family physician”—providing and coordinating a comprehensive basket of services for patients through a community-based family practice setting, and doing so continuously over time—that family physicians have proven their greatest value to our society. As shown by Starfield and Shi, populations with better access to continuing care over the years from the same personal physicians have fewer hospitalizations and better health outcomes.^{11,12} In a recent study in British Columbia, Hollander et al showed that the most cost-effective care and best outcomes for patients with chronic diseases occur when family physicians provide and coordinate their care.¹⁹ The trusting relationship between patients and their own family physicians, who provide both medical expertise and the knowledge and understanding of patients and their families gained over time, is considered a significant factor in producing these better outcomes. It is therefore important that all people in Canada be given the opportunity to have personal family physicians—a goal which could be achieved through the PMH. Whether it be in a small practice with only a few team members or in a larger practice with more complex teams, it would be beneficial to both the practice and its patients to make other caregivers available to work together with family physicians to deliver and coordinate the array of health and medical services patients need. While it should be left to each practice to determine who does what (within the boundaries of legal and professional regulations and standards), the MRP for the medical care for each patient in the practice should be the patient’s personal family physician.

Regardless of the specific roles defined for caregivers in each practice, family physicians will continue to carry significant responsibilities throughout our health care system. It is therefore essential that Canada maintain adequate numbers of and support for family physicians and their practices, including support for the other PMH team members, electronic records, etc. This is particularly true as we face changes in the use of health services due to an aging population, a greater prevalence of chronic diseases, the introduction of new drugs and technologies, and the expansion of patient and provider expectations.²⁵ To succeed, PMHs will require system support related to all of these elements.

RECOMMENDATIONS

- 2.1: By 2015, 95% of the people in each community throughout Canada should have a personal family physician.
- 2.2: By 2020, every person in Canada should have a personal family physician.
- 2.3: By 2022, every person in Canada should have a personal family physician whose practice serves as a Patient’s Medical Home.
- 2.4: Each patient in a Patient’s Medical Home should be registered to the practice of his or her personal family physician.

Team-Based Care

GOAL 3

A Patient’s Medical Home will offer its patients a broad scope of services carried out by teams or networks of providers, including each patient’s personal family physician working together with peer physicians, nurses, and others.

Way et al define collaborative practice as “an inter-professional process for communication and decision making that enables the separate and shared knowledge and skills of care providers to synergistically influence the client/patient care provided.”²⁶ The members of a health care team in a PMH should be focused on working collaboratively to care for patients.

Health care teams that are well-planned and well-supported and that function effectively can contribute significantly to achieving the goals of PMHs. Teams that are more cohesive in their approach to care appear to be associated with better health outcomes and higher patient satisfaction.²⁷ While research is emerging to support the value of teams, more information is still needed to help us better understand the elements that make teams work well and why some teams do not produce the desired outcomes. What seems certain, however, is that if teams are not properly designed or supported, the likelihood that they will be of benefit diminishes. If there is a lack of system support for everyone on the team—including a lack of appropriate funding, a lack of clarity or even disagreement among the team members about their roles and responsibilities, or if the responsibilities assigned do not match the knowledge and skills of those expected to carry them out—the chances increase that a team will be dysfunctional and will not produce the anticipated benefits for the patients being served.

As shown by Starfield and others,¹² the value of a continuous relationship between patients and their personal physicians that is built and strengthened over time contributes significantly to better health outcomes. These benefits could be further strengthened through team-based care where relationships are established between patients and other members of the health care team. It is therefore recommended that not only should patients of PMH practices be clearly linked to their personal family physicians, who will be the main providers of their medical care over the years, but they should also be given the opportunity to bond with each of the other main health care providers in their PMH practice. Patient–family–physician, patient–nurse, or patient–physician–assistant relationships should be encouraged and supported in the PMH. The family physician and other members of the practice linked to a patient should be identified as that individual’s personal PMH team. While others outside of the PMH can still provide care from time to time, it is these core members of the team who will be the most responsible for the ongoing care of their patients. Establishing these relationships will develop trust and confidence, and work toward the ultimate goal of achieving patient satisfaction with their care and having a positive effect on their health outcomes.

Each practice will be challenged to meet the needs and realities of their respective communities and patient populations. Their teams should be constructed accordingly. For example, PMH teams in some rural communities might include only one or two family physicians and a small number of support staff, and might wish to consider virtual links with caregivers in nearby or, if necessary, distant communities to expand their teams. PMH teams in larger rural or urban settings might involve several family physicians and, on occasion, other medical specialists or family physicians with special interests and skills, or possibly one or more other health care professionals, such as nurses, nurse practitioners, or physician assistants. For example, in populations with a significant incidence of diabetes, a PMH could add a registered dietitian to the team. Those trying to meet community needs for mental health services could benefit from including a mental health worker on the team. Many practices, including those dedicated to teaching students and residents, might see the advantages of making a clinical pharmacist available to their practices. Shared care strategies involving family physicians and other specialists such as those related to mental health care recommended by the Collaborative CFPC–Canadian Psychiatric Association Shared Mental Health Committee would be outstanding models to include in PMH practices.²⁸

Team members might be located in the same office or in the same building, but this is not strictly necessary. For both smaller and more remotely located practices and for larger centres, some of the team connections could be arranged with peers in other sites, with communications often taking place electronically; with advancing technology, in some instances referrals and consultations can be completed virtually. Virtual links between PMH practices and other specialists, hospitals, diagnostic services, etc., could be enhanced with more formal agreements and commitments to provide timely access to care and services.

Having sufficient health human resources, including physicians, nurses, and others will be critical to meeting patient needs and to the success of PMHs.^{29, 30(p256)} Starfield and Shi found that the greater the primary care physician supply, the better the health outcomes.^{11(p1495)} Health human resource strategies should not solely be provincially focused—we need a pan-Canadian plan that assesses the health needs of the population in each and every community and that ensures we have enough doctors, nurses, and other health providers to meet our population's constantly changing needs.

In Building on Values: The Future of Health Care in Canada, Commissioner Roy Romanow recommended transforming our health care system from one in which a multitude of participants, working in silos, focus primarily on managing illness, to one in which they work collaboratively to deliver a seamless, integrated array of services to Canadians, from prevention and promotion to primary, hospital, community, mental health, home, and end-of-life care.¹⁸

Source: Romanow, R. (2002) Building on Values: The Future of Health Care in Canada

RECOMMENDATIONS

- 3.1: A Patient's Medical Home may include one or more family physicians, each with his or her own panel of patients.
- 3.2: Family physicians with special interests or skills, along with other medical specialists, should be part of a Patient's Medical Home team or network, collaborating with the patient's personal family physician to provide timely access to a broad range of primary care and consulting services.
- 3.3: On-site, shared-care models to support timely medical consultations and continuity of care should be encouraged and supported as part of each Patient's Medical Home.
- 3.4: The composition of the teams or networks of health professionals and providers in Patients' Medical Homes may vary from one practice and community to another.
- 3.5: The location of each of the members of a Patient's Medical Home's team should be flexible, based on community needs and realities; team members may be on-site in the same facility or may function as part of physical or virtual networks located throughout local, nearby, or—for many rural and remote practices—distant communities.
- 3.6: The personal family physician and nurse should form the core of most Patient's Medical Home teams or networks, with the roles of others such as physician assistants, pharmacists, psychologists, social workers, physio- and occupational therapists, and dietitians to be encouraged and supported as needed.
- 3.7: Physicians, nurses, and other members of the Patient's Medical Home team should each be encouraged and supported to develop and sustain ongoing professional relationships with patients; each caregiver should be presented to each patient as a member of his or her personal medical home team.
- 3.8: Nurses and other health professionals who provide services as part of a Patient's Medical Home team should do so within their professional scopes of practice and personally acquired competencies. Their roles in providing both episodic and ongoing care should support and complement—but not replace—those of the family physician.
- 3.9: The roles and responsibilities of the team members of each Patient's Medical Home should be clearly defined. The leadership and support roles assigned to the different team members for the clinical, governance, and administrative/management responsibilities required in a Patient's Medical Home will vary from service to service and practice to practice, and thus should be determined within each setting.
- 3.10: Health system support, including appropriate funding, should be available to support all members of the health professional team in each Patient's Medical Home.
- 3.11: Each health provider/professional team member must have appropriate liability protection.
- 3.12: Ongoing research to evaluate the effectiveness of teams in family practice/primary care should be carried out in Patients' Medical Homes.

Timely Access

GOAL 4

A Patient's Medical Home will ensure i) timely access to appointments in the practice and ii) advocacy for and coordination of timely appointments with other health and medical services needed outside the practice.

Timely access to appointments is essential in the delivery of patient-centred care. It's not only about being available when the patient needs an appointment; it also means ensuring that efficient and effective care processes in the office setting respect the time a patient spends waiting for and attending the appointment.

Improved access to care can reduce redundancy and duplication of services (eg, when a patient accepts and keeps a later appointment but also consults another provider in the interim), improve health outcomes, achieve better patient and provider satisfaction, and lead to a reduction in emergency visits.

Same-day access

Unlike any other specialty, family medicine is a discipline defined in large part by its breadth and by the knowledge and skills required to deal with complex medical problems and patients presenting with undifferentiated symptoms that could be linked to many possible diagnoses. Compared with defining wait time targets and benchmarks for specific procedures such as hip replacements or cataract surgery, trying to define appropriate wait times for the many reasons patients might be seeking appointments with their family physicians or other PMH team members is exceedingly difficult. As noted in the CMA-CFPC Primary Care Wait Time Partnership's *The Wait Starts Here*,

"The difficulty in measuring primary care wait times for [a] myriad [of] illnesses and conditions... may impede progress in finding solutions to the wait time challenges that family doctors experience."^{31(p3)} Rather than setting specific wait time targets for each type of patient concern, the focus in family practice should be on enhancing access for patients regardless of the reason. Same-day scheduling, also known as open- or advanced-access scheduling, has emerged as a strategy many practices have introduced to address this challenge.

While same-day scheduling has been shown to enhance timely access for

Same-Day Access in Canada:

According to a Commonwealth Fund study, 17% of primary care practices in Canada offer patients same- or next-day appointments, placing Canada seventh out of seven nations surveyed. In the same study, Canada placed fifth out of seven with respect to accessing care on nights or weekends.⁷

Source: Davis, Schoen, Stremikis, (2010) *Mirror, Mirror on the Wall*

Nations in study: Australia, Canada, Germany, Netherlands, New Zealand, United Kingdom, United States.

patients and help physicians and teams become more organized and satisfied with their practices, it is important that those considering it refer first to resources that can help them understand its benefits and limitations and how to overcome the challenges associated with transitioning from a traditional appointment booking system. The CFPC's Primary Care Toolkit provides discussion and references related to many aspects of new models of practice, including advanced access booking.³²

Same-Day Access in Canada:

Alberta's access improvement measures (AIM) seeks to reduce or eliminate patient wait times and enhance practice efficiency and clinical care by achieving two goals: allowing for appointments of varied duration and facilitating same-day access for appointments. Physicians can review billing and diagnostic code data with information in their patients' electronic health records to determine what clinical areas need more attention (eg, checking blood pressure). Surveys indicate improvements in office efficiency and patient access, teamwork, work satisfaction, clarity in roles, clinical care, and continuity of care.³³

Source: Hutchison B, Roy DA. (2010) *Picking up the Pace: How to Accelerate Change in Primary Healthcare - Sharing success, learning from challenges*

According to Murray and Tantau, same-day scheduling is about doing today's work today, eliminating the "distinction between urgent and routine," but it doesn't mean every appointment is open.³⁴ The Murray and Tantau model leaves 65% of the day's bookings open and 35% booked. The 35% are for "patients who couldn't make it in on Friday and chose Monday instead or patients whom the physician deliberately scheduled today for follow-up."³⁴

It is important to balance timely access with the need to maintain continuity of care, which is essential to producing the best health outcomes for patients (see Goal 6). Although it will be necessary at times to book appointments with other professionals providing coverage in the practice, whenever possible patients should make their appointments with their personal family physicians and members of their PMH team.

As noted in Goal 1 regarding patient-centred care, patients should have the opportunity to provide input or feedback related to the appointment booking system in the practice. Wherever possible, the reasons for the medical visit should be clarified at the time the appointment is made. This will help ensure that adequate time is planned for patients with complex problems or with more than one significant problem. If the need to address multiple problems arises during a visit, these problems should be triaged by one of the PMH team members and arrangements made for the patient to have these concerns dealt with in a timely manner—if urgent, within minutes to hours of the same visit and if not urgent, at another appropriate appointment time. Arranging for appointments with other team members or interacting with patients by telephone or by other electronic communications can help address some patient needs. The decision to extend the time of an appointment with a patient whose multiple problems have only become evident during that visit should always take into consideration both the urgency of the problems and the need to respect the schedules of other patients waiting to be seen.

How, where, and when care could be provided by the Patient's Medical Home team

As appropriate supports (including resolution of privacy, liability, and remuneration issues) are introduced, patient interactions with their physicians and other health professionals will be increasingly carried out through more than traditional face-to-face interactions in the family practice office setting. Timely access to care and information, including extended hours, can be achieved through use of email, telephone, and websites. Haggerty et al found that being available to patients by telephone helped to improve accessibility and continuity.³⁵ Although more work is needed to provide the guidelines for use of email and other electronic communications between patients and health providers, some advice is already available from jurisdictions using these forms of interaction. Miller advises that face-to-face appointments are best when information is highly ambiguous, complicated, or emotionally charged, and that email or telephone discussions are best reserved for clear, simple, and emotionally neutral messages.^{36(pS72)}

PMHs should also include group visits for patients who share the same kinds of medical challenges or for sharing preventive medicine advice and discussions. When appropriate, care should be provided by members of the PMH team in settings other than the practice office, including the patient's home; the local hospital; nursing homes; and other continuing, palliative, and rehabilitative settings throughout the community.

Medical problems can arise at any time and patient access to the care or advice they need should not be limited to a narrow range of hours or calendar days; nor should the care always need to be delivered by the same caregiver. To achieve this, and to ensure continuity of care, each PMH should establish defined links with its community's network of services, including local hospitals; other specialists and medical care clinics; public health units; and laboratory, diagnostic imaging, physiotherapy, rehabilitation, and other facilities. These should include ongoing communication strategies and agreements to ensure timely access for referrals/consultations.

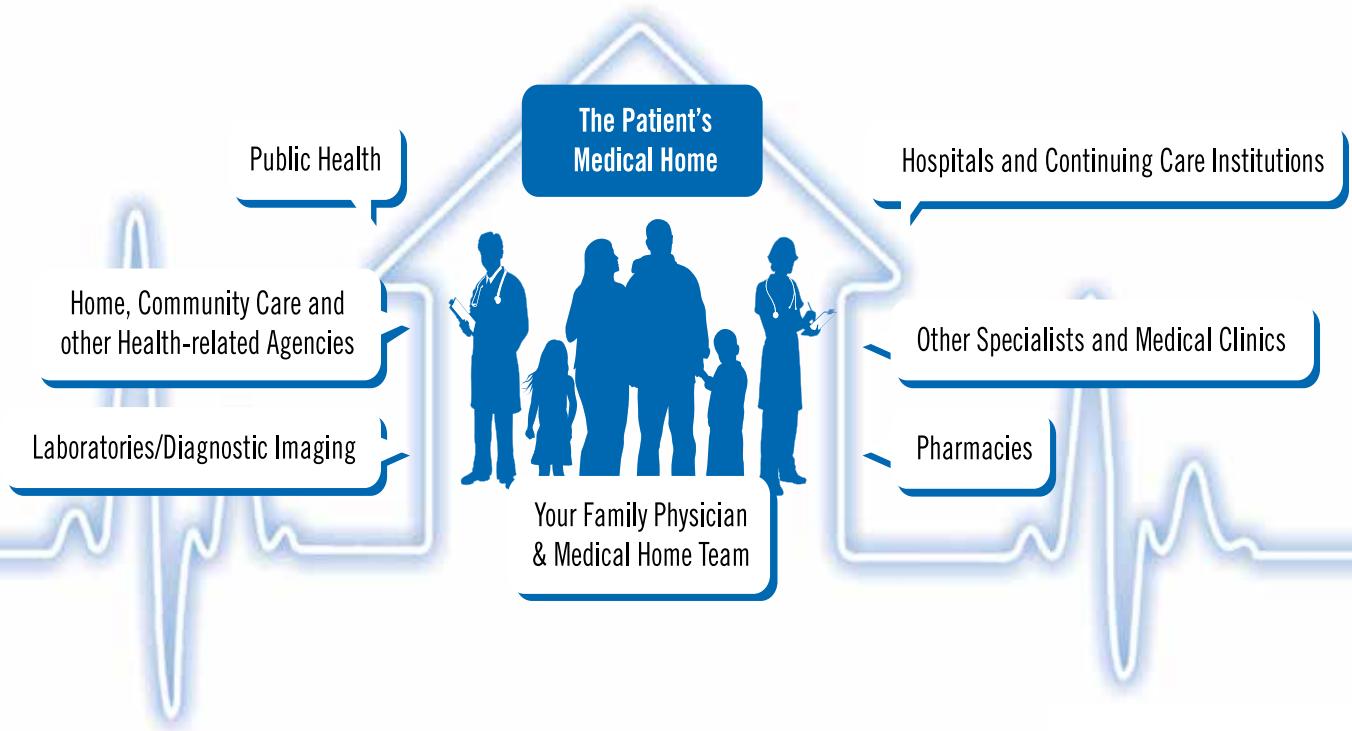
PMHs should provide access for their patients to after-hours telephone services to help guide them to the right place at the right time for the care they need. Directing this care appropriately to the next available appointment in the office setting or to hospital emergency departments as required is critical to the effective medical management of patients and the sustainability of our health care system.

Panel size/number of patients in a practice

The shortage of family physicians across Canada over the past decade has resulted in many practices reaching their limits with respect to the number of patients that can be safely managed. Some practices have accepted patients beyond optimal numbers; many have had to close their practices to new patients, leaving thousands of people without personal family physicians. Even those who have personal physicians have encountered busy times in their

physicians' practices, making it very difficult to get timely appointments with their own doctors or with other physicians. While emergency departments and walk-in clinics have played important roles in providing some of this episodic care, for emergency departments to attend to patients with non-emergent problems is a burden. Access to primary care/family practice teams has been shown to reduce emergency room use,³⁷ improve access to care, offer more preventive services, and enhance patient satisfaction.³⁸

Establishing and incorporating the goals and recommendations that will define PMH practices—a personal family physician for each patient, peer physicians and other health professionals working as teams with each family physician, advanced-access booking systems, strategies for after-hours coverage, etc.—may enable many physicians and practices to consider increasing their panel sizes (ie, the number of patients that can be accepted and registered with each practice). The actual panel size for each practice will vary depending on many factors, such as the number of physicians and other team members in the practice, the practice's obligations and commitment to teaching and research, and the demographics of the patient population being served, including the age of the patients and the complexity of their medical problems. When deciding on panel size, each practice must also determine how accepting more patients into the practice might impact access to appointments and care for the current practice population, as well as how it will affect the workload and lives of the physicians and other members of the PMH team.



The Patient's Medical Community

Arranging for care and coordinating care outside the PMH

One of the greatest challenges for both rural and urban family physicians and their patients is arranging timely access to services that will be delivered by others outside the practice. To be patient-centred and to ensure the best possible access and continuity of care, a PMH must function effectively as the central hub for all care provided for its patients, whether delivered within the practice setting or elsewhere. This requires a commitment by the PMH team to advocate for the consultations and other services patients need and to arrange and coordinate appointments outside the practice, sharing relevant information about referred patients with other caregivers. EMRs can facilitate communications between providers whether they are located in the same or different settings, and are becoming invaluable to the coordination and continuity of care essential to an effective referral–consultation process. Online programs to facilitate the referral–consultation process are being introduced in some provinces (eg, Manitoba) and should

be further explored as valuable resources to help improve access to specialty care for patients.³⁹

The Primary Care Wait Times initiative carried out by the CFPC and the CMA noted that one of the most significant access-to-care pressure points in our health care system has been the wait times experienced by patients whose family physicians have referred them for appointments with other specialists



or specialty services.³¹ The CFPC, The Royal College of Physicians and Surgeons of Canada (RCPSC), and the CMA, through the Collaborative Action Committee on Intraprofessionalism (CACI), have identified the problems in this referral–consultation process as a priority and have recommended strategies to address this issue both from the perspectives of educational (postgraduate training and continuing education) and practice environments (referral–consultation process).

The loss of doctors' lounges in hospitals and the decreased role of family physicians (and some other "generalist" specialists) in many hospitals has negatively impacted the communications that used to take place between referring physicians and consulting specialists. While family physicians in most rural and smaller communities still maintain significant roles in their hospitals, these physicians and their patients often face an even

greater challenge when referrals to larger centres or specialists located in distant settings are needed. Every PMH could benefit from establishing clearly defined links between themselves and other specialists' practices, hospitals, and other community-based diagnostic and treatment services—up to and including formal agreements—that could include commitments to priority access for their patients.

As noted elsewhere in this paper, one of the emerging solutions to providing timely access to specialty consultations is shared care, an approach in which patients are assessed by consultant medical specialists or family physicians with special interests and added skills at scheduled times in the family practice office setting. In this scenario, the consultant might assess several patients per visit to the family practice office, at which time a plan for ongoing care can be developed and agreed to by the family physician, the consultant, other team members, and the patient.

RECOMMENDATIONS

- 4.1: A Patient's Medical Home should ensure access for patients to medical advice and the provision of or direction to needed care 24 hours a day, 7 days a week, 365 days a year.
- 4.2: Patient's Medical Home practices should adopt advanced access or same-day scheduling strategies to ensure timely appointments with the patient's personal family physician or other appropriate members of the team.
- 4.3: When the patient's personal family physician is unavailable, appointments should be made with another physician, nurse, or other qualified health professional member of the Patient's Medical Home team.
- 4.4: Patients should have the opportunity to participate with their family physicians and Patient's Medical Home teams in planning and evaluating the effectiveness of the practice's appointment booking system to ensure timely access to and adequate time allotment for appointments.
- 4.5: Panel size for a Patient's Medical Home and its providers should be appropriate to ensure timely access to appointments and safe, high-quality care for each patient and the practice population being served.
- 4.6: Panel size should take into consideration the needs of the community, the workload of the health care providers, and the safety of the patients.
- 4.7: Defined links should be established between the Patient's Medical Home and other medical specialists and medical care services in the local or nearest community to ensure timely appointments for patients being referred for investigations, treatments, and other consultations.

Comprehensive Care

GOAL 5

A Patient’s Medical Home will provide each of its patients with a comprehensive scope of family practice services that also meets population and public health needs.

Family practice is defined by the complexity of the medical problems managed, the continuity of care provided over time, and the comprehensiveness of the services it offers. To achieve the goal of being patient centred, it is essential for the family physician and the PMH team

to provide a comprehensive range of family practice services for both the individual patients and the populations they serve.

Research has shown that regardless of socio-economic status, a population is healthier when it has access to comprehensive health care services; a more comprehensive “basket of services” can lead to better health outcomes for all, including vulnerable populations.^{11(p1497)} Not only does a wider range of services provided by primary care practitioners result in better health outcomes, it does so at lower cost.^{11(p1494)}

In 1996, the Ontario Provincial Coordinating Committee on Community and Academic Health Science Centre Relations (PCCCAR) defined 14 areas as comprising the basket or scope of services that would define comprehensiveness for a well-functioning family practice (see Appendix C).⁴⁰ The PCCCAR model was subsequently adapted by the Ontario College of Family Physicians (OCFP) to be aligned with the Four Principles of Family Medicine.²⁶ In 2011, The CFPC approved the Triple-C Family Medicine Curriculum, a curriculum that is comprehensive, focused on continuity of education and patient care, and centred in family medicine. The goal is to

reinforce and re-energize the critical importance of family physicians’ providing front-line, broad-scope medical care and services to patients of all ages throughout their lives. Triple C is intended to help guide both the lifelong learning and the practices of family physicians. Comprehensiveness and continuity are core defining elements of this framework. They

apply to training for or practice in different communities, whether in rural or urban settings. Comprehensiveness and continuity are currently described according to five domains.

- i) **Care of patients across the life cycle:** newborns, children and adolescents, adults, care of the elderly, end-of-life and palliative care
- ii) **Care across clinical settings in both rural and urban communities:** ambulatory/office practice, hospital and long-term care institutions, emergency care settings, care in the home
- iii) **Spectrum of clinical responsibilities:** prevention (including screening) and health promotion, diagnosis and management of undifferentiated presenting problems, acute and chronic disease management, maternity care, women's and men's health, mental health care, rehabilitation, supportive care, palliative care
- iv) **Care of marginalized/disadvantaged patients:** including but not limited to Aboriginal populations, patients with mental illness or addiction, recent immigrants
- v) **Procedural medicine:** defined by list of core procedural skills defined by the CFPC
see <http://www.cfp.ca/content/51/10/1364.full.pdf+html>)

The understanding of comprehensiveness is further complemented by the Four Principles of Family Medicine and the CanMEDS-FM Roles (see Goal 8, Recommendation 8.3).

Comprehensiveness in family practice: Managing undifferentiated illness and complexity

One of the most important attributes of a skilled family physician—and a core element that distinguishes family medicine from most other medical specialties—is expertise in managing undifferentiated illness and complex medical presentations.

The provision of comprehensive care in family practice includes not only offering a broad range of services for patients at different times, but also means frequently needing to manage undifferentiated and complex medical presentations, including comorbidities at each visit. Understanding and effectively managing complex presentations and comorbidities are of particular importance when caring for the elderly and those with chronic diseases. In a PMH, this comprehensive care must be executed by both the family physician and the PMH team.

While clinical practice guidelines and performance indicators are potentially beneficial initiatives focused on CQI and the best possible health outcomes for patients, to be relevant to primary care and family practice settings, they must be developed so that they are applicable to patients with comorbidities and complex medical histories (see Goal 9, Recommendation 9.3).

Population and public health

While family practices and PMHs focus primarily on the care of individuals and their families, it is important for physicians and other team members to understand and address the health challenges facing their practice populations within each community as a whole. With the help of EMRs, information about health patterns and the needs of populations is increasingly more readily available, helping practices to implement health promotion and preventive medicine programs. Each PMH should understand how the social determinants of health, such as

poverty, job loss, culture- or gender-related challenges, and homelessness are impacting both its patients and the populations residing and working in the practice's communities. With the increased movement of people across and between continents, it is important for practices to understand the health challenges facing populations throughout Canada, across North America, and around the world. As people travel into and out of our local communities, the impacts of global population and public health issues on patients of each family practice in Canada are becoming more significant.

Public health is the science and art of preventing disease, prolonging life, and promoting health through the organized efforts of society.⁴¹ While public health is centred on prevention and treatment of populations and the broader community, family medicine focuses on the same priorities for the individuals and families that make up these populations. Family physicians and their PMH teams are key providers in many important public health areas, including illness and injury prevention; health promotion; screening for diseases such as diabetes, hypertension, and cancer; immunizations; health surveillance; and chronic disease management. Practices that offer timely access to patient-centred, comprehensive, continuous, and coordinated care have been shown to have higher rates of preventive screening services, lower rates of emergency department visits and hospitalizations, and greater patient satisfaction.⁴² PMHs should prioritize the delivery of evidence-based care for illness and injury prevention and health promotion, reinforcing them at each patient visit and through other counselling opportunities.

Medical and nursing schools and professional colleges should ensure that population and public health issues are a core part of the formative and continuing education programs for all physicians and nurses.

PMHs and local or regional public health units should cultivate and maintain strong links with one another. Family physicians, nurses, and other health professionals who are part of PMH teams may take on advisory, educational, supportive, or active roles in public health initiatives, including population health screening and surveillance activities; immunization programs; or health promotion and illness and injury prevention activities in occupational, scholastic, or recreational settings throughout the community.

An effective public health system should be inextricably linked to community-based family physicians and to PMHs, recognizing and supporting them as essential to the achievement of the broader population and public health goals of our nation.

Chronic diseases and mental health

The management of patients with chronic diseases, including diabetes, hypertension, arthritis, and mental illness is recognized as one the most significant challenges facing Canada both today and—with projections of significant increases in our aging population—tomorrow. The management and coordination of care for patients with chronic diseases should be led by family physicians and the PMH team members working with them in their practices, and the communities in which their patients reside. If properly organized and supported within

our health care system, the interprofessional PMH teams could help prevent many chronic diseases or mitigate their impacts.

In particular, access to care at both the primary care and the consultation levels for patients with mental health problems has been identified as a significant challenge facing Canadians.⁴³ Well-supported PMHs have the potential to serve as hubs for the provision and coordination of the care needed by these patients, their families, and their personal caregivers.

Preventive health counseling, screening and immunization programs, the provision of comprehensive continuing coordinated care, teaching and supporting self-care for patients and their personal caregivers, and actively advocating for those with complex medical problems as they try to navigate their way through the health system are essential and highly valued services for patients with chronic diseases and can be provided by the family physicians, nurses, mental health professionals, social workers, dietitians, physio- and occupational therapists, and others involved in PMH team.



When needed, particularly for patients who are unable to attend the family practice/PMH office, services might be offered in other community settings or in group visits rather than traditional one-on-one visits. The Ontario Health Quality Council found that those with lower levels of education and income receive less preventive care or monitoring of their chronic diseases.⁴⁴ This can be explained, in part, by the difficulties these populations encounter in attending medical visits in traditional settings. Community-based services and programs, group visits, or the use of telephone and other electronic communications may help improve chronic disease management for these populations. However, system support for the legal and funding issues related to offering alternative care delivery strategies such as these must be in place before they can be more widely implemented.

Ongoing research related to the care of patients with chronic diseases is also imperative. This research must include studies of the incidence and patterns of chronic diseases, health system resource utilization (hospitalizations, emergency visits, etc.), and the effectiveness of different medical and health care interventions, along with management approaches, individual and population health outcomes, cost-effectiveness, etc.

The Canadian Primary Care Sentinel Surveillance Network (CPCSSN), which is focused on studying patients with chronic diseases, is funded by the Public Health Agency of Canada and is hosted and coordinated by the CFPC and family medicine research leaders from university departments of family medicine across Canada. It has established a network of family physicians in communities across the country in practices with EMRs and is gathering information from these practices related to patients with chronic diseases. This type of network and research is invaluable and will hopefully contribute to better access and coordination of care and the best possible health outcomes for the millions of Canadians currently living with chronic diseases and those who will be in the future.

Within each part of our country and within each community there are at-risk and underserved populations. These people are significantly impacted by many of the social determinants of health such as poverty, homelessness, and unemployment. They are less likely to receive preventive, acute, or ongoing care and are more vulnerable to a significant number of illnesses and injuries. Included among the increased medical problems encountered by these populations are many chronic diseases including diabetes and mental illness. Family practices functioning as PMHs should identify and help provide the medical care needed by these at-risk and underserved populations.

RECOMMENDATIONS

- 5.1: In a Patient's Medical Home, the patient's personal family physician should work collaboratively with the other team members to provide a comprehensive range of services for people of all ages, including the management of undifferentiated illness and complex medical presentations.
- 5.2: A Patient's Medical Home should meet the public health needs of the patients and population it serves.
- 5.3: Patients' Medical Homes should prioritize the delivery of evidence-based care for illness and injury prevention and health promotion, reinforcing these at each patient visit.
- 5.4: The health care system should support Patients' Medical Homes to ensure their key role in the management and coordination of care for patients with chronic diseases, including mental illness.
- 5.5: Patients' Medical Homes should address the health needs of both the individuals and populations they serve, incorporating the effects that social determinants such as poverty, job loss, culture, gender, and homelessness have on health.

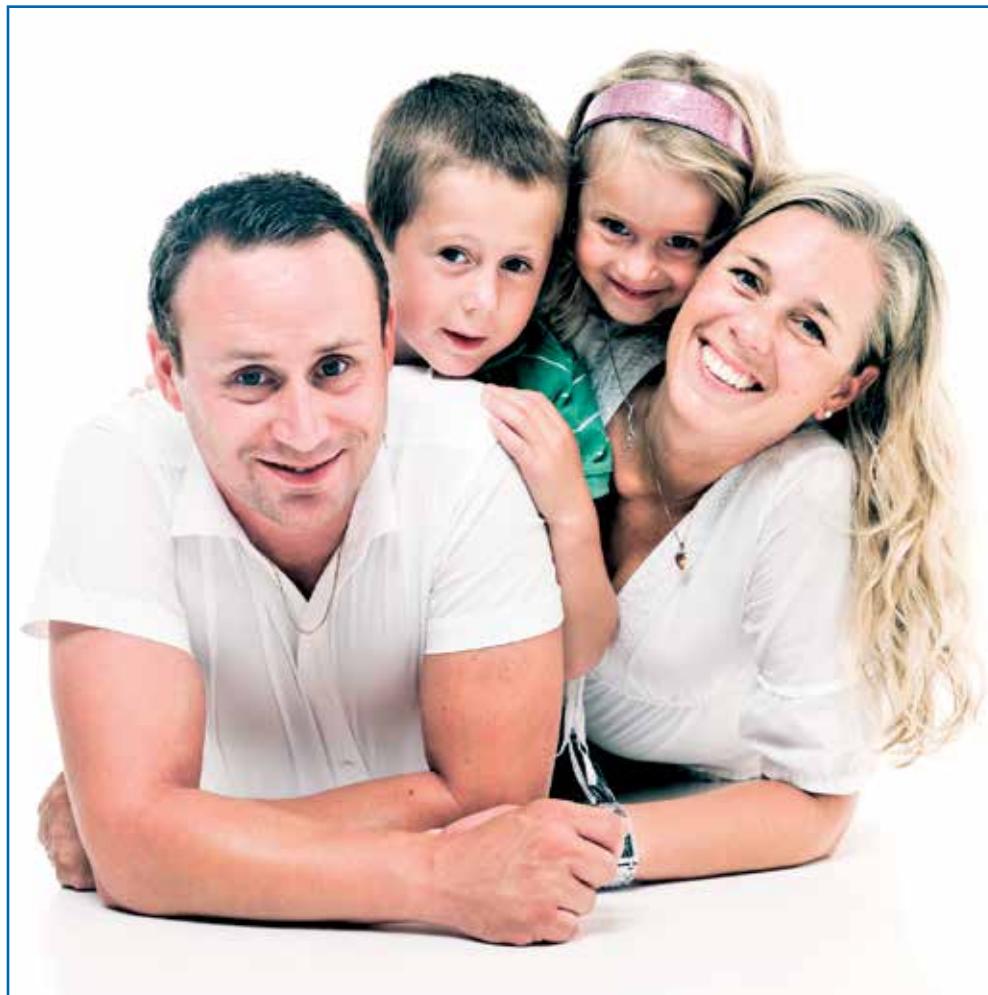
Continuity of care

GOAL 6

A Patient's Medical Home will provide continuity of care, relationships, and information for its patients.

Comprehensiveness and continuity of care are linked as defining elements of the discipline of family medicine and of a family practice's being a PMH. Continuity of care, information, and relationships are essential to a practice that hopes to offer patient-centredness, timely access to comprehensive and coordinated care, and the potential for the best possible health outcomes. The discipline and practice of family medicine has historically contributed to better patient care and outcomes in countries that have strong primary medical care and that understand and support the value and importance of the cumulative effect of regular visits with a personal physician.

Continuity of care is defined by consistency over time related to where, how, and by whom each person's medical care needs are addressed throughout the course of his or her life. Continuity of medical setting, information, and relationships all contribute to ensuring overall continuity of care. Having most medical services provided or coordinated in the same place by one's personal family physician and team has been shown to result in better health outcomes.¹¹ Knowing that their medical information from all sources is stored and available in one setting increases the comfort, trust, and confidence of patients regarding their care. When care must be provided in different settings or by different health professionals, as happens with referrals for investigations or



consultations that need more highly specialized interventions, continuity can still be preserved if the caregivers involved are committed to communicating effectively among themselves. Essential to ensuring continuity of care is continuity of information. A record of all the medical care provided for each patient should be available in each person's medical record (preferably an EMR) and kept in the family practice that serves as the PMH.

When the same physician attends to a person repeatedly over time, for both minor and more serious health problems, the critically important patient–doctor relationship is strengthened and the understanding between the relationship partners grows. The personal physician is able to offer his or her medical knowledge and expertise in the context of a more complete understanding of the patient as a person, including not only the patient's medical history but also the patient's personal, family, social, and work history; the patient's needs and fears; and the patient's patterns of response to illness, medications, and other treatments. Research reported by Starfield et al demonstrated that one of the most significant contributors to better population health outcomes is continuity of care. They found that those who see the same primary care physician continuously over time have better health outcomes than those who receive frequent care from many different physicians: "The more physicians patients see, the greater the likelihood of adverse effects; seeking care from multiple physicians in the presence of high burdens of morbidity will be associated with a greater likelihood of adverse side effects."⁴⁵ It was also reported that a regular source of care is associated with better access to preventive care services, regardless of the patient's financial status.^{11(p1495)}

RECOMMENDATIONS

- 6.1: Care for each person in a Patient's Medical Home should be provided continuously over time.
- 6.2: Patients' Medical Homes should foster continuity of relationships between patients and each of their caregivers.
- 6.3: Patient's Medical Home teams should ensure continuity of the care being provided for their patients in different settings, including the family practice office, hospitals, long-term care and other community-based institutions, and the patient's residence.
- 6.4: A Patient's Medical Home should advocate on behalf of its patients to help ensure continuity of their care throughout the health care system.
- 6.5: A Patient's Medical Home should serve as the hub that ensures coordination and continuity of the information related to all the medical care services their patients receive throughout the medical community.

Electronic Medical Records and Health Information Technology

GOAL 7

A Patient's Medical Home will maintain electronic medical records (EMRs) for its patients.

While modest goals for the establishment of EMRs in community-based practices across Canada have been set by governments and Canada Health Infoway, commitments to more specific and progressive targets are needed, along with supports to ensure these targets are met. By 2022 all family physicians in Canada should be using EMRs in their practices.

EMRs can enhance the capacity of every practice to store and recall medical information on each patient and on the practice population as a whole. Among other benefits, they facilitate day-to-day patient care, the sharing of information needed in the referral–consultation process, teaching, carrying out practice-based research, and the evaluation of the effectiveness of the practice as part of a commitment to CQI.

They support effective collaborative care, assist in understanding overall practice and community needs, help ensure timely access to appointments for patients, offer alerts and cues related to patient needs that must be addressed, and facilitate practice management and the use of quality indicator and health outcomes tracking.

Unfortunately, the introduction of EMRs in Canada has been slow. In a report examining the role of family physicians in decision making, the Health Council of Canada found that family physicians need greater access to decision-making tools, including EMR systems. It is widely known, however, that access to and use of these systems by family physicians is not as common in Canada as in other countries.²⁵

For the uptake of EMRs to be accelerated and to facilitate the transition from paper to electronic records, several challenges need to be addressed. These include the need for increased system support and guidance to help physicians identify the vendors and products that should be given priority consideration and to facilitate the transition in a practice from paper to electronic records. Concerns related to interoperability between systems, privacy and confidentiality, and patient access to their e-records must also be addressed.

EMRs must be adequately funded, have standardized language to ensure common data management, and be interoperable with other electronic health records relevant to the patient's care. There must also be ample training and ongoing technical support for all team members in the practice introducing EMRs. If practices know they will be well-supported as they go through the transition from paper to electronic records, the chances of their agreeing to undertake this challenge will increase. A comprehensive, systematic review of peer-reviewed and grey literature found that cost sharing or financial sponsorship from government entities is required to support the high cost of EMR adoption.⁴⁶ Governments in several European countries equip all primary care practices with interoperable, ambulatory care–

focused electronic health records that allow information to flow across settings to enhance the continuity and coordination of care.

Electronic Records and Privacy

Canadian Medical Protective Association:

“As with any patient information, physicians generally do not need a patient’s express consent to include his or her health information in an EMR/EHR, or to share patient information with other health care providers for the purpose of providing treatment. Physicians can generally rely on a patient’s implied consent to share information within the ‘circle of care’, which includes those health care professionals who ‘need to know’ the information for the purpose of providing care.”⁴⁸

*Source: CMPA (2009) Electronic Records Handbook, p.6
EHR = electronic health record*

Studies show that assigning a physician to champion the EMR project leads to success.⁴⁶ In addition to physician leadership, a team approach is critical during design, development, and implementation phases.⁴⁶ Since different members of the workforce bring different skills to the implementation, adopting an interdisciplinary approach can bring to bear the richness of all those varying perspectives on the project.⁴⁶ The ingredients for successful implementation are strong leadership, team recognition of the advantages of the approach, establishing standards, identifying local champions, strong support for and training of staff, low costs, and a practice-tailored application.^{47,46}

While it is important for Canada to move quickly to implement the EMR,

we must not neglect safeguards that vigilantly protect a patient’s privacy. Privacy, security, and confidentiality of patient information are vital to successful EMR implementation. Accordingly, a code of conduct for all those with access to health information should be developed and implemented, with a goal of protecting patient confidentiality in keeping with provincial and territorial health information legislation.

As indicated in the discussion regarding patient-centred care (Goal 1), patients should have access to their medical records, as agreed upon by them and their family physicians and PMH teams. Practices in some jurisdictions in Canada and internationally are beginning to develop and implement policies and protocols to support patient access to their EMRs. An example is Sunnybrook Health Sciences Centre’s e-Health initiative called MyChart™, which includes protocols addressing patients’ access to their records. MyChart considers the rights and needs of both patients and caregivers while also maintaining privacy and security related to certain kinds of information.⁴⁹

In addition to electronic medical and health records, information technology can be of great benefit in communicating and sharing information with patients, measuring patient progress, and facilitating patient adherence to care plans and medications. PMH team members might find it convenient to communicate with patients through secure Internet

channels or to devise an interactive medical home website. While there are reports of increased use of email and social media interactions with patients, health professionals still need to be cautious about when and how they carry out these interactions. It would be wise for those wishing to enter into these kinds of e-communications to follow the advice from regulatory authorities and medical insurers.

Despite the current shortcomings related to the use of electronic communications, family physicians and other health care professionals should be aware of the potential value of secure patient–family physician email messaging. While further research is needed, a recent American study found that “...the use of secure patient-physician e-mail within a two-month period was associated with a statistically significant improvement in effectiveness of care.”^{50(p1370)}

While embracing expanded use of electronic communication with patients may be of significant value to both patients and caregivers, it is also important for PMHs to be both aware of and sensitive to the socio-economic or demographic challenges that some patients may experience related to their access to the Internet and secure email. Canada should support the development of a health care electronic communication and information infrastructure that ensures secure access to their medical records and privacy and confidentiality of communications for all citizens and their medical and health care providers.

RECOMMENDATIONS

- 7.1: By 2022 all family physicians in Canada should be using EMRs in their practices.
- 7.2: System supports, including funding to support the transition from paper records, must be in place to enable every Patient’s Medical Home to introduce and maintain EMRs.
- 7.3: EMR products for use in Patients’ Medical Homes should be identified and approved by a centralized process that includes family physicians and other health professionals. Each practice should be allowed to select its EMR product and service providers from a list of provincially, territorially, or regionally approved vendors.
- 7.4: EMRs approved for family practice/Patients’ Medical Homes must include appropriate standards for recording and following patient care in a primary care setting; e-prescribing capacity; incorporated clinical decision support programs; e-referral and consultation tools; advanced-access e-scheduling programs; and systems that support teaching, research, evaluation, and continuous quality improvement in the practice.
- 7.5: EMR and electronic health record systems must be interconnected, user-friendly, and interoperable.
- 7.6: There should be a pan-Canadian electronic health care communication and information infrastructure that ensures secure access to medical records and privacy and confidentiality of communications for all citizens and their medical and health care providers.

Education Training and Research

GOAL 8

Patients' Medical Homes will serve as ideal sites for training medical students, family medicine residents, and those in other health professions, as well as for carrying out family practice and primary care research.

Education and training

PMH practices should welcome the opportunity to serve as training sites for medical students, family medicine residents, and those training to become nurses and other health professionals. They should be recognized as the gold standard for modelling and teaching practices focused on the essential roles of family physicians and interprofessional teams; timely access to appointments; the delivery of comprehensive, continuing, coordinated care; and the use of EMRs.

The goal of family medicine residency training is for residents to graduate as family physicians who are competent in and committed to providing comprehensive, continuing care in community-based practices. The future of family medicine training, as well as lifelong learning, will be increasingly focused on the achievement and maintenance of competencies defined by the CFPC's Triple C Family Medicine Curriculum (comprehensive, focused on continuity of care and education, and centred in family medicine). The Triple C curriculum includes five domains (see page 37): care of patients across the life cycle, care across clinical settings (urban and rural), a defined spectrum of clinical responsibilities, care of marginalized/disadvantaged patients and populations, and a defined list of core procedures.

Triple C also incorporates the Four Principles of Family Medicine and the CanMeds-FM Roles.[¶]

The Four Principles of Family Medicine:

- The family physician is a skilled clinician.
- The patient–doctor relationship is central.
- The family physician serves as a resource to his or her practice population.
- Family medicine is community based.

CanMEDS-FM Roles

Family Medicine Expert – eg, undifferentiated and complex patient presentations; provision of patient-centred, comprehensive, continuing care for people of all ages

Communicator – eg, explanation of differential diagnosis or planned investigations to patient and family; appropriate communication using electronic and social media

[¶] Adapted by the CFPC for family medicine from the Royal College of Physicians and Surgeons of Canada's CanMEDS Roles for Royal College Specialists.

Collaborator – eg, support and participation on practice-based interprofessional teams

Advocate – eg, public voice for importance of social determinants of health and preventive health care (immunizations, smoking cessation, mammograms, Pap smears, etc.)

Manager – eg, understanding and respect for resource implications of clinical care decisions; implementation of systems to facilitate timely appointments for patients

Scholar – eg, commitment to teaching, research, and maintenance of competence/certification, including personal lifelong learning/continuing professional development

Professional – eg, ethical practice, professionalism, social accountability; commitment to continuous quality improvement program in practice

Family practices that meet the definition of PMHs should become the ideal settings for family medicine students and residents to achieve the objectives of the Triple C curriculum and to learn how to incorporate the Four Principles of Family Medicine and the CanMEDS-FM roles into their professional lives. It should also serve as an optimal environment not only for family medicine students and residents, but also for trainees in other medical specialties and other health professions to gain valuable experience related to the delivery of patient-centred, team-based, high-quality care—the essential core elements of family practice, primary care, and health system reform in Canada.

Primary care and family medicine research

The Institute of Medicine defines Comparative Effectiveness Research (CER) as “the generation and synthesis of evidence comparing the benefits and harms of alternative methods to prevent, diagnose treat and monitor clinical conditions or to improve the delivery of care. Its purpose is to assist consumers, clinicians, purchasers, and policy makers to make informed decisions that will improve health care at both the individual and population levels.”⁵¹ CER, as described by the Institute of Medicine, is vital to the future of family practice and primary care, and points to a need for ongoing studies related to health outcomes of patients and populations and the effectiveness of different service delivery strategies.

In Canada, the Canadian Primary Healthcare Research Network and the commitment of the Canadian Institutes for Health Research’s (CIHR’s) “Strategy for Patient-Oriented Research” (SPOR) are vitally important.⁵² The focus on supporting patient-oriented research carried out in community primary care settings is consistent with the priorities of the PMH initiative. Competitions for research grants such as those announced by SPOR should be strongly encouraged and supported.

Family practices that function as PMHs can potentially serve as ideal laboratories for studies that embrace the principles of CER and the priorities defined by the Canadian Primary Healthcare Research Network and CIHR’s SPOR project. They will provide excellent settings for multisite research initiatives, including projects like those currently being undertaken by CPCSSN—a nationwide network of family physicians conducting surveillance of various

chronic diseases. These physicians utilize EMRs in their practices, enabling them to gather information from patients with specific chronic diseases (eg, hypertension, strokes) in communities across the country. Family physicians and the other health professionals working together with them on the PMH team should be encouraged and supported to participate in research activities. They should also mentor and stimulate medical students and residents who are training with them to take part in these projects. PMH groups should be competing aggressively for research grants (such as those being offered by the CIHR's SPOR), which provide opportunities to study the effectiveness of family practice/primary care in improving health outcomes and enhancing patients' health care experiences.

RECOMMENDATIONS

- 8.1: Patients' Medical Homes should be identified and supported by medical and other health profession schools as prime locations for the experiential training of their students and residents.
- 8.2: Patients' Medical Homes should teach and model their core defining elements including patient-centred care, teams/networks, EMRs, timely access to appointments, comprehensive continuing care, management of undifferentiated and complex problems, coordination of care, practice-based research, and continuous quality improvement.
- 8.3: Patients' Medical Homes should provide a training environment for family medicine residents that models and enables residents to achieve the objectives of the Triple C Competency-based Family Medicine Curriculum, the Four Principles of Family Medicine, and the CanMEDS—Family Medicine (CanMEDS-FM) Roles.
- 8.4: Patients' Medical Homes should be identified as optimal sites for training experiences for residents in all medical specialties.
- 8.5: Sufficient system funding and resources must be provided to ensure that teaching faculty and facility requirements will be met by every Patient's Medical Home teaching site.
- 8.6: Patients' Medical Homes should encourage and support their physicians, other health professionals, students, and residents to participate in research carried out in their practice settings.
- 8.7: Patients' Medical Homes should function as ideal sites for community-based research focused on patient health outcomes and the effectiveness of care and services.
- 8.8: Competitions for research grants relevant to primary care and family practice such as the Canadian Institutes of Health Research's Strategy for Patient-Oriented Research should be strongly supported.
- 8.9: Family physicians and other health professionals in Patient's Medical Home practices should be encouraged and supported to compete aggressively for research grants to study the effectiveness of the services they provide.

Evaluation

GOAL 9

A Patient's Medical Home will carry out ongoing evaluation of the effectiveness of its services as part of its commitment to continuous quality improvement (CQI).

Every PMH should be committed to a CQI program. Ongoing monitoring of the effectiveness of its services, the health outcomes of its patients, and the satisfaction of both patients and the health professionals and providers on the team should be carried out with the objective of addressing deficiencies and improving outcomes. The indicators selected should be appropriate to each practice and community setting and the CQI process could be introduced as a practice self-monitoring improvement program or as an assessment carried out by an external group. While possible using traditional hard-copy patient records, monitoring clinical indicators to assess the quality of care is most effective when EMRs are used to standardize data collection. The CQI process in each practice, including the indicators defined, the assessment process followed, the analysis and review of the results, and the recommendations arising from the process should be overseen by a group that includes representatives of all the key players involved in the practice: the family physician(s), other health professional members of the PMH team, and the patients.

As part of its CQI activity, a PMH team should track its patients' health outcomes, the processes of care being carried out in the practice, such as those related to timely access and patient safety, and patients' and PMH team members' satisfaction with the practice. According to Snyder et al, high-quality care should "... identify excellent comprehensive care. [It] must recognize successful management of multiple complex chronic conditions, meeting the counseling and communications needs of patients, and providing continuity of care and other attributes of comprehensive care. All measures must sustain and enhance appropriate patient care and the patient–physician relationship."⁵³ Quality should also be understood to mean the care that the medical home provides for patients both during and between visits.^{54(p788)}

Indicators are now being introduced to help evaluate quality of care in many primary care models in Canada and around the world. In some jurisdictions, funding support for practices from health system and private payers is being tied to achieving targets related to the indicators being followed, including those that provide evidence for the delivery of more cost-effective care and better health outcomes. Some provinces in Canada have begun to link financial incentives to clinical outcomes and targets that have been achieved ("pay for performance" models). Although there may be some benefits derived by this approach, there can also be risks if funding incentives and resource supports become overly focused on patients with certain medical problems or on those who have greater potential to reach prescribed targets, while at the same time care is being delayed or denied for others.

As indicated in the Comprehensive Care section (Goal 5), clinical practice guidelines and performance indicators as currently developed may be most beneficial and most relevant in the care of patients with isolated medical problems. Most patient care in Canada takes place in

Quality in Family Practice Project

McMaster University in Hamilton, Ontario, initiated the Quality in Family Practice Project. The program's aim is to implement a comprehensive and integrated CQI program in Ontario that promotes and celebrates excellence in family practice. The Quality project is designed to recommend an interdisciplinary assessment tool for use by family practices.

primary care and family practice settings, where significant proportions of patients—particularly the elderly and those with chronic diseases—present with multiple comorbidities. To be relevant to the populations in these settings, clinical practice guidelines and performance indicators must be developed to be applicable to patients with comorbidities and complex medical presentations.

The objectives, goals, and recommendations that define a PMH could be used to develop the quality indicators for CQI initiatives in family practices across Canada. These criteria could be augmented

by indicators being developed and recommended by organizations such as Accreditation Canada, Health Quality Ontario, and the Patient Centered Medical Home model in the United States (see Appendix D for further information). The CFPC is committed to collaborating with these other groups to further develop the CQI process for PMHs and family practices across Canada. We recommend that there be annual, national, multi-stakeholder forums to evaluate the effectiveness of PMHs. These forums would provide an opportunity for ongoing feedback regarding the progress and challenges faced by those involved in PMH family practices across Canada and would contribute to the development of CQI indicators that can be used by PMHs throughout the country. The forum would include representatives of the key stakeholders in PMH initiatives: family physicians, other health professionals, other organizations focused on quality and safety in family practice, governments, and patients.

RECOMMENDATIONS

- 9.1: Patients' Medical Homes should establish CQI programs that evaluate the quality and cost effectiveness of the services they provide and the satisfaction of their patients and providers.
- 9.2: Indicators should be defined to help guide the CQI activity of Patients' Medical Homes, based on the objectives, goals, and recommendations in this document, and other published quality indicators for family practice.
- 9.3: To ensure relevance for the populations being cared for in primary care/family practice settings, clinical practice guidelines and performance indicators must be applicable to patients with comorbidities and complex medical presentations.
- 9.4: All members of the health professional team, as well as trainees and patients, should participate in the CQI activity carried out in each Patient's Medical Home.
- 9.5: Annual national multi-stakeholder forums should be held to monitor and evaluate the effectiveness of Patient's Medical Home initiatives across Canada.

System Supports

GOAL 10

Patients' Medical Homes will be strongly supported i) internally, through governance and management structures defined by each practice and ii) externally by all stakeholders, including governments, the public, and other medical and health professions and their organizations across Canada.

i) Practice governance and management

Effective practice governance is essential to ensuring an integrated process of planning, coordination, implementation, and evaluation.⁵⁵ How governance models should be applied in each jurisdiction or practice depends on many variables and should be tailored to fit each setting. Practice governance should lay the framework for building and maintaining team relationships, carrying out strategic planning and financial management, determining and improving outcomes, establishing accountability, managing risks, ensuring a dispute resolution process, and setting parameters for administrative functionality.⁵⁶

Every PMH practice should clearly define its governance and administrative management structure and functions, and clearly identify those responsible for each function. While the complexity will vary depending on the size of each practice, the number of members on the health professional team, and the needs of the population being served, every PMH should have an organizational plan in place. From a governance perspective, policies and procedures should be developed and regularly reviewed and updated, especially in larger practices. These policies and procedures will offer guidance in areas such as organization of clinical services, appointment/booking systems, information management, facilities, equipment and supplies, human resources, defining PMH team members' clinical and administrative/management roles and responsibilities, budget and finances, legal and liability issues, patient and provider safety, and CQI.

Case Study: Family Practice Partnership

The Vancouver Division of Family Practice in British Columbia is a collaborative approach to care through a partnership between the Family Physicians of Vancouver, the General Practice Services Committee, Vancouver Coastal Health Authority, the Ministry of Health Services, Health System Planning Division and the British Columbia Medical Association (collectively referred to as the "Partners"). The Division of Family Practice was developed in response to requests from family physicians and the public for improved access to the benefits of primary care, quality improvement, practice enhancement, and greater confidence in the health care system. The Division of Family Practice does not duplicate the roles and responsibilities of the Health Authority, but provides formal family practice clinical influence and leadership at the community, regional, and provincial level.⁵⁵

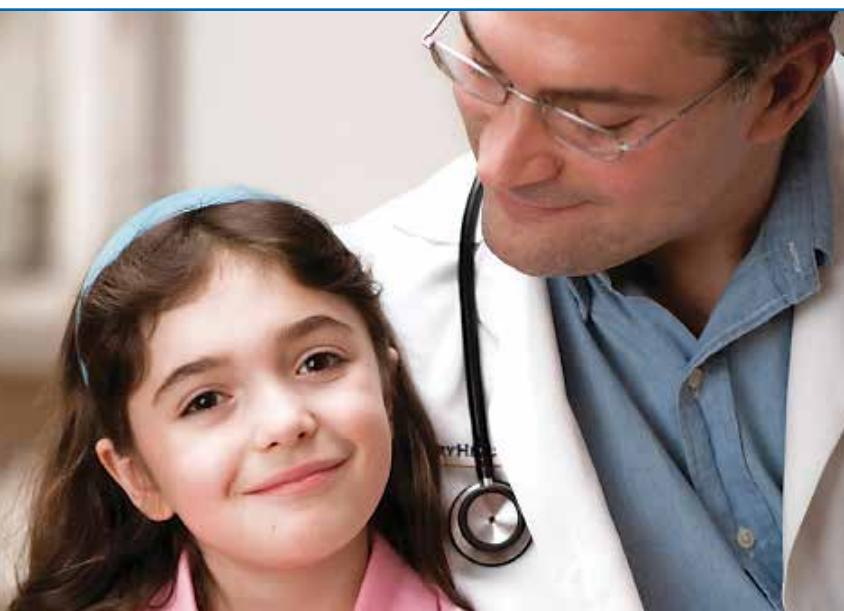
Source: Thompson Region Division of Family Practice. 2010 Annual Report

While each patient's family physician should be the most responsible provider for his or her ongoing medical care, clinical services at a given visit will also be provided by other team members within their regulated professional scope of practice and in keeping with their personally-demonstrated competencies. These clinical roles and responsibilities, as well as the governance and administrative/management responsibilities will vary from one setting to the next and should be determined by those responsible for the oversight of each PMH practice. Whatever is decided should be clearly described in the policies and procedures guiding each PMH. Leadership development programs should be offered to those who will be assuming the governance, administrative, and management roles in the PMH.

Every PMH should also include opportunities for patient input and participation in the planning and ongoing evaluation of the services offered by the practice.

In addition to the essential guidance provided by the governance and administrative structures within each PMH practice, additional benefits may accrue from collaboration with

practices throughout a community or region. The Vancouver Division of Family Practice is such a venture that, among other things, has the potential to offer peer support in the development of new models or strategies in family practice, carry out collaborative physician and health human resource planning, identify and respond to access problems and health care needs of the community,



and evaluate the health outcomes of the population being served.

ii) Stakeholder support

The vision of every family practice in Canada becoming a PMH will only be achievable with the participation and support of the many stakeholders throughout the system. This includes family physicians; the other health professionals who will play critical roles on the PMH teams organizing and providing care for patients both within the practices and via networks linked to them throughout the community or region; the federal, provincial, and territorial governments; and most importantly, Canadians themselves—the people being served—who must understand and support this vision.

To achieve their objectives, PMHs will need the support of governments across Canada through leadership messaging and the provision of adequate funding and other resources.

This must include the assurance of funding to support all members of the PMH team and their clinical, research, and administrative responsibilities. There must also be support for core practice components such as EMRs, patient-centred practice strategies such as group visits, and electronic communications between patients and health professionals. The system must also ensure that all health professionals on the PMH team have appropriate liability protection and that adequate resources are provided to ensure that each PMH practice can provide an optimal setting for teaching students and residents and for conducting practice-based research.

The sustainability of Canada's health care system depends on ensuring a strong primary care and family practice foundation. Future funding for health care, in particular from the federal government through federal, provincial, and territorial agreements, must be sustained for at least another decade beyond the end of the current accord in 2014. Unlike past agreements, these health care funding agreements must include clear accountability provisions with the requirement that each jurisdiction eligible to receive funds must meet explicitly defined targets. These agreements must maintain or increase the commitments to primary care and family practice, as well as to illness and injury prevention, population health, EMRs, home care, and pharmacare, each of which are vital to PMH's achieving their commitments to being patient centered and offering comprehensive continuing care. As Commissioner Roy Romanow commented when releasing the final report of the Commission of the Future of Health Care in Canada, "The new money that I propose investing in health care is to stabilize the system over the short-term, and to buy enduring change over the long-term. I cannot say often enough: that the status quo is not an option."⁵⁷

Investing in well-supported family practices that function as PMHs could lead to lower costs and better health outcomes. Hollander et al demonstrated the potential for this benefit in their report related to patients with chronic diseases (diabetes and congestive heart failure).¹⁹ In the United States, it was found that through significant investment in Patient-Centered Medical Homes, the costs were recouped within the first year by shifting patient utilization patterns, particularly away from use of emergency care.⁵⁸ Those with continuity of care provided in a primary care practice by their own family physicians were associated with reduced hospitalization rates and overall lower costs to the system. Starfield et al also found that consistency of provider/continuity of care has potential benefit for all patient populations, including those with chronic diseases.¹² As is emphasized in the CMA and Canadian Nurses Association's Healthcare Transformation Project, while fiscal responsibility is important, the ultimate goal for Canada is to achieve timely access to health services and the best possible health outcomes. If appropriately supported, PMHs can help achieve this by serving as central hubs enabling access to and coordination of all the medical services needed by the populations they serve, thus strengthening the vital primary care foundation of our health care system.

Physician remuneration

In 1994, a group of family medicine leaders proposed a blended payment model (including capitation, fee-for-service, and targeted incentive bonuses) as an approach for the remuneration of family physicians.^{59,60} In 2001, the Canadian Health Services Research Foundation (CHSRF) commissioned a team of researchers to create a policy synthesis on

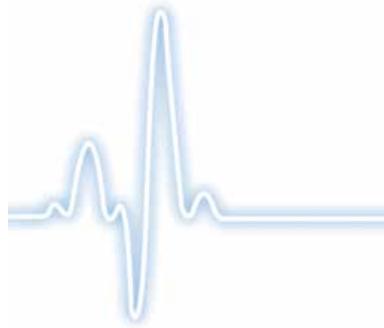
primary health care. Their report recommends that sessional payments for physicians should be promoted, or a blended model of capitation, sessional payment, and/or fee-for-service.⁶¹

Experience accumulating through new models of family practice, such as Family Health Teams in Ontario, suggests that, where available, blended funding models are emerging as the preferred approach to pay family physicians. Ongoing research is needed to determine the impact of this method of remuneration on meeting targets for access to care, patient and population health outcomes, and patient and physician satisfaction. PMH practices could serve as excellent laboratories to study the impacts and cost-effectiveness of blended funding or other physician payment strategies. Appropriate remuneration must be in place not only for family physicians but for all members of the PMH team.

RECOMMENDATIONS

- 10.1: Governance, administrative, and management roles and responsibilities should be clearly defined and supported in each Patient's Medical Home.
- 10.2: The individuals responsible for assuming and carrying out the governance, administrative, and management roles and responsibilities will vary from one Patient's Medical Home to another and should be determined by the stakeholders involved in each practice.
- 10.3: Leadership development programs should be offered for those assuming the governance, administrative, and management roles in each Patient's Medical Home.
- 10.4: Sufficient system funding must be available to support Patients' Medical Homes, including the clinical, teaching, research, and administrative roles of all members of Patient's Medical Home teams.
- 10.5: Blended payment models should be introduced in every province/territory as a preferred option for remunerating family physicians in practices functioning as Patients' Medical Homes.
- 10.6: Research evaluating the impact and effectiveness of different physician payment models on access to care, patient health outcomes, and patient and provider satisfaction should be ongoing.
- 10.7: Governments, the public, family physicians, and other medical and health professions and their organizations, should support and participate in establishing and sustaining Patients' Medical Homes across Canada.
- 10.8: Future federal/provincial/territorial health care funding agreements must include clear accountability provisions with a requirement that each jurisdiction eligible to receive funds must meet explicitly defined targets, including those related to primary care and comprehensive family practice.
- 10.9: Future federal/provincial/territorial agreements must include commitments to primary care/family practice/Patient's Medical Home priorities including illness and injury prevention, population health, EMRs, home care, and pharmacare.
- 10.10: The current federal/provincial/territorial Health Accord, which expires in 2014, must be extended for at least another decade.

Conclusion



Family Practice: The Patient’s Medical Home is presented to the people of Canada as a vision—a vision of the future of family practice, a vision for better patient-centred care and better health outcomes.

The Patient’s Medical Home recognizes both the changing needs of the people of Canada and the evolution that is unfolding in the way family physicians and other health professionals care for them. It is focused on enhancing patient-centredness through the collaborative roles of each patient’s family physician and a team of health professionals. The PMH is intended to build on the longstanding historical contribution of family physicians and other health providers to the health and well-being of Canadians, as well as on the recent models of family practice and primary care that are being introduced across the country. It is not intended to replace these emerging programs, but rather to add to and strengthen them. The PMH presents an opportunity for these different models of family practice currently in place or being introduced across Canada to incorporate the best of all experiences into their individual realms, while remaining focused on the unique needs that each must address within its own province, territory, and community.

Importantly, this vision provides goals and recommendations that can serve as indicators, enabling patients, family physicians, other health professionals, researchers, payers, health planners, and policy makers to evaluate the effectiveness of any and all models of family practice throughout Canada. Those family practices that meet the goals and recommendations described in this vision will have become PMHs. Every family practice across Canada should be supported and encouraged to achieve this objective. Every person in Canada seeking the best possible care for themselves and their loved ones deserves to see this vision fulfilled.





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Appendix A

Family Practice/Primary Care Medical Home Models in Canada

British Columbia – Integrated Health Network (IHN)

<http://www.primaryhealthcarebc.ca/phc/> (general, doesn't discuss teams as such)
http://www.viha.ca/phc_cdm/phc_cdm_prog/ihn.htm (sample, Victoria Island)

Alberta – Primary Care Network (PCN)

<http://www.albertapci.ca/Pages/default.aspx>

Saskatchewan – Primary Health Care Network and Teams

<http://www.health.gov.sk.ca/primary-health-care-networks-and-teams>
http://www.healthcouncilcanada.ca/docs/rpts/2009/TeamsInAction_Saskatchewan_Summary.pdf

Manitoba – Physician Integrated Network (PIN)

<http://www.gov.mb.ca/health/phc/pin/index.html>

Ontario – Family Health Teams

http://www.health.gov.on.ca/transformation/fht/fht_mn.html

Quebec – Family Medicine Group, Groupe de médecine de famille

<http://www.msss.gouv.qc.ca/en/sujets/organisation/gmf.php> (English)
<http://www.msss.gouv.qc.ca/index.php> (French)

New Brunswick – Family Health Centres

<http://www.gnb.ca/0051/0053/chc-e.asp>
http://www.healthcouncilcanada.ca/docs/rpts/2009/TeamsInAction_NewBrunswick_Summary.pdf

Nova Scotia – Primary Care Teams

http://www.healthcouncilcanada.ca/docs/rpts/2009/TeamsInAction_NovaScotia_Summary.pdf
<http://www.healthteamnovascotia.ca/>

Prince Edward Island – Family Health Care Teams

<http://www.gov.pe.ca/health/index.php3?number=1020492&lang=E>

Newfoundland and Labrador – Primary Care Teams

http://www.healthcouncilcanada.ca/docs/rpts/2009/TeamsInAction_Newfoundland_Summary.pdf

Yukon

http://www.healthcouncilcanada.ca/docs/rpts/2009/TeamsInAction_Yukon_Summary.pdf

Northwest Territories

http://www.healthcouncilcanada.ca/docs/rpts/2009/TeamsInAction_NorthwestTerritories_Summary.pdf

Nunavut

http://www.healthcouncilcanada.ca/docs/rpts/2009/TeamsInAction_Nunavut_Summary.pdf



Appendix B

Consultation on the Discussion Paper

In a 2009 discussion paper, the CFPC defined a PMH as a patient-centred medical care setting in which 1) patients have personal family physicians who provide and direct their medical care; 2) care is for the patient as a whole; 3) care is coordinated, continuous, and comprehensive with patients having access to an interprofessional team; 4) there is enhanced access for appointments; 5) the practice includes well-supported information technology including EMRs; 6) remuneration supports the model of care; and 7) quality improvement and patient safety are key objectives.

Following the release of that discussion paper, feedback was received from over 170 individuals and organizations—a broad audience that included family physicians (CFPC members and non-members), public members, family medicine and primary care researchers, sister medical and health care organizations, regulatory bodies, federal and provincial/territorial governments, and members of the public.

An extensive summary document, including the above feedback, was prepared and reviewed by the CFPC's Working Group on the Medical Home (reporting to the CFPC's Advisory Committee on Family Practice). The summary document was then the focus of a CFPC Leader's Forum on the Medical Home held in April 2010, where forum participants further refined comments and provided direction for this Vision Paper.

The draft of this Vision Paper was reviewed for feedback within the CFPC as well as with representatives of patient and selected peer health professional groups.

Appendix C



Provincial Coordinating Committee on Community and Academic Health Science Centre Relations (PCCCCAR) Model

Principle I: The physician-patient relationship is essential

- Advocacy for the patient in the system
- Primary mental health care including psychosocial counselling
- Support for the terminally ill

Principle II: The family physician is a competent clinician

- Appropriate interventions for episodic illness and injury
- Primary reproductive care
- Diagnosis and initial and ongoing treatment of chronic illnesses
- Care of the majority of illnesses (in conjunction with consultants, if required)
- Supportive care in hospital, in home and in community care facilities

Principle III: The family physician is a resource to the practice population

- Health assessments
- Clinical evidence-based health promotion and illness prevention
- Education and support for self-care

Principle IV: The family physician is community based

- Arrangement for 24-hour, 7-days a week response for urgent problems
- Service coordination and referral
- Coordination and access to rehabilitation



Appendix D

Examples of Community Primary Care/ Family Practice Quality Improvement Indicators

Accreditation Canada (AC) is a not-for-profit, independent organization accredited by the International Society for Quality in Health Care (ISQua). AC provides national and international health care organizations with an external peer-review process to assess and improve the services they provide to their patients and clients based on standards of excellence. AC's recently developed standards for primary care service can be found at <http://www.accreditation.ca/accreditation-programs/qmentum/standards/primary-care-services-standards/>.

The Patient-Centered Medical Home care model in the United States was developed and is being led by the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association. In addition, the Patient-Centered Primary Care Collaborative (PCPCC), a coalition of over 260 patient advocate groups, major employers, health plans, and physician membership organizations, has joined to advance the Patient-Centered Medical Home. Included in their work was the development of the Patient-Centered Medical Home Checklist which can be found at http://www.aafp.org/online/etc/medialib/aafp_org/documents/membership/pcmh/checklist.Par.0001.File.tmp/PCMHChecklist.pdf.

Health Quality Ontario (HQO)** coordinates, consolidates, and strengthens the use of evidence-based practice initiatives and technologies; supports continuous quality improvement; and continues to monitor and publicly report on health system outcomes. HQO's mandate includes recommending evidence informed care, providing continuous support for the adoption of standards of care among health care providers, and monitoring and reporting on health system performance. HQO's primary care quality improvement initiatives can be found at http://www.qiip.ca/quality_improvement.php and <http://www.qiip.ca/qualityinplc.php>. HQO's Tools for Quality Improvement (QI) teams can be found at http://www.ohqc.ca/en/qi_teams.php.

**On April 1, 2011, HQO joined together the Ontario Health Quality Council (OHQC) and the Quality Improvement and Innovation Partnership (QIIP) with the goal to support more efficient, patient-centred care.

Resources/Additional Reading

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