SUMMARY OF A NEW VISION FOR CANADA

FAMILY PRACTICE– THE PATIENT'S MEDICAL HOME 2019

THE COLLEGE OF FAMILY PHYSICIANS OF CANADA
LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA

PATIENT'S MEDICAL HOME

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The CFPC acknowledges endorsements of PMH 2019 by several organizations, including:

Canada Health Infoway

Canadian Association of Social Workers

Canadian Family Practice Nurses Association

Canadian Home Care Association

Canadian Medical Association

Canadian Nurses Association

Canadian Public Health Association

Royal College of Physicians and Surgeons

Working for Change

For a complete list of endorsements, please visit the **Patient's Medical Home** website.

INTRODUCTION

The evolving needs of patients and their communities place ever-changing demands on the health care system to maintain and improve the quality of services provided. Changing population demographics, increasing complexity, and new technology make for a dynamic system. Family physicians are at the heart of the health care system, acting as the first point of contact and a reliable medical resource to the communities they serve, caring for patients and supporting them throughout all interactions with the health care system. The Patient's Medical Home (PMH) is a vision that emphasizes the role of the family practice and family physicians in providing high-quality, compassionate and timely care.

The success of a PMH depends on collaboration and teamwork—from the patient's participation in their care, to interprofessional and intraprofessional care providers working together, to policy-makers who can offer infrastructure support and funding. This vision paper was created with invaluable feedback from a broad range of stakeholders reflective of such a joint approach. Its goal is to make the PMH a reality for patients and providers across Canada.

In 2011 the College of Family Physicians of Canada (CFPC) released ***A Vision for Canada: Family Practice – The Patient's Medical Home***. It outlined a vision for the future of primary care by transforming the health care system to better meet the needs everyone living in Canada. The vision outlined the 10 pillars that make up the PMH and provided detailed recommendations to assist family physicians and their teams, as well as policy-makers and health care system administrators, to implement this new model across the country.

PURPOSE OF THIS DOCUMENT

PMH 2019 outlines 10 revised pillars that make up a PMH. Key attributes are defined and explained for each pillar. Supporting research is provided to demonstrate the evidence base for each attribute. This document is intended to support family physicians currently working in a PMH to better align their practice with the PMH pillars, or assist those practices looking to transition to a PMH model. Furthermore, this document can guide governments, policy-makers, other health care professionals, and patients on how to structure a primary health care system that is best-suited to meet the needs of Canadians.

Many resources for the PMH have been developed and will continue to be available. These include practical **Best Advice guides** on a range of topics and the **self-assessment tool** that can help quantify a practice's progress toward PMH alignment. Moving forward, additional materials that address the new themes identified in the revised vision and tools to support physicians in the transition to PMH structures—for example, the PMH Implementation Kit—will be available at **patientsmedicalhome.ca**.

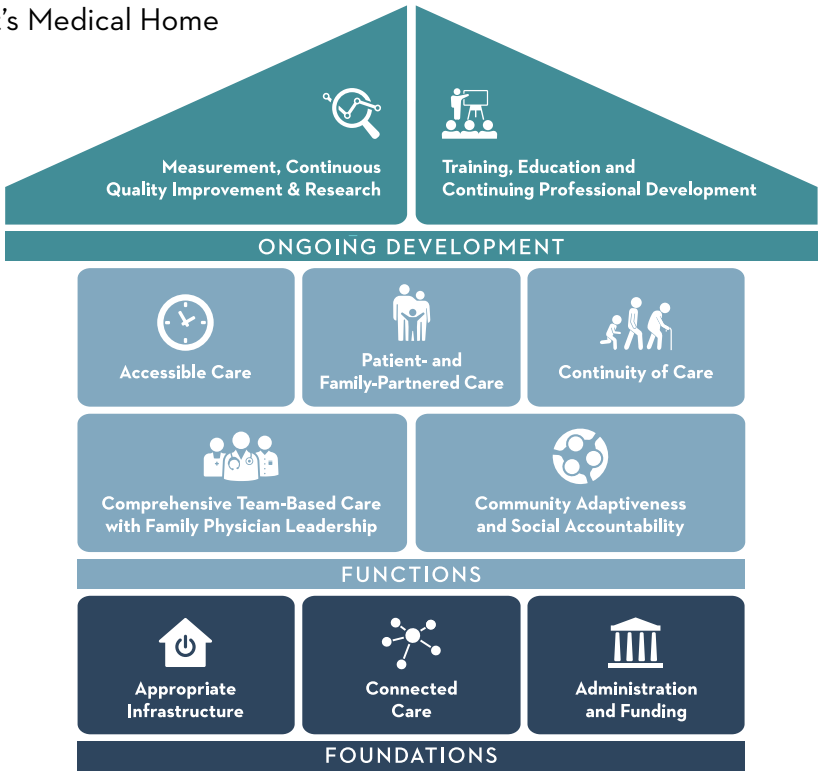
What is a Patient's Medical Home?

The PMH is a family practice defined by its patients as the place they feel most comfortable presenting and discussing their personal and family health and medical concerns. The PMH can be broken down into three themes: Foundations, Functions, and Ongoing Development (see **Table 1**).

Table 1. 10 Pillars of the revised PMH vision

THEME	PILLAR
Foundations	1. Administration and Funding 2. Appropriate Infrastructure 3. Connected Care
Functions	4. Accessible Care 5. Community Adaptiveness and Social Accountability 6. Comprehensive Team-Based Care with Family Physician Leadership 7. Continuity of Care 8. Patient- and Family-Partnered Care
Ongoing Development	9. Measurement, Continuous Quality Improvement, and Research 10. Training, Education, and Continuing Professional Development

Figure 1. The Patient's Medical Home



FOUNDATIONS

PMH foundations are the underlying, supporting structures that enable a practice to exist, and facilitate providing each PMH function. Without a strong foundation, the PMH cannot successfully provide high-quality, patient-centred care. The foundations are Administration and Funding (includes financial and governmental support and strong governance, leadership, and management), Appropriate Infrastructure (includes physical space, human resources, and electronic records and other digital supports), and Connected Care (practice integration with other care settings enabled by health IT).

Pillar 1: Administration and Funding

Practices need staff and financial support, advocacy, governance, leadership, and management in order to function as part of the community and deliver exceptional care.	
1.1	Governance, administrative, and management roles and responsibilities are clearly defined and supported in each PMH.
1.2	Sufficient system funding is available to support PMHs, including the clinical, teaching, research, and administrative roles of all members of PMH teams.
1.3	Blended remuneration models that best support team-based, patient-partnered care in a PMH should be considered to incentivize the desired approach.
1.4	Future federal/provincial/territorial health care funding agreements provide appropriate funding mechanisms that support PMH priorities, including preventive care, population health, electronic records, community-based care, and access to medications, social services, and appropriate specialist and acute care.

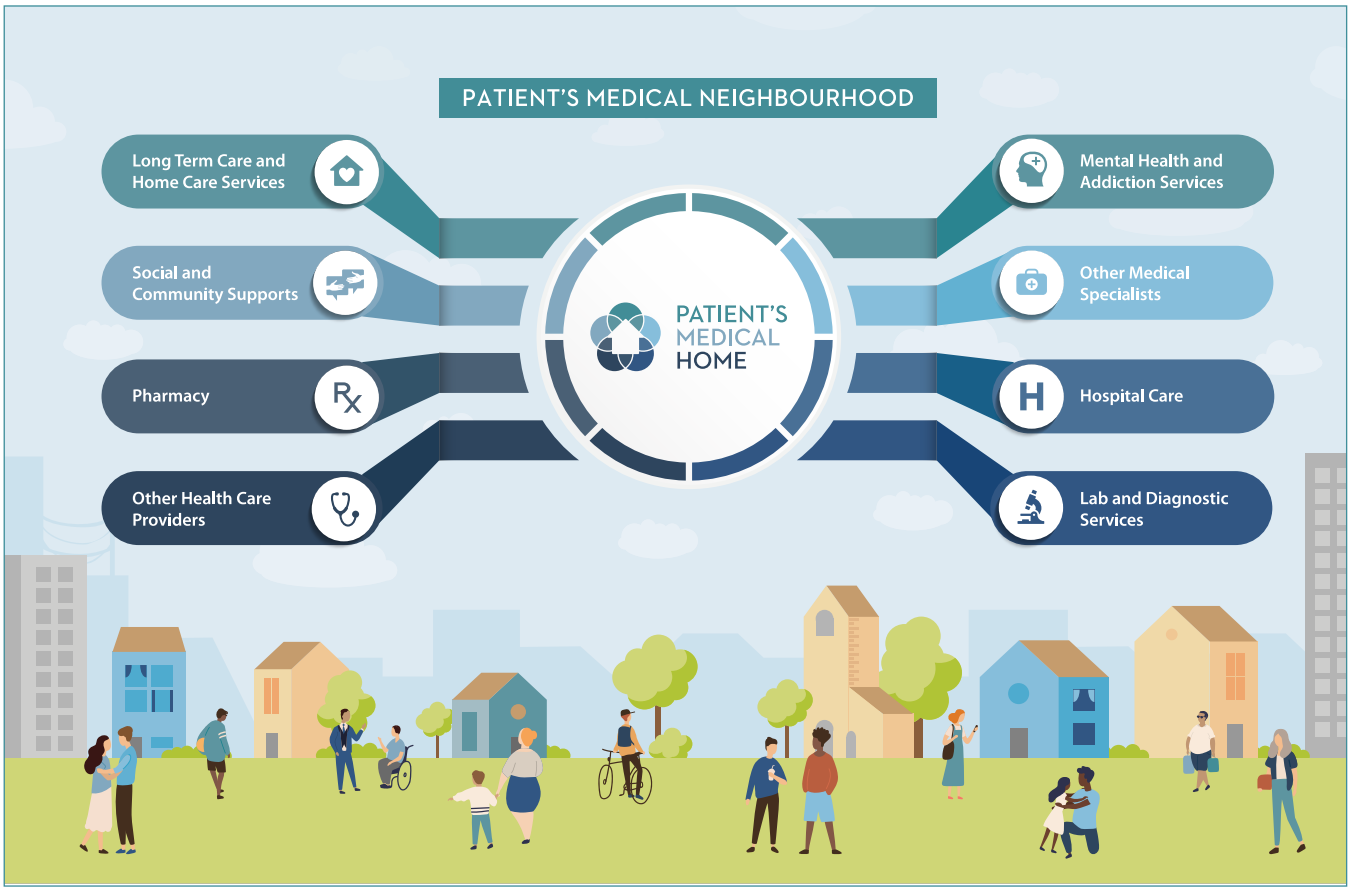
Pillar 2: Appropriate Infrastructure

Physical space, staffing, electronic records and other digital supports, equipment, and virtual networks facilitate the delivery of timely, accessible, and comprehensive care.	
2.2	EMR products intended for use in PMHs are identified and approved by a centralized process that includes family physicians and other health care professionals. Practices are able to select an EMR product from a list of regionally approved vendors.
	EMRs approved for PMHs will include appropriate standards for managing patient care in a primary care setting; e-prescribing capacity; clinical decision support programs; e-referral and consultation tools; e-scheduling tools that support advanced access; and systems that support data analytics, teaching, research, evaluation, and CQI.
2.4	Electronic records used in a PMH are interconnected, user-friendly, and interoperable.
	Co-located PMH practices are in physical spaces that are accessible and set up to support collaboration and interaction between team members.
2.6	A PMH has the appropriate staff to provide timely access (e.g., having physician assistants and/or registered nurses to meet PMH goals).
2.8	Sufficient system funding and resources are provided to ensure that teaching faculty and facility requirements will be met by every PMH teaching site.

Pillar 3: Connected Care

Practice integration with other care settings and services, a process enabled by integrating health information technology.	
3.1	A PMH is connected with the health and social services available in the community for patient referrals.
3.2	Defined links are established between the PMH and other medical specialists, and medical care services in the local or nearest community to ensure timely referrals.
3.3	The PMH serves as a hub for collecting and sharing relevant patient information through information technology. It ensures the continuity of patient information received throughout the medical and social service settings.

Figure 2. The Patient's Medical Neighbourhood



FUNCTIONS

The functions describe the heart of the PMH and the care provided by PMH practices. These are the key elements that differentiate a PMH from other forms of primary care. A PMH offers: Accessible Care; Community Adaptiveness and Social Accountability; Comprehensive Team-Based Care with Family Physician Leadership; Continuity of Care; and Patient- and Family-Partnered Care.

ACCESSIBLE CARE
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COMMUNITY ADAPTIVENESS & SOCIAL ACCOUNTABILITY
PAGE 7 ►

COMPREHENSIVE TEAM-BASED CARE WITH FAMILY PHYSICIAN LEADERSHIP
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CONTINUITY OF CARE
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PATIENT & FAMILY PARTNERED CARE
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Pillar 4: Accessible Care

By adopting advanced and timely access, virtual access, and team-based approaches, accessible care ensures that patients can be seen quickly.	
4.1	A PMH ensures patients have access to medical advice, and information on available care options 24 hours a day, 7 days a week, 365 days a year.
4.2	Every patient is registered with a PMH.
4.3	PMH practices offer scheduling options that ensure timely access to appropriate care.
4.4	When the patient's personal family physician is unavailable, appointments are made with another physician, nurse, or other qualified health professional member of the PMH team.
4.5	Patients are able to participate in planning and evaluation of their medical home's appointment booking system.
4.6	Panel sizes for providers in a PMH should be appropriate to ensure timely access to appointments and safe, high-quality care.

Pillar 5: Community Adaptiveness and Social Accountability

A PMH is accountable to its community, and meets their needs through interventions at the patient, practice, community, and policy level.	
5.1	PMHs strive to assess and address the social determinants of health (e.g., income, education, housing, immigration status) as relevant for the individual, community, and policy levels.
5.2	Panel size will consider the community's needs and patients' safety.
5.3	PMHs use data about marginalized/at-risk populations to tailor their care, programming, and advocacy to meet unique community needs.
5.4	Family doctors in the PMH act as health advocates at the individual, community, and policy levels, using the CanMEDs–Family Medicine (CanMEDS-FM) Framework as a guide to advocacy and are supported in doing so.
5.5	Family doctors and team members within the PMH provide care that is anti-oppressive and culturally safe, seeking to mitigate the experiences of discrimination faced by many patients based on their age, gender, race, class, sexual orientation, gender identity, ability, etc.

Pillar 6: Comprehensive Team-Based Care with Family Physician Leadership

A broad range of services is offered by an interprofessional team. The patient does not always see their family physician but interactions with all team members are communicated efficiently within a PMH. The team might not be co-located but the patient is always seen by a professional with relevant skills who can connect with a physician (ideally the patient's own personal physician) as necessary.

6.1	A PMH includes one or more family physicians, who are the most responsible provider for their own panel of registered patients.
6.2	Family physicians with enhanced skills, along with other medical specialists, are part of a PMH 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.
6.3	On-site, shared-care models to support timely medical consultations and continuity of care are encouraged and supported as part of each PMH.
6.4	The location and composition of a PMH's team is flexible, based on community needs and realities; team members may be co-located or may function as part of virtual networks.
6.5	The personal family physician and nurse with relevant qualifications form the core of PMH teams, with the roles of others (including but not limited to physician assistants, pharmacists, psychologists, social workers, physiotherapists, occupational therapists, dietitians, and chiropractors) encouraged and supported as needed.
6.6	Physicians, nurses, and other members of the PMH team are encouraged and supported in developing ongoing relationships with patients. Each care provider is recognized as a member of the patient's personal medical home team.
6.7	Nurses and other health professionals in a PMH team will provide services within their defined roles, professional scopes of practice, and personally acquired competencies. Their roles providing both episodic and ongoing care support and complement—but do not replace—those of the family physician.

Pillar 7: Continuity of Care

Patients live healthier, fuller lives when they receive care from a responsible provider who journeys with them and knows how their health changes over time.	
	The PMH enables and fosters long-term relationships between patients and the care team, thereby ensuring continuous care across the patient's lifespan.
7.2	PMH teams ensure continuity of care is 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.
	A PMH serves as the hub that ensures coordination and continuity of care related to all the medical services their patients receive throughout the medical community.

Pillar 8: Patient- and Family-Partnered Care

Family practices respond to the unique needs of patients and their families within the context of their environment.	
8.1	Care and care providers in a PMH are patient-focused and provide services that respond to patients' feelings, preferences, and expectations.
8.2	Patients, their families, and their personal caregivers are active participants in the shared-decision making process.
8.3	A PMH facilitates patients' access to their medical information through electronic medical records as agreed upon with their care team.
8.4	Self-managed care is encouraged and supported as part of the care plans for each patient.
8.5	Strategies that encourage access to a range of care options beyond the traditional office visits (e.g., telehealth, virtual care, mobile health units, e-consult, etc.) are incorporated into the PMH.
8.6	Patient participation and formalized feedback mechanisms (e.g., patient advisory councils, patient surveys) are part of ongoing planning and evaluation.

ONGOING DEVELOPMENT

Each PMH strives for ongoing development to better achieve the core functions. The PMH and its staff are committed to Measurement, Continuous Quality Improvement, and Research; and Training, Education, and Continuing Professional Development.

MEASUREMENT, CONTINUOUS QUALITY IMPROVEMENT, AND RESEARCH
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TRAINING, EDUCATION, AND CONTINUING PROFESSIONAL DEVELOPMENT
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Pillar 9: Measurement, Continuous Quality Improvement, and Research

Family practices strive for progress through performance measurement and CQI. Patient safety is always a focus, and new ideas are brought to the fore through patient engagement in QI and research activities.	
9.1	PMHs establish and support CQI programs that evaluate the quality and cost effectiveness of teams and the services they provide for patient and provider satisfaction.
9.2	Results from CQI are applied and used to enhance operations, services, and programs provided by the PMH.
9.3	All members of the health professional team (both clinical and support teams), as well as trainees and patients, will participate in the CQI activity carried out in each PMH.
9.4	PMHs support their physicians, other health professionals, students, and residents to initiate and participate in research carried out in their practice settings.
9.5	PMHs function as ideal sites for community-based research focused on patient health outcomes and the effectiveness of care and services.

Pillar 10: Training, Education, and Continuing Professional Development

Emphasis on training and education ensures that the knowledge and expertise of family physicians can be shared with the broader health care community, and also over time by creating learning organizations where both students and fully practising family physicians can stay at the forefront of best practice.	
10.1	PMHs are identified and supported by medical and other health professional schools as optimal locations for the experiential training of their students and residents.
10.2	PMHs teach and model their core defining elements including patient-partnered care, teams/networks, EMRs, timely access to appointments, comprehensive continuing care, management of undifferentiated and complex problems, coordination of care, practice-based research, and CQI.
10.3	PMHs provide a training environment for family medicine residents that models, and enables residents to achieve, the competencies as defined by the Triple C Competency-based Family Medicine Curriculum, the Four Principles of Family Medicine, and the CanMEDS-FM Roles.
10.4	PMHs will enable physicians and other health professionals to engage in continuing professional development (CPD) to meet the needs of their patients and their communities both individually and as a team.
10.5	PMHs enable family physicians to share their knowledge and expertise with the broader health care community.

CONCLUSION

The revised PMH vision of a high-functioning primary care system responds to the rapidly evolving health system and the changing needs of Canadians. The pillars and attributes described in this document can guide practices at various stages in the transition to a PMH model, and many characteristics are found in other foundational documents of family medicine such as the **Family Medicine Profile** and the **Four Principles of Family Medicine**. Supporting resources, such as the PMH Implementation Kit, are available to help those new to the transition overcome barriers to change. Although the core components of the PMH remain the same for all practices, each practice will implement the recommendations according to their unique needs.

Those family practices that meet the goals and recommendations described in this vision will have become PMHs, but the concept is ever evolving. As family physicians commit to making change in their practices, the CFPC commits to supporting developments in the PMH by creating and promoting new resources, which will be available through the **PMH website**. The CFPC will also play an important advocacy role to ensure that the necessary supports are in place to reach the goals of a PMH. Every family practice across Canada should be supported and encouraged by the public, governments, and other health care stakeholders (the pentagram partners: policy-makers—federal, provincial, territorial, and regional health authorities; health and education administrators; university; community; health professionals—physicians and teams) to achieve this objective. Doing so will ensure that every person in Canada is able to access the best possible primary care for themselves and their loved ones.

The CFPC acknowledges the endorsements of:

Canada Health Infoway

"We are proud to support the CFPC and its vision for the Patient's Medical Home," said Dr. Rashaad Bhyat, Clinician Leader, Canada Health Infoway. "Working together with patients, care providers and policy makers, the PMH principles can help deliver better primary care for Canadians and improve health outcomes."

Dr. Rashaad Bhyat, Clinician Leader, Canada Health Infoway

CASW ACTS
Canadian Association of Social Workers / Association canadienne des travailleuses et travailleurs sociaux

"Social workers are key members of Interprofessional teams and we strongly support tools that will continue building the momentum in adopting patient centred family practice teams."

Fred Phelps
Executive Director,
Canadian Association of Social Workers

CFPNA
Canadian Family Practice Nurses Association

"As a core member of the PMH team, Family Practice Nurses, are excited to use the Patient's Medical Home 2019 document as a guiding tool in designing and implementing effective and efficient patient services with our Family Physician colleagues."

Treena Klassen R.N., B.N., A.S.M.H., M.Ed
President, Canadian Family Practice Nurses Association

Canadian Home Care Association
canadienne de soins et services à domicile

"The updated vision of family practice in Canada aligns with the CHCA's harmonized principles for home care and sets a clear foundation for achieving patient- and family-centered care that is accessible, accountable, evidence-informed, integrated and sustainable. We strongly endorse the College of Family Physicians of Canada's Patient's Medical Home 2019 as an enabler to make this happen."

Nadine Henningsen, CEO
Canadian Home Care Association

Association médicale canadienne / Canadian Medical Association

"When it comes to taking concrete action on improving primary care in Canada, the Patient's Medical Home 2019 is a compelling roadmap for health decision makers, health professionals and patients. Physicians understand how the collaborative approach can have a real impact, ensuring efficiency along the way and this is why the CMA is pleased to endorse the 2019 vision."

Dr. Gigi Osler,
President
Canadian Medical Association

Canadian Nurses Association / Association des infirmières et infirmiers du Canada

"The Canadian Nurses Association supports the College of Family Physicians of Canada's Patient Medical Home (PMH) and its vision to strengthen, spread and broaden patient-partnered care in Canada. Nurses have a unique and integral role to play in advancing primary care through interprofessional and patient-partnered approaches - and the PMH goes a long way to promoting collaboration among patients and health care providers to respond to the evolving needs of patients and communities."

Mike Villeneuve, CEO
Canadian Nurses Association

Canadian Public Health Association / Association canadienne de santé publique

"The Patient's Medical Home 2019 is an important foundational piece in the transformation of the health care system to better meet the needs of Canadians. Its emphasis on intersectoral action on the social determinants of health is important in an age when bold action is required to meaningfully improve health status and also reduce the burden on our country's acute care system."

Dr. Richard Musto, Chair
Canadian Public Health Association

Royal College of Physicians and Surgeons of Canada / Collège royal des médecins et chirurgiens du Canada

"Collaboration between and among all specialists in Family Medicine and Royal College disciplines, allied health providers, patients and their care partners is critical to the successful delivery of healthcare that meets the needs and expectations of patients and communities in Canada. We strongly support the vision of the Patients' Medical Home in delivering comprehensive and timely care for all."

Andrew Padmos, BA, MD, FRCPC, FACP, FRCP,
Chief Executive Officer
Royal College of Physicians and Surgeons of Canada

WORKING FOR CHANGE
A HOME. A JOB. A FRIEND AND SOCIAL CHANGE

"Working for Change is pleased to endorse the Patient's Medical Home 2019 vision. The PMH vision describes the kind of care that Working for Change program participants need from their family physicians and other primary care providers. Care that is compassionate, accessible and connected. Care that is socially accountable and adaptive to the needs of our community. Care that partners with patients and their families."

Joyce Brown, Executive Director
Working for Change

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