



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

© 2019 The College of Family Physicians of Canada

All rights reserved. This material may be reproduced in full for educational, personal, and non-commercial use only,
with attribution provided according to the citation information below.
For all other uses permission must be acquired from the College of Family Physicians of Canada.

How to cite this document: College of Family Physicians of Canada.
A new vision for Canada: Family Practice—The Patient's Medical Home 2019.
Mississauga, ON: College of Family Physicians of Canada; 2019.

TABLE OF CONTENTS

INTRODUCTION	1
WHY A REVISED PMH?	1
PURPOSE OF THIS DOCUMENT	2
PROGRESS ON THE PMH TO DATE	4
FOUNDATIONS.....	6
Pillar 1: Administration and Funding.....	7
Pillar 2: Appropriate Infrastructure	9
Pillar 3: Connected Care	12
FUNCTIONS.....	14
Pillar 4: Accessible Care	15
Pillar 5: Community Adaptiveness and Social Accountability	17
Pillar 6: Comprehensive Team-Based Care with Family Physician Leadership ..	20
Pillar 7: Continuity of Care	23
Pillar 8: Patient- and Family-Partnered Care	25
ONGOING DEVELOPMENT.....	27
Pillar 9: Measurement, Continuous Quality Improvement, and Research.....	28
Pillar 10: Training, Education, and Continuing Professional Development	30
CONCLUSION.....	32
REFERENCES	33



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. PMH 2019 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*.¹ It outlined a vision for the future of primary care by transforming the health care system to better meet the needs of 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.

WHY A REVISED PMH?

Since 2011 many principles of the PMH vision have been embraced in primary care reforms. New models have been introduced across Canada (see Progress on the PMH to Date). To better reflect current realities, meet the evolving needs of family physicians and their teams, and support continued implementation of the PMH, the CFPC has developed this revised edition of the vision. It reflects evolving realities of primary care in Canada, including the rapid adoption of electronic medical records (EMRs)^{2,3} and a shift toward interprofessional practice structures.²

While progress has been made, there is still work to be done to fully achieve the PMH vision. In 2016 almost 75 per cent of Canadians rated the quality of care received from their family physicians as good or excellent.⁴ In 2017 a CFPC survey found that 79 per cent of respondents rate the care they receive from their family doctor as excellent or good.⁵ However, at the same time 55 per cent of Canadians also believed that the overall health care system still required fundamental changes.⁴ In addition, Canada continues to perform below the international average on certain aspects of patient-centred care; for example, same- or next-day access to appointments. While most Canadians (84.7 per cent) have a regular doctor or place of care, they generally report longer wait times for medical care than adults in

comparable countries.⁴ PMH 2019 addresses these concerns and proposes solutions that can help further improve the primary care system for all.

Although the specific components of the revised PMH have been updated (see What is the Patient's Medical Home?), the core principles remain the same. PMH 2019 focuses on providing high-quality, patient-centred, and comprehensive care to patients and their families during their lifetime. It embraces the critical role that family physicians and family practices play in the health care system, reflecting the fact that systems with strong primary health care deliver better health outcomes, enhance efficiency, and improve quality of care.⁶ PMH 2019 recognizes that a patient will not be able to see their personal family physician at every visit, but can rely on the PMH's qualified team of health professionals to provide the most appropriate care responding to patient needs with continuous support and leadership from family physicians. PMH 2019 highlights the central importance of community adaptiveness and social accountability in primary care with a new pillar. The importance of being responsive to community needs through engagement, and ensuring the provision of equitable, culturally safe, anti-oppressive practise that seeks to assess and intervene into social determinants of health (SDoH), is now more clearly featured.

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. 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 PMH 2019 and the 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 and Figure 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
Ongoing Development	8. Patient- and Family-Partnered Care
	9. Measurement, Continuous Quality Improvement, and Research
	10. Training, Education, and Continuing Professional Development

The three Foundation pillars are the supporting structures that facilitate the care provided by the PMH. All three aspects are required for the successful implementation and sustainability of a PMH.

The Functions are areas central to the operation of a family practice and consist of the five core PMH pillars. These principles govern the type of care provided by the PMH practices to ensure it is effective and efficient for meeting the needs of the patients, families, and communities they serve. The pillars in this section reflect the **Four Principles of Family Medicine**,⁷ which underlines the important place they take in the overall PMH 2019.

The pillars in Ongoing Development are essential to advancing the PMH vision. These areas make it possible for physicians to provide the best possible care for patients in various settings. Applying these pillars, the PMH will thrive through practising quality improvement (QI) principles to achieve the results necessary to meet the needs of their patients, their communities, and the broader health care community, now and in the future.

The PMH is a vision to which every practice can aspire. Many practices across Canada have already begun transitioning to a PMH, thanks to the dedication and leadership of family physicians and their teams across

the country. This vision is a resource for these practices as they engage in ongoing practice assessment and QI initiatives. It can also assist other stakeholders, including government planners, policy-makers, and funders to better understand what defines an effective patient-centred family practice. By involving patients in all stages of the development, evaluation, and continuous quality improvement (CQI) activities of the practice, the PMH can contribute significantly to furthering the goals of transformation to a patient-centred health care system.⁸

What the Patient’s Medical Home is Not

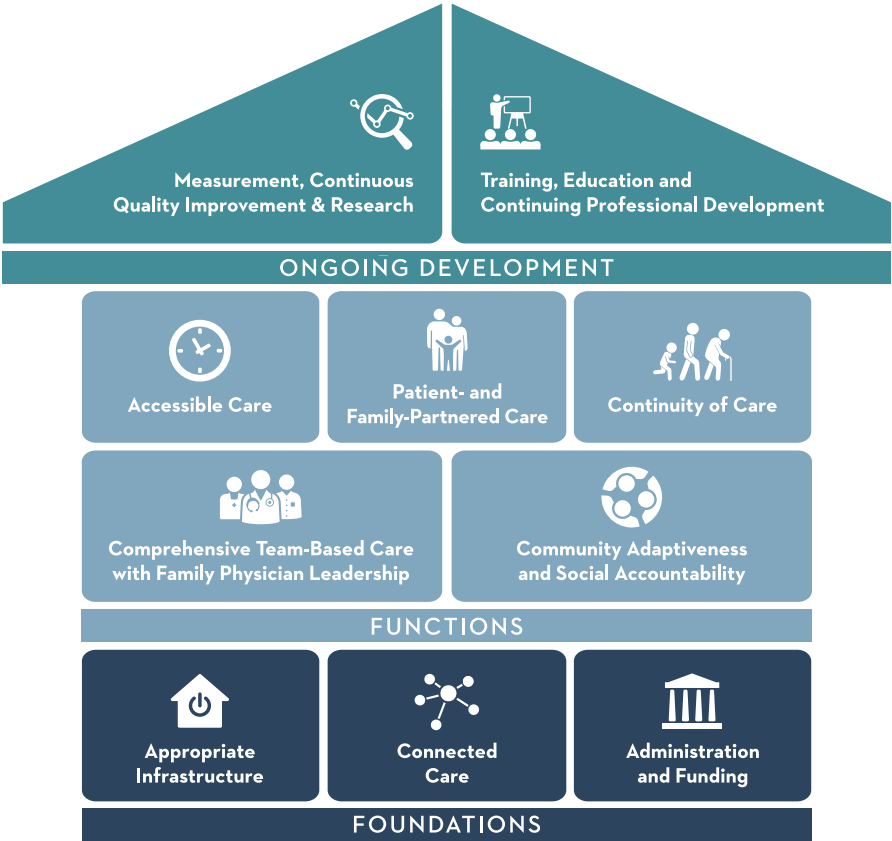
While it is important to understand what the PMH aspires to be, it is also important to highlight that it is not a one-size-fits-all solution. Solo practices in rural or remote settings or large group practices serving inner-city populations can align with PMH principles by incorporating strategies that match the realities of their unique settings. In fact, social accountability and community adaptiveness is an important new addition to the revised PMH vision to account for the need of

every family practice to adapt and respond to the needs of their patients and communities. What works for one practice will not work for all.

The PMH vision does not require that all practices be relocated or re-engineered, or that significant financial investments be made by physicians or other health care professionals. Instead, system level support and involvement is required to achieve the vision. The pillars and attributes listed in this document are signposts along the way to reform that aids practices on their journey.

It is important to note that this vision is not intended to undermine or change any exciting initiatives involving family practice currently under way across Canada (several of which already embrace and incorporate the medical home concept; see Progress on the PMH to Date). Rather, it is meant to build on and strengthen these efforts. The more that health care initiatives meet PMH objectives, the more likely it is that the overall goals of creating a patient-centred health care system throughout Canada will be realized.

Figure 1. The Patient’s Medical Home



PROGRESS ON THE PMH TO DATE

Since the release of the original PMH vision document, system-level change has occurred in almost all jurisdictions in Canada. More specifically, PMH-type practices are gaining traction in various provinces and currently exist in various stages of development.

The CFPC took a snapshot of PMH uptake in all provinces in the **PMH Provincial Report Card**, published in early 2019.⁹ That report contains grades and descriptions for progress in each province up to late 2018, which acts as a useful gauge for where the vision stands at the time of publication of this new edition.

Alberta

In Alberta, **primary care networks** (PCNs)¹⁰ were established to link groups of family physicians and other health care professionals. Within PCNs clinicians work together to provide care specific to community and population health care needs. Currently, there are 42 PCNs operating in Alberta, comprised of more than 3,700 (or 80 per cent of) family physicians, and over 1,100 other health care practitioners. PCNs provide care to close to 3.6 million Albertans, 80 per cent of the population in Alberta.

Primary care clinics are being asked to collect data for Third Next Available (TNA) appointments to improve access for Albertans.¹¹ TNA measures the delay patients experience in accessing their providers for a scheduled appointment. TNA is considered a more accurate system measure of access than the “next available” appointment, since the next or second next available appointment may have become available due to a cancellation or other event that is not predictable or reliable.

British Columbia

The British Columbia government’s new primary care strategy focuses on expanding access to team-based care through PCNs.¹² PCNs are in the initial stages of adoption and when fully rolled out will provide a system-level change—working to connect various providers to improve access to, and quality of, care. They will allow patients to access the full range of health care options, streamline referrals, and provide better support to family physicians, nurse practitioners, and other primary health care providers. The **General Practice Services**

Committee¹³ (GPSC; a partnership of the provincial government and Doctors of BC) specifically references and builds on the PMH concept in their vision for the future of British Columbia’s health care system.

Manitoba

In Manitoba, PMHs are Home Clinics and PCNs are My Health Teams. My Health Teams bring together teams of health care providers (physicians, nurses, nurse practitioners, etc.) to collaborate in providing high-quality care based on community and patient needs.¹⁴ As suggested by the name of the initiative itself, the goal is to improve health care by developing teams of health care professionals who will work together to address primary health care needs of Manitobans.¹⁵ The first two My Health Teams were established in 2014, and there are now 15 across the province.¹⁶ The Manitoba Centre for Health Policy did some work assessing the impact of My Health Teams.

New Brunswick

In 2017 the government announced the New Brunswick Family Plan, which placed a specific emphasis on access to team-based care. To achieve this goal, the provincial government and the New Brunswick Medical Society established a voluntary program called **Family Medicine New Brunswick**. In this team-based model, physicians have their own rosters of patients, but also provide a service to all patients of doctors on their team.¹⁷ It was announced in 2018 that 25 family physicians will be added to the provincial health care system to ensure more New Brunswick residents have access to a primary care physician and to help reduce wait times.¹⁸

Newfoundland and Labrador

In 2015 the Newfoundland and Labrador government released **Healthy People, Healthy Families, Healthy Communities: A primary health care framework for Newfoundland and Labrador**. The strategy’s goals include ensuring “timely access to comprehensive, person-focused primary health care services and supports,” and “primary health care reform should work to establish teams of providers that facilitate access to a range of health and social services tailored to meet

the needs of the communities they serve.”¹⁹ Both goals align with the general PMH principles. Primary health care teams have been introduced in St. John’s and are planned for Corner Brook and Burin.²⁰ Many initiatives under way as a part of this strategy are in the early stages of development. Continuing in the direction laid out will move Newfoundland and Labrador closer to integrating the PMH vision in their delivery of primary health care.

Northwest Territories

The recent creation of a single Territorial Health Authority has enabled work on primary care improvements across the Northwest Territories. In August 2018 the NWT Health and Social Services Leadership Council unanimously voted in favour of a resolution supporting redesigning the health care system toward a team- and relationship-based approach, consistent with PMH values. In several regions, contracted physicians are already assigned to regularly visit remote communities and work closely with local staff to provide continuity of remote support between visits. Planning is under way for implementing PMH-based multidisciplinary care teams in several larger regional centres, with enhanced continuity and access to physician and nursing staff as well as co-located mental health support and other health care disciplines. This work is facilitated by a territory-wide EMR and increased use of telehealth and other modalities of virtual care.

Nova Scotia

The 2017 *Strengthening the Primary Health Care System in Nova Scotia* report recommended establishing “health homes,” consisting of interprofessional, collaborative family practice teams. The model is based on a population health approach that focuses on wellness and chronic disease management/prevention and incorporates comprehensive, team-based care. There are approximately 50 **collaborative family practice**²¹ teams and a number of primary care teams across Nova Scotia.

Ontario

The model most aligned with the PMH framework is the **family health team** (FHT).²² FHTs are comprised of family physicians, nurse practitioners, and other health care professionals, and provide community-centred primary care programs and services. The 184 FHTs collectively serve over three million enrolled Ontarians. Based on the results of a five-year evaluation undertaken by the Conference Board of Canada in 2014, FHTs have achieved improvements

at the organizational and service-delivery levels.²³ Much progress has also been made through patient enrolment models. Patient enrolment, or rostering, is a process in which patients are formally registered with a primary care provider or team. Patient enrolment facilitates accountability by defining the population for which the provider is responsible. Formal patient enrolment with a primary care physician lays the foundation for a proactive approach to chronic disease management and preventive care.²⁴ Studies show that the models have achieved some degree of success in enhancing health system efficiency in Ontario through the reducing use of emergency departments for non-emergent care.²⁵

Prince Edward Island

In Prince Edward Island, primary care is provided through five **PCNs**.²⁶ Each network consists of a team that includes family physicians, nurse practitioners, registered nurses, diabetes educators, licensed practical nurses, clerical staff, and in some cases dietitians and mental health workers. They offer a broad range of health services including diagnosis, treatment, education, disease prevention, and screening.

Quebec

The **Groupe de médecine de famille**²⁷ (GMF) is the team-based care model in Quebec most closely aligned with the PMH. GMF ranking (obligations, financial, and professional supports) is based on weighted patient rostering. One GMF may serve from 6,000 to more than 30,000 patients. The resource allocation (financial and health care professionals) depends on the weighted patient target under which the GMF falls. In a GMF, each doctor takes care of their own registered patients, but all physicians in the GMF can access medical records of all patients. GMFs provide team-based care with physicians, nurses, social workers, and other health care professionals working collaboratively to provide appropriate health care based on community needs.

Saskatchewan

Saskatchewan has made investments in a Connected Care Strategy, which focuses on a team approach to care that includes the patient and family, and extends from the community to the hospital and back again. It is about connecting teams and providing seamless care for people who have multiple, ongoing health care needs, with a particular focus on care in the community.²⁸

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).



ADMINISTRATION
& FUNDING
PAGE 7 ►



APPROPRIATE
INFRASTRUCTURE
PAGE 9 ►



CONNECTED CARE
PAGE 12 ►



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.

Practice governance and management

Effective practice governance is essential to ensuring an integrated process of planning, coordinating, implementing, and evaluating.³⁰ Every PMH should clearly define its governance and administrative structure and functions, and identify staff responsible for each function. While the complexity of these systems varies depending on the practice size, the number of members on the health care professional team, and the needs of the population being served, every PMH should have an organizational plan in place that helps guide the practice operations.

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 and

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. In some cases, standardized defaults for these may be available based on the province of practice and existing structures supporting interprofessional teams. Structures and systems need to be in place that allow for compensated time for providers to undertake and actively participate in CQI activities. This needs to be scheduled and remunerated so that it is seen as being as important and critical as clinical time.

To ensure that all PMH team members have the capacity to take on their required roles, leadership development programs should be offered. Enabling physicians to engage in this necessary professional development requires sufficient government funding to cover training

Patients as partners in health care

Patient-centred or patient-partnered? Understanding and acknowledging patients as full partners in their own care is a small but powerful change in terminology. Considering and respecting patients as partners allows health care providers to better recognize and include the skills and experience each patient brings to the table. Patient perspectives and feedback can be more inclusively incorporated in the QI processes in place to improve care delivery. Understanding the nature of patient partnerships can help physicians better establish trusting relationships with those in their care.²⁹

costs and financial support to ensure lost income is not a barrier (see Pillar 10: Training, Education, and Continuing Professional Development).

External supports

Every family practice in Canada can become a PMH and an optimal learning environment will only be achievable with the participation and support of all stakeholders throughout the health care system. This includes family physicians; other health professionals who will play critical roles on PMH teams; federal, provincial, and territorial governments; academic training programs; governing bodies for physicians and allied health care providers; and most importantly, the people of Canada themselves, individually and in their communities—the recipients of care provided by the PMH.

To achieve their objectives, PMHs need the support of governments across Canada through the provision of adequate funding and other resources. Given that the structure, composition, and organization of each PMH will differ based on community and population needs, funding must be flexible. More specifically, PMH practices will differ in terms of the staff they require (clinical, administrative, etc.). Funding must be available to ensure that PMH practices can determine optimal staffing levels and needs, to best meet community needs. The health care system must also ensure that all health care 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. These characteristics are also reflected in the Four Principles of Family Medicine, reinforcing the centrality of family medicine to the delivery of care.

Experience through new models of family practice, such as patient enrolment models (PEMs) in Ontario, suggests that blended funding models are emerging as the preferred approach to paying family physicians.^{31–33} These models are best suited to incentivizing team-based, patient-partnered care. The current fee-for-service (FFS) model incentivizes a series of short consultations that might be insufficient to address all

of the patient's needs, while blended remuneration provides for groups of physicians to work together to provide comprehensive care through office hours and after-hours care for their rostered patients. Capitation allows for more in-depth consultations depending on population need, rather than a volume-based model.

Research has also found that blended capitation models can lead to small improvements in processes of care (e.g., meeting preventive care quality targets)³⁴ and can be especially useful for supporting patients in managing and preventing chronic diseases.³⁵ The CFPC advocates for governments to implement blended payment mechanisms across the country to achieve better health outcomes (see the **Best Advice guide: Physician Remuneration in a Patient's Medical Home**³⁶ for more information).

It is important to ensure that additional practice activities such as leadership development, QI, and teaching are supported through dedicated funding or protected time intended specifically for these activities and are not seen as financially disadvantageous.

The sustainability of Canada's health care system depends on a foundation of strong primary care and family practice.³⁷ Indeed, “high-performing primary care is widely recognized as the foundation of an effective and efficient health care system.”³⁸ Future funding for health care—in particular from the federal government through federal, provincial, and territorial agreements—must be sustained through appropriate and well-designed funding agreements that incentivize PMH visions of primary care; other medical home priorities including preventive care, population health, EMRs; community-based care; along with access to medications, social services, and appropriate specialist and acute care.

For the PMH vision to be successful and a part of the future of family practice care in Canada, we need the commitment and support of everyone in the Canadian health care system, including decision makers and patients. By working with all levels of government and with patients, we can improve the health care system so that everyone in Canada has access to patient-centred, comprehensive, team-based 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.

- 2.1** All PMHs use EMRs in their practices and are able to access supports to maintain their EMR systems.
- 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.
- 2.3** 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.
- 2.5** 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).
- 2.7** A PMH has technology to enable alternative forms of care, such as virtual care/telecare.
- 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.

The shift in Canada from paper-based patient records to EMRs is reaching saturation. As delivery of care evolves with greater integration of technology, potential applications to improve patient care expand.³⁹ The proportion of family physicians using EMRs has grown from 16 per cent in 2004 to 85 per cent in 2017.⁴⁰

As it becomes ubiquitous in health care delivery, information technology can be of great benefit in sharing information with patients, facilitating adherence to treatment plans and medication regimes, and using health information technology (HIT) in new and innovative methods of care. However, HIT also poses new risks and can create new barriers. Providers should be mindful of how the application about new technologies may hinder good quality patient care.

When properly implemented, EMRs can help track data over time, identify patients who are due for preventive visits, better monitor patient baseline parameters (such as vaccinations and blood pressure readings), and improve overall quality of care in a practice.¹ 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. They can facilitate sharing information needed for referrals and consultations. The information in an electronic record can be used for teaching, carrying out practice-based research, and evaluating the effectiveness of the practice change as part of a commitment to CQI.¹ EMRs and HIT actively support other pillars in the PMH vision.

In addition to storing and sharing information, the biggest benefit of this technology is the ability to collect data for practice performance and health outcomes of patients served by family practices.⁴¹ The data allow practices to measure progress through CQI goals. Larger-scale collection allows for the aggregation of anonymized data sets and measuring performance beyond the practice level.⁴¹ Strict privacy regulations ensure that patient data remain secure and confidential. Overall, QI and research benefit patients by guiding more appropriate and efficient care, which forms the basis of another key pillar of

the PMH vision— Pillar 9: Measurement, Continuous Quality Improvement, and Research.

As EMR use becomes common, issues shift from roll-out to optimization in the practice. Ideally, EMRs must be adequately supported financially and use a universal terminology to allow for standardized data management, and be interoperable with other electronic health records relevant to patient care.¹ Training and ongoing technical support for effective use of technology must also be available. Digital information sources, especially in the sensitive areas of patient information and care planning, require a higher level of technical support to maintain faith in their use and application across stakeholder groups.

A comprehensive, systematic analysis of peer-reviewed and grey literature found that cost sharing or financial sponsorship from governments is required to support the high cost of EMR adoption and maintenance. Governments in several European countries equip all primary care practices with interoperable, ambulatory care-focused electronic health records (EHRs) that allow information to flow across settings to enhance the continuity and coordination of care.¹ Ensuring that government supports enable adoption, maintenance and effective use, coordination, and interoperability of electronic tools is crucial for meaningful use of this technology.

A PMH will also use technology for alternative forms of care. Virtual care is clinical interactions that do not require patients and providers to be in the same room at the same time.⁴² Virtual visits will be financially compensated by provincial health plans. Consultations may be asynchronous, where patients answer structured clinical questions online and then receive care from a physician at a later time (e-visits), or synchronous, where patients interact with physicians in real time via telephone (teleconsultations), videoconference (virtual visits), or text.⁴³ Virtual care increases accessibility for those living in rural and remote areas, but also in urban areas where some patients do not have a regular

primary care physician or cannot access their physician for in-person appointments within a time frame that meets their current needs.⁴³ Virtual care can also be an alternative solution for patients living in long-term care facilities and/or with mobility issues.⁴³

Strong communication between team members allows PMH practices to function on a virtual basis when the health care professionals are not stationed in the same physical space. It is important to recognize when co-location is not feasible and maintain effective information flow in these situations, which may be especially relevant in rural and remote areas.

Practices should ensure the electronic records they use are set up to support collaboration and interaction between all members of the team as much as possible, which includes all health care providers within the PMH as well as the patient's circle of support. For example, ensuring that when patients see someone other than their most responsible provider is logged into the system and is easy to review to maintain the continuity of care. This becomes complex in situations where providers are not co-located, and further system level supports up to the level of more interoperable and universal electronic records is a prerequisite for full application of this principle.

Appropriate infrastructure in a PMH is not just about technology—it includes efficient, effective, and ergonomically well-designed reception, administration, and clinical areas in the office. This is of significant benefit to staff and patients alike.⁴⁴ Having a shared physical and/or virtual space where multiple team members can meet to build relationships and trust, and communicate with each other regarding patient care is essential to creating a collaborative practice. Team-based care thrives when care is intentional, when planned and regular patient care meetings are incorporated into usual PMH practice, and when these steps are included in remuneration. This collaboration ensures that patients are involved in all relevant

Satisfaction with virtual visits

A British Columbia study found that over 93 per cent of patients indicated that their virtual visit was of high quality, and 91 per cent reported that their virtual visit was very or somewhat helpful to resolve their health issue.⁴³

discussions and are receiving the best care from professionals with a comprehensive set of skills.

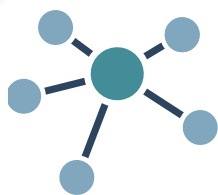
A family practice should be physically accessible to patients and their families. This includes ensuring all public areas, washrooms, and offices are wheelchair accessible.⁴⁴ An examination room should comfortably accommodate the patient and whatever appropriate companion, or health care professionals, who may be in the room at the same time. Having multi-purpose rooms also reduces or eliminates the need to wait for an appropriate room to be available.

To achieve their objectives, PMHs need the support of governments across Canada through the provision of adequate funding and other resources. Research demonstrates that in the case of EMRs, key barriers to adoption by family physicians include financial and time constraints, lack of knowledgeable support personnel, lack of interoperability with hospital and pharmacy systems,⁴⁵ as well as provincial/territorial EHR systems. Therefore, government must assure funding to support the PMH team in 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 (see Pillar 1: Administration and Funding). EMRs should help improve the delivery of care in community-based practices by enhancing productivity and processes. They are not intended to reduce time with patients, nor should they cause physician burnout or have a negative impact on physician wellness. While the structures supporting the PMH practices differs by province, it is important they cover a common set of principles enabling the base functionalities described in this document. The system must also ensure that all health professionals on the PMH team have appropriate liability protection and that adequate resources are provided so that each PMH practice can provide an optimal setting for teaching students and residents and for conducting practice-based research. Provider autonomy is critical to provider wellness: as physician leadership within the PMH is one of the key pillars, preservation of physician autonomy, while respecting the autonomy and ensuring the accountability of both patients and other health care professionals, must be addressed.

Figure 2. The Patient's Medical Neighbourhood





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.

Connectivity and effective communication within and across settings of care is a crucial concept of a PMH. This ensures that the care patients receive is coordinated and continuous. To achieve this, each PMH should establish, maintain, and use defined links with secondary and tertiary care providers, including local hospitals; other specialists and medical care clinics; public health units; and laboratory, diagnostic imaging, physiotherapy, mental health and addiction, rehabilitation, and other health and social services.

Connected care is a priority for many health care organizations in Canada. For example, the Canadian Foundation for Healthcare Improvement (CFHI) has established a unique program that looks at improving care connections between providers through improved use of technology.⁴¹ (See the Canadian Foundation for Healthcare Improvement textbox for more information). The Canadian Nurses Association (CNA), Canadian Medical Association (CMA), and HEAL recognize that giving Canadians the best health and health care requires creating a functionally integrated health

system along the full continuum of care—a system based on interprofessional collaborative teams that ensure the right provider, at the right time, in the right place, for the right care.⁴⁶ Similarly, Canada Health Infoway focuses on expanding digital health across the system to improve quality of and access to care.

The PMH exists within the broader patient's medical neighbourhood (see Figure 2), with links to all other providers in the community. It is important to maintain connections with colleagues in health care as well as social support organizations within the community, as described in Pillar 5: Community Adaptiveness and Social Accountability.

Through links within the neighbourhood, PMH practices work with other providers to ensure timely access for referrals/consultations and define processes for information sharing. Establishing and maintaining these links requires open and frequent communication between all those involved in patient care.

Canada Health Infoway





Established in 2001, **Canada Health Infoway**⁴⁷ is an independent, not-for-profit organization funded by the federal government. It seeks to improve health care access, moving beyond traditional in-person care models to innovative strategies that accelerate the development, adoption, and effective use of digital health solutions across Canada. Key digital health priorities include electronic records, telehomecare, virtual visits, and patient portals.

Ideally PMH practices act as the central hub for patient care by collecting and coordinating relevant patient information from external care providers and patients. This includes medical care and care accessed through other health and social services; for example, services received through home care programs. PMH practices should also be able to share relevant information with external providers where and when appropriate, while strictly adhering to relevant privacy regulations. This two-way flow of information ensures that all providers in the network of care have access to the most accurate and comprehensive information available, allowing them “... to spend less time looking for information and more time on what matters: treating the patient.”⁴⁹

Overall, connected care in the PMH and the health system is enabled through HIT systems. PMH practices continuously strive to work efficiently with other

providers in the patient’s medical neighborhood by taking advantage of developing technologies that make links quicker to establish and easier to maintain.

To use HIT systems for coordinated care, the following are required:⁵¹

-  Data standardization
-  Interoperable EMR and other health information systems
-  Real-time access to data and the ability to relay accurate information in a timely manner
-  Reliable communication mechanisms between various health and social service providers and the PMH

Canadian Foundation for Healthcare Improvement

The **Canadian Foundation for Healthcare Improvement** supports the RACE (Rapid Access to Consultative Expertise) and BASE eConsult services, which use telephone and web-based systems to connect patients with specialists.⁴⁸ These programs have been successful and demonstrate that remote consultations can reduce wait times for accessing specialty care by enabling family physicians to more efficiently manage their patients in primary care settings.

Privacy for patient information

It is important to keep in mind that any patient information, generated during the provision of care, belongs to the patient, as outlined in the Personal Information Protection and Electronics Document Act (PIPEDA). The practice is responsible for secure and confidential storage and transfer of the information. Refer to the **Data Stewardship module** of the **Best Advice guide: Advanced and Meaningful Use of EMRs**⁵⁰ for more information.

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
PAGE 15 ►



COMMUNITY ADAPTIVENESS &
SOCIAL ACCOUNTABILITY
PAGE 17 ►



COMPREHENSIVE TEAM-BASED
CARE WITH FAMILY PHYSICIAN
LEADERSHIP
PAGE 20 ►



CONTINUITY OF CARE
PAGE 23 ►



PATIENT & FAMILY PARTNERED CARE
PAGE 25 ►



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.

Accessible primary care is fundamental to a high-performing health care system and is considered by patients⁵² and other health care organizations as one of the most important characteristics of primary health care. For care to be accessible, all patients should have access to a family physician who acts as their most responsible provider and is supported by a team of qualified health professionals. Patients must be able to access medical care and treatment when needed. While most Canadians currently have a regular family doctor,⁴ it is important that the goal be for everyone in Canada to have access to their own family physicians. Accessible care is about more than just quick access to appointments. It does include timely access principles, but also advanced access, virtual access, and team-based approaches to care that ensure patients can be seen by the most appropriate provider when they need to be seen.

Because visits occur for different reasons it is not useful to define appropriate wait times for each type of visit unlike in other areas of health care, such as surgery. Therefore, the focus in family practice should be on enhancing access to ensure patients can access care when they feel it is necessary. This is not to say that family physicians in a PMH must be on call 24/7/365, but that methods for patients to access care through the design of practice operations and scheduling should be given more attention. On the other hand, as patients are offered more choice (e.g., by phone or e-communication), they should also expect practices to establish realistic parameters for what is reasonable. Practices should communicate clearly about what kind of provider availability and response time is reasonable to expect depending on access method and availability of resources. Obtaining this understanding from a practice's patients and striving to meet these expectations is a

Equitable and ethical practices

The CMA has identified equitable access to care as a key priority for reform in the health care system.⁵³ Similarly, accessibility is a key component of the primary health care approach, which is advocated for by the CNA.⁵⁴ Through the CNA's Social Justice Gauge, and with the further development of the social justice initiative, the CNA maintains its position as a strong advocate for social justice and a leader in equitable and ethical practices in health care and public health.⁵⁵

good way to maintain the patient-centred focus of the practice as described in Pillar 1: Administration and Funding. Significant shifts in providing alternative access must be supported by funding bodies.

Same-day scheduling has been introduced in many PMH practices to better accommodate patient needs. Frequently referred to as doing “today’s work today,” advanced access offers the vast majority of patients the opportunity to book their appointments on the day they call regardless of the reason for the visit.⁶⁰ Read more about same day scheduling in the **Best Advice guide: Timely Access to Appointments in Family Practice**.⁶¹

Whenever possible, patients should have clear reasons for the appointment at the time of booking. This ensures that adequate time is planned for each patient visit. If the need to address multiple problems arises, the problems can be triaged on the spot by one of the team and arrangements made to have these concerns dealt with in a timely manner either during the same visit or at another time.

It is not always possible for patients to book appointments with their most responsible family physician. To ensure continuity, appointments can be made with other physicians or health care professionals in the team. The decision about who provides care in these cases is based on the patient’s needs, the availability of team members, and the scope of practice for each team member. In these cases, any relevant information from the appointment is communicated to the most responsible provider and taken into account in the long-term care of the patient.

PMH practices can further meet patients’ needs through extended office hours, in which the responsibilities for coverage and care are shared by family physicians in one or more practices, as well as by increased involvement of other team members. PMH practices also provide their patients with email, after-hours telephone, and virtual services to guide them to the right place at the right time for the care they need. Appropriately directing patients to the next available appointment, or to a hospital or another emergency service, is critical to the effective management and sustainability of our health care system.^{62,63} A PMH can help ensure that patients are aware of where they can go to access care and health information 24 hours a day, 365 days a year by providing this information to patients in person or via other systems (website, voice mail messages, etc.).

In alignment with Pillar 9: Measurement, Continuous Quality Improvement, and Research, PMH practices offer opportunities for patients to provide feedback on the accessibility of the practice. Specifically, patients should have the opportunity to evaluate and provide input for the appointment booking system. Mechanisms and supports need to be in place to ensure that practices and governing bodies can review and respond to feedback appropriately and communicate this back to patients.

Determining the optimal panel size for each PMH practice is critical to ensuring accessible and safe, high-quality care.⁶⁴ Establishing and incorporating recommendations from the PMH vision may enable practices to consider increasing their panel size. Actual panel size will vary depending on the number of physicians and other team members in the practice, the practice’s obligations and

Accessible care

Accessible care reduces redundancy and duplication of services (e.g., when a patient takes a later appointment and also consults another provider in the interim), improves health outcomes, leads to better patient and provider satisfaction, and reduces emergency visits.^{56–58}

After-hours care

A Waterloo, Ontario, study found that providing after-hours clinical services reduced wait times, with services from other health care providers seen as a key for improving patient access.⁵⁹

commitment to teaching and research, and the needs of the population being served (see Pillar 5: Community Adaptiveness and Social Accountability). When deciding panel size, each practice must determine how accepting more patients into the practice might impact the

current population, the sustainability of the workload for physicians and other members of the PMH team, and the consequences of panel size on experience of care. Refer to the **Best Advice guide: Panel Size** for more information.⁶⁵



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.

Social accountability refers to the family physicians' obligation to meet the needs of Canada's communities.⁶⁶ For health care to be socially accountable, it must be accessible by everyone and responsive to the needs of patients, communities, and the broader population.⁴ This obligation is embedded in the Family Medicine Professional Profile and the Four Principles of Family Medicine, highlighting that family physicians are community-adaptive, responding to the needs of their patients and communities. These principles of family medicine align well with the principles of social accountability. Family practice is relationship-based care that embraces all issues of need and endures over time and place of care. A generalist keeps the whole in mind while attending

to the individual parts, the system in mind when fixing individual problems, and the end in mind when commencing the journey. Tools exist to help family physicians and other health care providers enhance their skills and training regarding social accountability and cultural safety through many professional organizations and cross-Canada resource hubs like the **National Collaborating Centre of Determinants of Health**⁶⁷ and the **National Collaborating Centre on Aboriginal Health**,⁶⁸ as examples.

PMH practices are aware of how the SDoH influence the health of patients and communities. Family physicians are often the best-situated primary care professionals to act on

issues that affect patients' SDoH. Advocating for patients and the health care system overall is a natural part of a PMH structure. Advocacy can occur at three levels:⁶⁹

- 🌀 **Micro:** In the immediate clinical environment, daily work with individual patients and predicated on the principles of caring and compassion
- 🌀 **Meso:** In the local community, including the patient's cultural community, the local community of medical providers, and the larger civic community, in which health professionals are citizens as well as practitioners
- 🌀 **Macro:** In the humanitarian realm, where physicians are concerned with the welfare of their entire patient population and seek to improve human welfare through healthy public policy (such as reducing income inequality, supporting equitable and progressive taxation, and expanding the social safety net)

The principles of advocacy in family practice are found in the **CanMEDS-Family Medicine 2017**⁶⁹ competency framework, under the Health Advocate role. The **Best Advice guide: Social Determinants of Health**⁷⁰ describes how family physicians in the PMH can make advocacy a practical part of their practice.

Poverty is a significant risk factor for chronic disease, mental illness, and other health conditions. Low income and other SDoH also present significant barriers to accessing care.⁷¹ To meet the needs of these patients, practices may need to extend hours, be more flexible and responsive, and spend additional time helping patients navigate and access necessary care. PMH practices consider other specific community needs when determining appropriate panel size. Demographics and health status of the patient population can influence the length and frequency of appointments needed, thereby impacting a physician's caseload.⁶⁵ For example, a PMH in a community with high rates of chronic conditions may need to reduce the panel size to provide timely and high-quality care, given that patients require more care time and resources. Similarly, a patient's social situation may impact the time a family physician spends with them. Family physicians and team members may need to use a translator at clinical appointments, and may need to provide written resources in alternative languages, all factors affecting the time required to provide care. Enabling PMH practices to adjust panel size based on community needs requires governments to establish blended payment mechanisms. These remuneration systems ensure family physicians are adequately compensated, and are not financially disincentivized from spending the necessary time with patients (see Pillar 1: Administration and Funding, for more information).

Importance of social accountability

Social accountability is a key value for health care organizations and professionals. For example, the Royal College of Physicians and Surgeons of Canada (Royal College), Resident Doctors of Canada, and the Association of Faculties of Medicine amongst others, have adopted policies that highlight the importance social accountability within their organizations and the work they do.

Social accountability and cultural competency

Part of the response to being more socially accountable with care offered to the community resides within each and every health professional. While courses on cultural competency are now a standard part of medical education, physicians can take this learning further by seeking to reflect on, be aware of, and correct any unconscious biases that naturally forms and holds as a result of individual life experiences. Working to resolve implicit biases is a lifelong effort, but done diligently, can contribute to improving the quality of care provided,⁷² as well as the satisfaction of being an effective healer—of ourselves, our patients and our societies.

Family physicians and their PMH teams are situated at the nexus of individual and population health, and can engage with their patients in addressing health promotion and disease prevention in creative ways. From accompanying individual patients through teachable moments (e.g., the smoker with pneumonia ready to quit) to influencing civic policy to address homelessness, the stories entrusted to family physicians in daily practice are powerful tools for healthy change. These teams are also key providers in many important public health areas, including illness and injury prevention; health promotion; screening and managing chronic diseases; immunizations; and health surveillance. PMH practices prioritize delivering evidence-based care for illness and injury prevention and health promotion, reinforcing them at each patient visit and other counselling opportunities. PMHs and local or regional public health units should cultivate and maintain strong links with one another. Health care professionals who are part of PMH teams may take on advisory, educational, supportive, or active roles in public health initiatives, in many different occupational, educational, or recreational settings throughout the community. An effective public health system should be inextricably linked to community-based family physicians and PMHs, recognizing and supporting them as essential to the achievement of the broader population and public health goals.

While PMHs focus primarily on the care of individuals and their families, it is important for team members to understand and address the health challenges facing their practice populations and the larger community. These broader challenges represent upstream factors (SDoH) that have greater impact on the health of patients than do the efforts of individual physicians. However, the relationships embedded in individual and collective

practices can be central to engaging patients and citizens in building more just and healthier communities and societies. For example, with the help of HIT, details about the needs of populations can be more easily accessed through extraction from practice EMRs, or participation in programs such as the **Canadian Primary Care Sentinel Surveillance Network** (CPCSSN).⁷³ The CPCSSN networks collect health information from EMRs of participating primary care providers, extract anonymous data, and share information on chronic conditions with governments, health care providers, and researchers to help inform meaningful systems and practice change. Programs like the CPCSSN allow practices to better understand the needs of their communities and implement specific health promotion and prevention programs that can contribute to the population's overall well-being. Initiatives like this also ensure the avoidance of data duplication, and recognise that practices do not need (or have the resources) to collect data on their own. However, these data are just a part of caring—the heart of generalism is keeping the whole in mind while attending to its parts, whether it is at the level of the whole patient, the whole family, or the whole society.

To meet the needs of their diverse panel of patients, family physicians and other team members in the PMH work to provide anti-oppressive and culturally-safe care, seeking to mitigate experiences of discrimination faced by many patients based on their SDoH. This requires understanding how historical and current injustices have impacted the well-being of certain populations, and working to ensure a safe and welcoming practice environment by focusing on the principles of caring and compassion.

Sociodemographic data benefits

The FHT at St Michael's Hospital routinely collects sociodemographic data on all patients. Patients are surveyed about income, housing status, gender identity, and other key SDoH factors, and their responses are integrated into the secure EMR. This information is used to inform and direct individualized patient-centred care. The data will also be used for planning and evaluating the FHT's programs.⁷⁴



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.

Primary care practice teams

Many allied health professional organizations have prioritized the importance of working together in a team to provide patients with the best possible care. The CFPC worked collaboratively with organizations—such as the CNA, the Canadian Association of Social Workers, the Canadian Psychological Association, and the Dietitians of Canada—to create the **Best Advice guide: Team-Based Care in the Patient's Medical Home**.⁷⁵ The guide includes implementation strategies for creating a primary practice team, and general descriptions of roles found in a collaborative team.

Team-based care is a core function of the PMH. Building a team with a diverse mix of professional backgrounds creates an opportunity to redefine what is considered optimal, based on the needs of the practice and the community it serves. A high-performing team is essential to delivering more comprehensive, coordinated, and effective care centred on the patient's needs. While different circumstances call for aspects of patient care to be provided by different health professionals, it is important to ensure that family physician expertise is available to all team members through consultation.

To practice effectively in an interprofessional health care team, there must be a clear understanding of each member's unique contributions, including educational background, scopes of practice and knowledge, and areas of excellence and limitations.⁷⁶ Practices that draw on the expertise of a variety of team members are more likely to provide patients with the care they need and respond to community needs.⁷⁷

Relationships across all dynamics within a practice, whether between a patient and family physician or between a patient and other members of the team, should be encouraged and supported in the PMH. Establishing these relationships develops trust and confidence, and works toward the ultimate goal of achieving better health outcomes. While it should be left to each practice to determine who does what (within the boundaries of professional scopes of practice), the most responsible provider for the medical care for each patient in the practice should be the patient's personal family physician.

Family physicians with enhanced skills and family physicians with focused practices play an important role in collaborating with the patient's personal family physician and team to provide timely access to a range of primary care and consulting services. They supplement their core skills and experience with additional expertise in a particular field, while remaining committed to their core generalist principles.⁷⁸ These doctors can draw extensively on their generalist training and approach to disease management and patient-centred care, enabling them to work collaboratively at different levels of care, including with other specialists, to meet patient needs.⁷⁹ These clinicians also serve as a resource for other physicians in their local health system by enhancing care delivery and learning and teaching opportunities. The **Best Advice guide: Communities of Practice in the Patient's Medical Home**⁸⁰ provides more information about intraprofessional collaboration between family physicians.

Shared care strategies provide patients with timely access to consultations with other specialists or family physicians with enhanced skills at scheduled times in the family practice office setting. The consultant might assess several patients per visit, at which time a plan for ongoing care can be developed and agreed to by the family physician, consultant, other team members, and the patient.

There is no one-size-fits-all model when determining what mix of health care professionals is right. Team composition depends on the professional competencies, skills, and experiences needed to address the health needs of the patient population.⁸¹ These needs vary, depending on the communities' defining characteristics;

Additional members of practice teams

Not all health care professionals in a team need to be hired as a full-time team member. For example, a practice can hire a dietitian for specific days to lead a diabetes education program and see scheduled patients. Practices can also host other health care professionals, such as those employed with a regional health authority, to provide care to patients on-site. However, funding bodies should recognize that family practice clinics hosting other health care professionals often carry the overhead costs associated with these practitioners working on site, and further supports should be made available to ensure that costs do not unduly fall on the physicians. Pillar 1: Administration and Funding and Pillar 2: Appropriate Infrastructure highlight that a PMH needs to be properly funded and have access to the right infrastructure (physical and governance) to support the initiatives described in this vision.

for example, geography, culture, language, demographics, disease prevalence. Family physicians are encouraged to identify the gaps in health care provision in the local practice environment and work with other health care providers to meet those needs as much as possible. Data from EMRs—as well as input from patients, community members, and stakeholders—should inform team planning. Factors to consider include:

- ✿ Patient population
- ✿ Identified community health care needs
- ✿ Hours available for patient access
- ✿ Hours available for each physician to work
- ✿ Roles and number of non-physician providers
- ✿ Funds available⁸¹

Overlapping or variations of similar competencies can result in ambiguous expectations of what a defined role is within a practice. When teams are planned and developed, roles should be clearly outlined. This is best done at the local practice level relative to community needs and resources. This approach considers changes over the course of a health care professional's career, including skills development, achievement of certifications, and professional interests.⁸² It is important to include time for team members to become comfortable in their role, at the outset of team-based care and with any changes to the team. It is also important to recognize that

these arrangements are flexible and subject to change, provided the team engages in discussion and reaches consensus on needed adjustments.

Team members might be in the same office or in the same building, but this is not necessary. For smaller and more remote practices, or larger urban centres where proximate physical space may be a barrier, some connections may be arranged with peers in other sites. Applying HIT judiciously allows for virtual referrals and consultations. Virtual links between PMH practices and other specialists, hospitals, diagnostic services, etc., can be enhanced with more formal agreements and commitments to provide timely access to care and services.

By providing patients with a comprehensive array of services that best meet their needs, team-based care can lead to better access, higher patient and provider satisfaction, and greater resource efficiency.^{61,77,83} Although there are presently many systems in place that support the creation of health care teams, practices can also create a successful team on their own. To ensure team success, providers must have a clear understanding of the different role responsibilities and ensure that there are tools available to engage open dialogue and communication. Teams within the PMH are supported by a model that is flexible and adaptable to each situation. The skills that family physicians acquire during their training (as described in the CanMEDS-FM framework) make them well suited to provide leadership within interprofessional teams. As an important part of a PMH, teams are central to the concept of patient-centred care that is comprehensive, timely, and continuous.





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.

- 7.1** 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.
- 7.3** 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.

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 their life.⁸⁴ With strong links to comprehensive team-based care (see Pillar 6: Comprehensive Team-Based Care with Family Physician Leadership), continuity of care is essential to any practice trying to deliver care truly centred on the needs of the patient. Continuity of care is rooted in a long-term patient-physician partnership in which the physician knows the patient's history from experience and can integrate new information and decisions from a whole-person perspective efficiently without extensive investigation or record review.⁸⁴ From the patient's perspective, this includes understanding each person's life journey and the context this brings to current health status, and the trust they have in their provider that is built over time.

Past studies show that when the same physician attends to a person over time, for both minor and more serious health problems, the patient-physician relationship is strengthened and understanding grows—an essential element of effective primary health care.⁸⁵ The personal physician offers their medical knowledge and expertise for a more complete understanding of the patient as a person, including the patient's medical history and their broader social context, such as personal, family, social, and work histories (see Pillar 5: Community Adaptiveness and Social Accountability). In this model, patients, their families and/or personal caregivers, and all health care providers in the PMH team are partners in care, working together to achieve the patient's goals and engaging in shared decision making. Understanding the

patient's needs, hopes, and fears, and their patterns of response to illness, medications, and other treatments, deepens the physician's ability to respond to larger trends, not just the medical issue presented at any given appointment. Continuity of care can ideally support the health and well-being of patients actively and in their daily lives without focusing only on care when they are ill. The strong physician-patient relationship developed over time allows them to maintain good health and prevent illness and injury, as the physician uses their deep knowledge of their patient to work with teams of qualified health professionals to best support the patient's well-being.

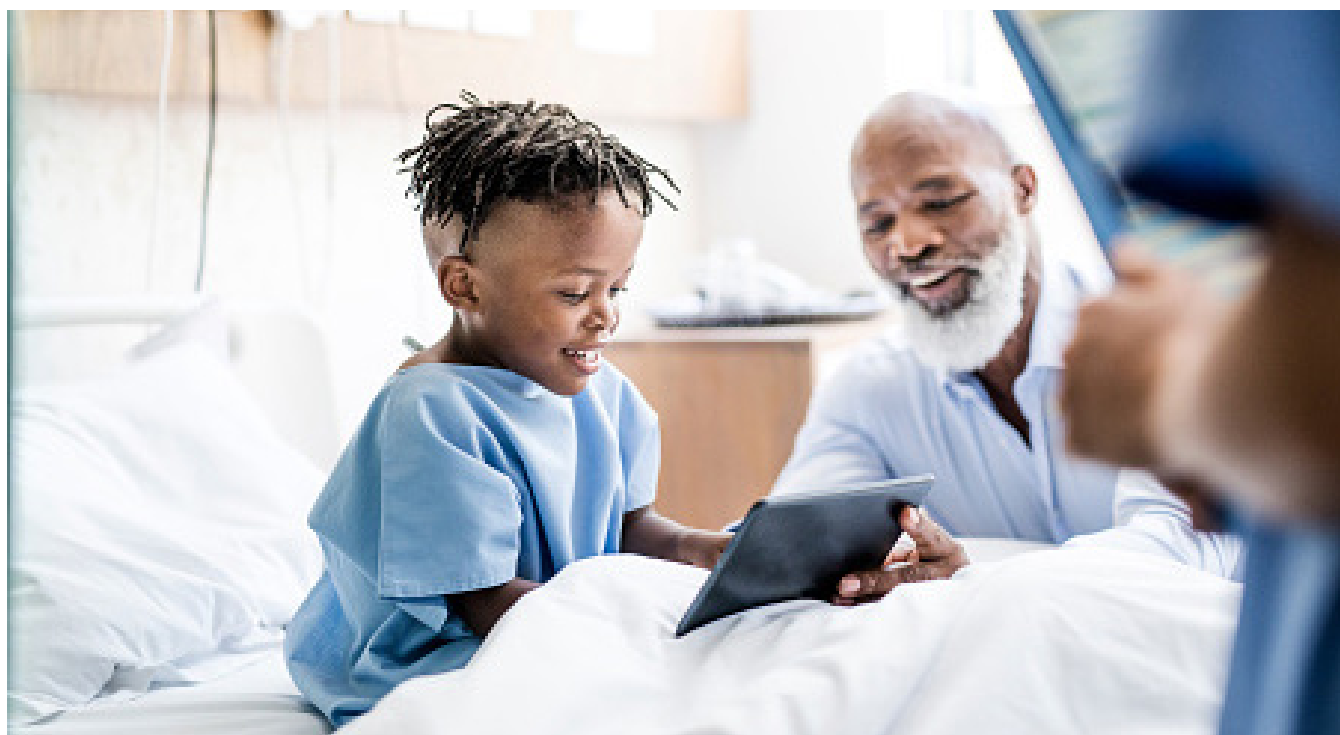
Family physicians in the PMH, acting as the most responsible provider, can provide continuous care over the patient's lifespan and develop strong relationships with patients. Research demonstrates that one of the most significant contributors to better population health is continuity of care.^{86,87} It found that those who see the same primary care physician continuously over time have better health outcomes, reduced emergency department use, and reductions in hospitalizations versus those who receive care from many different physicians. A Canadian study found that after controlling for demographics and health status, continuity of care was a predictor of decreased hospitalization for ambulatory care-sensitive conditions (such as COPD, asthma, diabetes, and heart failure) and decreased emergency department visits for a wide range of family practice-sensitive conditions.⁸⁵ Overall "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.”⁸⁶ It has been reported that a regular and consistent source of care is associated with better access to preventive care services, regardless of the patient’s financial status.

Continuity of care also requires continuity in medical settings, information, and relationships. 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.⁸⁸ As described in Pillar 3: Connected Care, when care must be provided in different settings or by different health professionals (i.e., the medical neighbourhood), continuity can still be preserved if the PMH plays a coordination role and communicates effectively with other providers. The PMH liaises with external care providers to coordinate all aspects of care provided

to patients based on their needs. This includes but is not limited to submitting and following up on referrals to specialized services, coordinating home care, and working with patients before and after discharge from hospitals or other critical care centres.

In addition to this coordination role, the PMH acts as a hub by sharing, collecting, storing, and acting as a steward for all relevant patient information. This ensures that the family physician, as the most responsible provider, has a complete overview of the patient’s history. A record of care provided for each patient should be available in each medical record (preferably through an EMR) and available to all appropriate care providers (see Pillar 2: Appropriate Infrastructure for more information about EMRs). Knowing that medical information from all sources (i.e., providers inside and outside the PMH) is consolidated in one location (physical or virtual) increases the comfort and trust of patients regarding their care.



Continuity for patient health

Research demonstrates that continuity of care is a key contributor to overall population health. Patients with a regular family physician experience better health outcomes and fewer hospitalizations as compared to those without.⁶⁹



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.

Patient-centred care is at the core of the PMH. Dr. Ian McWhinney—often considered the “father of family medicine”—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.”⁸⁹ In this model, patients, their families and/or personal caregivers, and all health care providers in the PMH team are partners in care, working together to achieve the patient’s goals and engaging in shared-decision making. Care should always reflect the patient’s feelings and expectations and meet their individual needs. Refer to the **Best Advice guide: Patient-Centred Care in a Patient’s Medical Home**⁹⁰ for more information.

Family caregivers* play an important role in the PMH. They help patients manage and cope with illness and can assist physicians by acting as a reliable source of health information and collaborating to develop and enact treatment plans.⁹³ The level and type of engagement from family caregivers should always be determined by the patient. Physicians “should routinely assess the patient’s wishes regarding the nature and degree of caregiver participation in the clinical encounter and strive to provide the patient’s desired level of privacy.”⁹⁴ They should revisit this conversation regularly and make changes based on patient desires. PMH practices focus on providing patient-centred care and ensuring that family caregivers are included.

* Family caregivers include relatives, partners, friends, neighbours, and other community members.

External factors for patient health care

Patient- and family-partnered care is considered a key value to stakeholders across the health care system. In 2011, the CMA and the CNA released a set of principles to guide the transformation of Canada’s health care system.⁹¹ Patient-centred care is listed as the first principle, and as a key component of improving the overall health care experience.⁹¹ Similarly, in 2016 Patients Canada called on all levels of government to ensure that patients are at the centre of any new health accords and future health care reform.⁹²

As part of their commitment to patient-centred care, PMH practices facilitate and support patient self-management. Self-management interventions such as support for decision making, self-monitoring, and psychological and social support, have been demonstrated to improve health outcomes.⁹⁵ PMH team members should always consider recommendations for care from the patient's perspective. They should work collaboratively with patients and their caregivers to develop realistic action plans and teach problem-solving and coping. This is particularly important for those with chronic conditions, who must work in partnership with their physician and health care team to manage their condition over time. (Refer to the **Best Advice guide: Chronic Care Management in a Patient's Medical Home**⁹⁶ for more information). The goal of self-managed care should be to build the patient's and caregiver's confidence in their ability to deal effectively with illnesses, improve health outcomes, and foster overall well-being.

To facilitate patient- and family-partnered care, a range of user-friendly options for accessing information and care beyond the traditional office visit should be available to patients when appropriate. These include email, telehealth, virtual care, mobile health units, e-consults, home visits, same-day scheduling, group visits, self-care strategies, patient education,

and treatment sessions offered in community settings. Providing a range of options allows patients to access the type of care they prefer based on individual needs. Patients also need to be informed about how they can access information and resources available to them; for example, resources such as Prevention in Hand (**PiH**).⁹⁷

Allowing patients to access to their medical records can improve patient-provider communication and increase patient satisfaction.^{98,99} The specific information accessible to patients should be discussed and agreed upon by the patient and their care team. Patient education about accessing and interpreting the available information is necessary. Facilitating this type of access requires each PMH to have an EMR system that allows external users to access information securely (see Pillar 2: Appropriate Infrastructure).

Patient surveys and opportunities for patients to participate in planning and evaluating the effectiveness of the practice's services should be encouraged; practices must be willing respond and adapt to patient feedback. To strengthen a patient-centred approach, practices may consider developing patients' advisory councils or other formalized feedback mechanisms (e.g., using patient surveys) as part of their CQI processes (see Pillar 9: Measurement, Continuous Quality Improvement, and Research).

Patient self-management

The Ajax Harwood Clinic (AHC) is a good example of how a practice that enables patient self-management can improve long-term health outcomes, especially for patients with chronic conditions.⁹⁴ The AHC has created an environment of learning and seeks to encourage health literacy among its patients through its various programs. The clinic is focused on patient education and empowerment, and all programs at the clinic are free of charge to patients to remove financial barriers to access.

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
PAGE 28 ►



TRAINING,
EDUCATION, AND
CONTINUING
PROFESSIONAL
DEVELOPMENT
PAGE 30 ►



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.

CQI is an essential characteristic of the PMH vision. It encourages health care teams to make practical improvements to their practice, while monitoring the effectiveness of their services, the health outcomes and safety of their patients, and the satisfaction of both patients and the health professionals on the team. Every PMH is committed to establishing a CQI program that will improve patient safety, and enhance efficiency and quality of the services provided to patients. As part of CQI activities, a structured approach is used to evaluate current practice processes and improve systems and to achieve desired outcomes.

To engage in CQI, the PMH team must identify the desired outcomes and determine appropriate evaluation strategies. Once the process and the desired outcome are defined with patients, the CQI activity will track performance through data collection and comparison with the baseline. Performance measures can be captured through structured observation, patient and staff surveys (see Pillar 8: Patient- and Family-Partnered Care), the PMH self-assessment tool,

and the practice's EMR (see Pillar 1: Administration and Funding and Pillar 3: Connected Care). The indicators selected should be appropriate to each practice and community setting, be meaningful to the patients and community, and the CQI process could be introduced as a practice's self-monitoring improvement program or as an assessment carried out by an external group.

In some jurisdictions, funding is tied to achieving performance targets, including those that provide evidence for the delivery of more cost-effective care and better health outcomes.¹⁰¹ Some provinces in Canada have begun to link financial incentives to clinical outcomes and targets that have been achieved ("pay for performance" models).¹⁰² 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.^{101,103} Future development

Continuous quality improvement

CQI is an important value among health organizations such as the CFHI.¹⁰⁰

of financial incentive models should consider these unintended consequences that might impair the ability of practices to provide good quality patient care to their full population.

The objectives that define a PMH could be used to develop the indicators for CQI initiatives in family practices across Canada. These criteria could be augmented by indicators recommended by organizations such as Accreditation Canada, Health Quality Ontario, Health Standards Organization, and the Patient-Centered Medical Home model in the United States. The CFPC is committed to collaborating with these groups to further develop the CQI process for PMHs and family practices. Consult the CFPC's **Practice Improvement Initiative (Pii)**¹⁰⁴ for a list of available resources.

CQI is a team activity and should involve all members of the PMH team as well as patients and trainees. This will ensure buy-in from the team, allow for patient engagement and participation, and provide trainees with valuable learning opportunities.¹⁰⁵ PMHs are committed to using the results of CQI initiatives to make tangible changes in their practice to improve operations, services, and programs.

Time and effort invested into participation in CQI activities should be recognized as valuable and not be disincentivized through existing remuneration models.

Dedicated time and capacity to perform these activities should be built into the practice operational principles.

On a larger scale, PMHs function as ideal sites for community-based research focused on patient health outcomes and the effectiveness of care and services. The PMH team should be encouraged and supported to participate in research activities. They should also advocate for medical students, residents, and trainees to take part in these projects. In Canada, the Canadian Primary Healthcare Research Network (CPHRN) and the commitment of the Canadian Institutes for Health Research's (CIHR's) Strategy for Patient-Oriented Research (SPOR) are vitally important.¹⁰⁶ The focus on supporting patient-oriented research carried out in community primary care settings is consistent with the priorities of the PMH.

Competitions for research grants such as those announced by SPOR should be strongly encouraged and supported. PMHs are ideal laboratories for studies that embrace the principles of comparative effectiveness research (CER) and the priorities defined by the CPHRN and CIHR's SPOR project. They provide excellent settings for multi-site research initiatives, including projects like those currently undertaken by the CPCSSN—a nationwide network of family physicians conducting surveillance of various chronic diseases.





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. |

PMH practices serve as training sites for medical students, family medicine residents, and those training to become nurses and other health care professionals.¹⁰⁷ They create space for modelling and teaching practices focused on the essential roles of family physicians and interprofessional teams as part of the continuum of a health care system. One of the goals of family medicine residency training is for residents to learn to function as a member of an interdisciplinary team, caring for patients in a variety of settings including family practice offices, hospitals, long-term care and other community-based institutions, and patients' residences.^{70,108}

A PMH also models making research and QI initiatives a standard feature of a family practice. Professional development and opportunities to participate in these activities should be available and supported within PMH practices through resources, guidance, and specifically dedicated time.

Family medicine training is increasingly focused on achieving and maintaining competencies defined by the CFPC's **Triple C Family Medicine Curriculum**.¹⁰⁹ Triple C includes five domains of care: 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.

PMHs allow family medicine students and residents to achieve the competencies of the Triple C curriculum and to learn how to incorporate the Four Principles of Family Medicine, the Family Medicine Professional Profile, and the CanMEDS-FM roles into their professional lives. Learners gain experience with 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—essential elements of family practice in Canada. Furthermore, PMH practices serve as optimal sites for trainees in other medical specialties and health professions to gain valuable experience working in interprofessional teams and providing high quality, patient-centred care. Medical schools and residency programs should encourage learners to conduct some of their training within PMH practices.

Practising family physicians must engage in CPD to keep current on medical and health care developments and to ensure their expertise reflects the changing needs of their patients, communities, and learners.

Mainpro+® (Maintenance of Proficiency) is the CFPC's program designed to support and promote family physicians' CPD across all CanMEDS-FM Roles and competencies.

CPD refers to physicians' professional obligation to engage in learning activities that address their own identified needs and the needs of their patients; enhance knowledge, skills, and competencies across all dimensions of professional practice; and continuously improve their performance and health care outcomes within their scope of practice.¹⁰ Three foundational principles for CPD in Canada have been recently described:

- ☼ Socially responsive to the needs of patients and communities
- ☼ Informed by scientific evidence and practice-based data
- ☼ Designed to achieve improvement in physician practice and patient outcomes

CPD is inclusive of learning across all CanMEDS-FM Roles and competencies, including clinical expertise, teaching and education, research and scholarship, and in practice-based QI.

PMH practices support their physicians, and all other staff members, to engage in CPD activities throughout their

careers by creating a learning culture in the organization. This includes providing protected time for learning and team-based learning, and access to practice data both to discern patient/community need and practice gaps to inform CPD choices and to evaluate the impact of learning on patient care. This learning culture and the will to be constantly improving quality and access to care is essential to ensuring that the PMH continues to support high performing care teams.

To ensure that all PMH team members have the capacity to take on their required roles, leadership development programs should be offered. Enabling physicians to engage in this necessary professional development requires sufficient funding by governments to cover costs of training and financial support to ensure lost income and practice capacity do not prevent this.

Physicians in the PMH share their knowledge with colleagues in the broader health care community and with other health care professionals in the team by participating in education, training, and QI activities in collaboration with the pentagram partners.[†] This is particularly relevant for family physicians who are focused on a particular area of practice (possibly holding a Certificate of Added Competence) and are able to share their extended expertise with others. This can happen either informally or through more official channels. For example, physicians may participate in activities organized by the CFPC or provincial Chapters (e.g., Family Medicine Forum, provincial family medicine annual scientific assemblies), or lend their expertise to interprofessional working groups addressing specific topics in health care. Family physicians should be encouraged to engage in these types of events to share their knowledge and skills for the betterment of the overall health system.

[†] Pentagram partners: policy-makers—federal, provincial, territorial, and regional health authorities; health and education administrators; university; community; health professionals—physicians and teams

Continuing professional development

CPD is an integral value across the entire health care system. Organizations such as the Royal College, CMA, and CNA emphasize the value and importance of continuing education for health care professionals to improve patient care.

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, and many characteristics are found in other foundational documents of family medicine such as the **Family Medicine Professional 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.

The PMH is focused on enhancing patient-centredness in the health care system through collaboration, access, continuity, and social accountability. It is intended to build on the long-standing historical contribution of family physicians and primary care to the health and well-being of Canadians, as well as on the emerging models of family practice and primary care that have been

introduced across the country. Importantly, this vision provides goals and recommendations that can serve as indicators. It enables patients, family physicians, other care health professionals, researchers, health planners, and policy-makers 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, 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) 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.



REFERENCES

- College of Family Physicians of Canada. *A Vision for Canada: Family Practice - The Patient's Medical Home*. Mississauga, ON: College of Family Physicians of Canada; 2011. Available from: www.cfpc.ca/uploadedFiles/Resources/Resource%20Items/PMH_A_Vision_for_Canada.pdf. Accessed 2019 Jan 21.
- National Physician Survey. 2014 National Physician Survey website. <http://nationalphysiciansurvey.ca/surveys/2014-survey/>. Accessed 2019 Jan 22.
- Canadian Medical Association. CMA Workforce Survey 2017 website. <http://cma.andornot.com/en/surveydata/default.aspx>. Accessed 2019 Jan 22.
- Canadian Institute for Health Information. *How Canada Compares: Results from the Commonwealth Fund's 2016 International Health Policy Survey of Adults in 11 Countries*. Ottawa, ON: Canadian Institute for Health Information; 2017. Available from: www.cihi.ca/sites/default/files/document/text-alternative-version-2016-cmwf-en-web.pdf. Accessed 2019 Jan 22.
- Ipsos Public Affairs. *The College of Family Physicians of Canada: Family Medicine in Canada Report*. Toronto, ON: Ipsos; 2017.
- World Health Organization. Primary Health Care website. www.who.int/primary-health/en/. Accessed 2019 Jan 22.
- College of Family Physicians of Canada. Four Principles of Family Medicine website. www.cfpc.ca/Principles/. Accessed 2019 January.
- Canadian Medical Association. *Health Care Transformation in Canada: Change that works. Care that lasts*. Ottawa, ON: Canadian Medical Association; 2018. Available from: <http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD10-05.PDF>. Accessed 2019 Jan 22.
- College of Family Physicians of Canada. *The Patient's Medical Home Provincial Report Card—February 2019*. Mississauga, ON: College of Family Physicians of Canada; 2019. Available from: https://patientsmedicalhome.ca/files/uploads/PMH_ReportCard_2018.pdf. Accessed 2019 February.
- Alberta Health. Primary Care Networks website. www.health.alberta.ca/services/primary-care-networks.html. Accessed 2018 August 16.
- Access Improvement Measures (AIM) Alberta. Third Next Available Appointments website. <https://aim.alberta.ca/index.php/2016/07/19/the-world-of-third-next-available-appointments-2/>. Accessed 2019 Jan 22.
- Office of the Premier, Ministry of Health. *B.C. government's primary health-care strategy focuses on faster, team-based care* [news release]. Victoria, BC: Government of British Columbia; 2018.
- General Practice Services Committee. *What We Do: Patient Medical Homes website*. www.gpscbc.ca/what-we-do/patient-medical-homes-and-primary-care-networks. Accessed 2018 Aug 22.
- Government of Manitoba. Frequently Asked Questions about My Health Teams website. www.gov.mb.ca/health/primarycare/myhts/faq.html#manitoba. Accessed 2018 Aug 15.
- Chateau D, Katz A, Metge C, Taylor C, McDougall C, McCulloch S. *Describing Patient Populations for the My Health Team Initiative*. Winnipeg, MB: Manitoba Centre for Health Policy; 2017. Available from: http://mchp-appserv.cpe.umanitoba.ca/reference//hiusers_Report_web.pdf. Accessed 2019 Jan 22.
- Government of Manitoba. *Budget Paper F: Reducing Poverty and Promoting Community Involvement*. Winnipeg, MB: Government of Manitoba; 2018. Available from: www.gov.mb.ca/finance/budget18/papers/F_Reducing_Poverty_r.pdf. Accessed 2019 Jan 22.
- Government of New Brunswick. *New model for family medicine aims to improve physician access* [news release]. Fredericton, NB: Government of New Brunswick; 2017. Available from: www2.gnb.ca/content/gnb/en/news/news_release/2017/06/0849.html. Accessed 2019 Jan 22.
- Health, Office of the Premier. *Twenty-five new doctors to be added to New Brunswick's health-care system to reduce wait times* [news release]. Fredericton, NB: Government of New Brunswick; 2018. Available from: www2.gnb.ca/content/gnb/en/news/news_release/2018/02/0140.html. Accessed 2019 Jan 22.
- Government of Newfoundland and Labrador. *Healthy People, Healthy Families, Healthy Communities: A Primary Health Care Framework for Newfoundland and Labrador 2015-2025*. St. John's, NL: Government of Newfoundland and Labrador; 2015. Available from: www.health.gov.nl.ca/health/publications/PHC_Framework_update_Nov26.pdf. Accessed 2018 November.
- Health and Community Services. *Supporting Health Communities: Primary Health Care Team has Success at the Gathering Place* [news release]. St. John's, NL: Government of Newfoundland and Labrador; 2016. Available from: www.releases.gov.nl.ca/releases/2016/health/1124n01.aspx. Accessed 2018 Nov.
- Nova Scotia Health Authority. Collaborative Family Practice Teams website. [www.nshealth.ca/collaborative-family-practice-teams](http://nshealth.ca/collaborative-family-practice-teams). Accessed 2019 January.
- Government of Ontario. Family Health Teams website. www.health.gov.on.ca/en/pro/programs/fht/. Accessed 2018 August 16.
- Conference Board of Canada. *Final Report: An External Evaluation of the Family Health Team (FHT) Initiative*. Ottawa, ON: The Conference Board of Canada; 2014. Available from: www.conferenceboard.ca/e-library/abstract.aspx?did=6711. Accessed 2019 Jan 22.
- Kralj B, Kantarevic J, OMA Economics Department. Primary care model enrolment and hospital length of stay in Ontario: patient rostering associated with reduced length of stay, significant health system savings. *Ontario Medical Review*. Sept 2012, 16-19. Available from: www.oma.org/wp-content/uploads/sept2012_primary_care_model.pdf. Accessed 2019 Jan 22.
- Tiagi R, Chechulin Y. The Effect of Rostering with a Patient Enrolment Model on Emergency Department Utilization. *Healthcare Policy*. 2014;9(4):105-121. Available from: www.longwoods.com/content/23809/the-effect-of-rostering-with-a-patient-enrolment-model-on-emergency-department-utilization. Accessed 2019 Jan 22.
- Health PEI. *Health Centres Offer Primary Care* [news release]. Charlottetown, PE: Government of Prince Edward Island; 2015. Available from: [www.princeedwardisland.ca/en/information/health-pe/health-centres-offer-primary-care](http://princeedwardisland.ca/en/information/health-pe/health-centres-offer-primary-care). Accessed 2019 Jan 22.
- Gouvernement du Québec. Groupe de médecine de famille (GMF), groupe de médecine de famille universitaire (GMF-U) et super-clinique website. www.quebec.ca/sante/systeme-et-services-de-sante/organisation-des-services/gmf-gmf-u-et-super-clinique/. Accessed 2019 January.
- Government of Saskatchewan. *Fact Sheet: Connected Care* [news release]. Regina, SK: Government of Saskatchewan; 2018.
- Pomey MP, Ghadiri DP, Karazivan P, Fernandez N, Clavel N. Patients as partners: a qualitative study of patients' engagement in their health care. *PLoS One*. 2015;10(4):e0122499.
- Pointer DD, Orlikoff JE. *Board Work: Governing Health Care Organizations*. 1st ed. San Francisco, CA: Jossey-Bass; 1999.
- Canadian Foundation for Healthcare Improvement. *Mythbusters: Most Physicians Prefer Fee-for-Services Payments*. Ottawa, ON: Canadian Foundation for Healthcare Improvement; 2010. Available from: www.cfhi-fcass.ca/sf-docs/default-source/mythbusters/Myth-Fee-for-Service-E.pdf?sfvrsn=0. Accessed 2019 Jan 22.
- Blomqvist A, Busby C. *How to Pay Family Doctors: Why "Pay per Patient" is Better than Fee for Service*. Toronto, ON: C.D Howe Institute; 2012. Available from: www.cdhowe.org/sites/default/files/attachments/research_papers/mixed/Commentary_365.pdf. Accessed 2019 Jan 22.
- Holden M, Madore O. *Remuneration of Primary Care Physicians* (PRB 01-35E). Ottawa, ON: Library of Parliament, Parliamentary Research Branch; 2002. Available from: <http://publications.gc.ca/collections/Collection-R/LoPBdP/PRB-e/PRB0135-e.pdf>. Accessed 2019 Jan 22.
- Carter R, Riverin B, Levesque JF, Garipey G, Quesnel-Vallee A. The impact of primary care reform on health system performance in Canada: a systematic review. *BMC Health Serv Res*. 2016;16:324.
- Kiran T, Kopp A, Moineddin R, Glazier RH. Longitudinal evaluation of physician payment reform and team-based care for chronic disease management and prevention. *CMAJ*. 2015;187(17):E494-502.
- College of Family Physicians of Canada. *Best Advice guide: Physician Remuneration in a Patient's Medical Home*. Mississauga, ON:

- College of Family Physicians of Canada; 2016. Available from: <https://patientsmedicalhome.ca/resources/best-advice-guides/best-advice-guide-physician-remuneration-patients-medical-home/>. Accessed 2019 Jan 22.
37. Hutchison B, Levesque JF, Strumpf E, Coyle N. Primary health care in Canada: systems in motion. *Milbank Q*. 2011;89(2): 256-288.
38. Aggarwal M, Hutchison B. *Toward a Primary Care Strategy for Canada*. Ottawa, ON: Canadian Foundation for Healthcare Improvement; 2012. Available from: www.cfhi-fcass.ca/Libraries/Reports/Primary-Care-Strategy-EN.sflb.ashx. Accessed 2019 Jan 22.
39. PricewaterhouseCoopers. *Canada Health Infoway: The emerging benefits of electronic medical record use in community-based care*. Toronto, ON: PricewaterhouseCoopers; 2013. Available from: www.pwc.com/ca/en/healthcare/publications/pwc-electronic-medical-record-use-community-based-care-report-2013-06-en.pdf. Accessed 2018 Jul 3.
40. Canada Health Infoway. *Use of Electronic Medical Records among Canadian Physicians, 2017 Update*. Toronto, ON: Canada Health Infoway; 2017.
41. College of Family Physicians of Canada. *Supporting access to data in electronic medical records for quality improvement and research* [position statement]. Mississauga, ON: College of Family Physicians of Canada; 2017. Available from: www.cfpc.ca/uploadedFiles/HealthPolicy/CFPCPolicyPapersandEndorsements/CFPCPolicyPapers/CFPC-Position-Statement-Supporting-access-data-electronic-medical-records-EN.pdf. Accessed 2019 Jan 22.
42. Jamieson T, Wallace R, Armstrong K, Agarwal P, Griffin B, Wong I, et al. *Virtual Care: A Framework for a Patient-Centric System*. Toronto, ON: Women's College Hospital Institute for Health Systems Solutions and Virtual Care; 2015. Available from: www.womenscollegethospita.ca/assets/pdf/wihv/WIHV-VirtualHealthSymposium.pdf. Accessed 2019 Jan 22.
43. McGrail KM, Ahuja MA, Leaver CA. Virtual Visits and Patient-Centered Care: Results of a Patient Survey and Observational Study. *J Med Internet Res*. 2017;19(5):e177.
44. Canadian Medical Association. Managing your Practice website. www.cma.ca/managing-your-practice. Accessed 2019 Jan 22.
45. Chang F, Gupta N. Progress in electronic medical record adoption in Canada. *Can Fam Physician*. 2015;61(12):1076-1084.
46. Canadian Nurses Association, Canadian Medical Association, Health Action Lobby. *Integration: A New Direction for Canadian Health Care—A Report on the Health Provider Summit Process*. Ottawa, ON: Canadian Nurses Association; 2013. Available from: www.cna-aic.ca/-/media/cna/files/en/cna_heal_provider_summit_transformation_to_integrated_care_e.pdf. Accessed 2019 Jan 22.
47. Canada Health Infoway website. www.infoway-inforoute.ca/en/. Accessed 2019 Jan 22.
48. Canadian Foundation for Healthcare Improvement. Connected Medicine website. www.cfhi-fcass.ca/WhatWeDo/connected-medicine. Accessed 2018 Aug 15.
49. Rajakulendra N, Macintosh E, Salah H. *Transforming Health: Toward decentralized and connected care*. Toronto, ON: MaRS Discovery District; 2014. Available from: www.marsdd.com/wp-content/uploads/2014/09/Sep15-MaRS-Whitepapers-SmartHealth.pdf. Accessed 2019 Jan 22.
50. College of Family Physicians of Canada. Best Advice guide: *Advanced and Meaningful Use of EMRs*. Mississauga, ON: College of Family Physicians of Canada; 2018. Available from: <https://patientsmedicalhome.ca/resources/best-advice-guides/best-advice-guide-advanced-and-meaningful-use-of-emrs/>. Accessed 2019 Jan 22.
51. Ontario Primary Care Council. *Position Statement: Care Co-ordination in Primary Care*. Toronto, ON: Ontario Primary Care Council; 2015. Available from: www.afho.ca/wp-content/uploads/OPCC_Care-Coordination-Position.pdf. Accessed 2019 Jan 22.
52. Wong ST, Watson DE, Young E, Regan S. What do people think is important about primary healthcare? *Healthcare Policy*. 2008; 3(3):89-104.
53. Canadian Medical Association. *CMA Position Statement: Ensuring Equitable Access to Care: Strategies for Government, Health System Planners and the Medical Profession*. Ottawa, ON: Canadian Medical Association; 2014. Available from: www.cma.ca/sites/default/files/2018-11/PD14-04-e.pdf. Accessed 2019 Jan 22.
54. Canadian Nurses Association. *Position Statement: Primary Health Care*. Ottawa, ON: Canadian Nurses Association; 2015. Available from: www.cna-aic.ca/-/media/cna/page-content/pdf-en/primary-health-care-position-statement.pdf. Accessed 2019 Jan 22.
55. Canadian Nurses Association. *Social Justice ... a means to an end, an end in itself*; 2nd edition. Ottawa, ON: Canadian Nurses Association; 2010. Available from: www.cna-aic.ca/-/media/cna/page-content/pdf-en/social-justice-2010-e.pdf. Accessed 2019 Jan 22.
56. Barry DW, Melhado TV, Chacko KM, Lee RS, Steiner J, Kutner JS. Patient and physician perceptions of timely access to care. *J Gen Intern Med*. 2006;21(2):130-133.
57. Glass DP, Kanter M, Jacobsen SJ, Minardi PM. The impact of improving access to primary care. *J Eval Clin Pract*. 2017;23(6):1451-1458.
58. Hudec JC, MacDougall S, Rankin E. Advanced access appointments: effects on family physician satisfaction, physicians' office income, and emergency department use. *Can Fam Phys*. 2010;56(10):e361-e367.
59. Stalker CA. *How have physicians and patients at New Vision Family Health Team experienced the shift to a family health team model? Final Report*. Unpublished; 2010.
60. Murray M, Tantau C. Same-day appointments: exploding the access paradigm. *Fam Pract Manag*. 2000;7(8):45-50.
61. College of Family Physicians of Canada. Best Advice guide: *Timely Access to Appointments in Family Practice*. Mississauga, ON: College of Family Physicians of Canada; 2012. Available from: <https://patientsmedicalhome.ca/resources/best-advice-guides/best-advice-guide-timely-access/>. Accessed 2019 Jan 22.
62. Lemire F. First contact: what does it mean for family practice in 2017? *Can Fam Phys*. 2017;63(3):256.
63. Williams DL. Balancing rationalities: gatekeeping in health care. *J Med Ethics*. 2001;27(1):25-29.
64. Murray M, Davies M, Boushon B. Panel size: How many patients can one doctor manage? *Fam Pract Manag*. 2007;14(4):44-51.
65. College of Family Physicians of Canada. Best Advice guide: *Panel Size*. Mississauga, ON: College of Family Physicians of Canada; 2012. Available from: <https://patientsmedicalhome.ca/resources/best-advice-guides/best-advice-guide-panel-size/>. Accessed 2019 Jan 22.
66. Buchman S, Woollard R, Meili R, Goel R. Practising social accountability. *Can Fam Phys*. 2016; 62(1):15-18.
67. National Collaborating Centre of Determinants of Health website. www.nccdh.ca/. Accessed 2019 Jan 22.
68. National Collaborating Centre on Aboriginal Health website. www.nccah-cnca.ca/en/. Accessed 2019 Jan 22.
69. College of Family Physicians of Canada. *CanMEDS-Family Medicine 2017: A competency framework for family physicians across the continuum*. Mississauga, ON: College of Family Physicians of Canada; 2017. Available from: www.cfpc.ca/uploadedFiles/Resources/ResourceItems/HealthProfessionals/CanMEDS-Family-Medicine-2017-ENG.pdf. Accessed 2019 Jan 22.
70. College of Family Physicians of Canada. Best Advice guide: *Social Determinants of Health*. Mississauga, ON: College of Family Physicians of Canada; 2017. Available from: <https://patientsmedicalhome.ca/resources/best-advice-guides/best-advice-guide-social-determinants-health/>. Accessed 2019 Jan 22.
71. Lightman E, Mitchell A, Wilson B. *Poverty is making us sick: A comprehensive survey of income and health in Canada*. Toronto, ON: The Wellesley Institute; 2008. Available from: www.wellesleyinstitute.com/wp-content/uploads/2011/11/povertyismakingussick.pdf. Accessed 2019 Jan 18.
72. White AA 3rd, Logghe HJ, Goodenough DA, Barnes LL, Hallward A, Allen IM, et al. Self-Awareness and Cultural Identity as an Effort to Reduce Bias in Medicine. *J Racial Ethn Health Disparities*. 2018;5(1):34-49.
73. Canadian Primary Care Sentinel Surveillance Network website. <http://cpcssn.ca/>. Accessed 2019 Jan 22.
74. Pinto AD, Bloch G. Framework for building primary care capacity to address the social determinants of health. *Can Fam Phys*. 2017;63(11):e476-482.

75. College of Family Physicians of Canada. Best Advice guide: *Team-Based Care in the Patient's Medical Home*. Mississauga, ON: College of Family Physicians of Canada; 2017. Available from: <https://patientsmedicalhome.ca/resources/best-advice-guides/best-advice-guide-team-based-care-patients-medical-home/>. Accessed 2019 Jan 22.
76. Grant R, Finocchio L, Pew Health Professions Commission, California Primary Care Consortium. *Interdisciplinary collaborative teams in primary care: a model curriculum and resource guide*. San Francisco, CA: Pew Health Professions Commission; 1995.
77. Schottenfeld L, Petersen D, Peikes D, Ricciardi R, Burak H, McNellis R, et al. *Creating Patient-Centered Team-Based Primary Care*. AHRQ Pub. No. 16-0002-EF. Rockville, MD: Agency for Healthcare Research and Quality; 2016.
78. Department of Health. Part 3: The accreditation of GPs and Pharmacists with Special Interests. In: *Implementing care closer to home: Convenient quality care for patients*. London, UK: Department of Health; 2007. Available from: www.pcc-cic.org.uk/sites/default/files/articles/attachments/improved_quality_of_care_p3_accreditation.pdf. Accessed 2019 Jan 22.
79. Department of Health. Part 1: Introduction and overview. In: *Implementing care closer to home: Convenient quality care for patients*. London, UK: Department of Health; 2007. Available from: www.pcc-cic.org.uk/sites/default/files/articles/attachments/improved_quality_of_care_p1_introduction.pdf. Accessed 2019 Jan 22.
80. College of Family Physicians of Canada. Best Advice guide: *Communities of Practice in the Patient's Medical Home*. Mississauga, ON: College of Family Physicians of Canada; 2016. Available from: <https://patientsmedicalhome.ca/resources/best-advice-guides/communities-practice-patients-medical-home/>. Accessed 2019 Jan 22.
81. Dinh T. *Improving Primary Health Care Through Collaboration: Briefing 2—Barriers to Successful Interprofessional Teams*. Ottawa, ON: The Conference Board of Canada; 2012. Available from: www.conferenceboard.ca/e-library/abstract.aspx?did=5181&AspxAutoDetectCookieSupport=1. Accessed 2019 Jan 22.
82. Nelson S, Turnbull J, Bainbridge L, Caulfield T, Hudon G, Kendel D, et al. *Optimizing Scopes of Practice: New Models for a New Health Care System*. Ottawa, ON: Canadian Academy of Health Sciences; 2014.
83. Mautner DB, Pang H, Brenner JC, Shea JA, Gross KS, Frasso R, et al. Generating hypotheses about care needs of high utilizers: lessons from patient interviews. *Popul Health Manag*. 2013;16(Suppl):S26-33.
84. American Academy of Family Physicians. Definition of Continuity of Care website. www.aafp.org/about/policies/all/definition-care.html. Accessed 2018 July 25.
85. Canadian Institute for Health Information. *Continuity of Care With Family Medicine Physicians: Why It Matters*. Ottawa, ON: Canadian Institute for Health Information; 2015. Available from: https://secure.cihi.ca/free_products/UPC_ReportFINAL_EN.pdf. Accessed 2019 Jan 22.
86. Starfield B, Chang HY, Lemke KW, Weiner JP. Ambulatory specialist use by nonhospitalized patients in us health plans: correlates and consequences. *J Ambul Care Manage*. 2009;32(3):216-25.
87. Pereira Gray DJ, Sidaway-Lee K, White E, Thorne A, Evans PH. Continuity of care with doctors—a matter of life and death? A systematic review of continuity of care and mortality. *BMJ Open*. 2018;8(6):e021161.
88. Starfield B, Shi L. The medical home, access to care, and insurance: a review of evidence. *Pediatrics*. 2004;113(Supplement 4):1495.
89. McWhinney I. The Need for a Transformed Clinical Method. In: *Communicating with Medical Patients*. London, UK: Sage; 1989:25.
90. College of Family Physicians of Canada. Best Advice guide: *Patient-Centred Care in a Patient's Medical Home*. Mississauga, ON: College of Family Physicians of Canada; 2014. Available from: <https://patientsmedicalhome.ca/resources/best-advice-guides/best-advice-guide-patient-centredness/>. Accessed 2019 Jan 22.
91. Canadian Medical Association, Canadian Nurses Association. *Principles to Guide Health Care Transformation in Canada*. Ottawa, ON: Canadian Medical Association; 2011.
92. Patients Canada. *Why we need a Health Accord with Patients at the Centre* [news release]. Toronto, ON: Patients Canada; 2016. Available from: <https://patientscanada.ca/2016/01/18/why-we-need-a-health-accord-with-patients-at-the-centre/>. Accessed 2019 Jan 22.
93. Omole FS, Sow CM, Fresh E, Babalola D, Strothers H. Interacting with patients' family members during the office visit. *Am Fam Physician*. 2011; 84(7): 780-784.
94. Mitnick S, Leffler C, Hood VL; American College of Physicians Ethics, Professionalism and Human Rights Committee. Family caregivers, patients and physicians: ethical guidance to optimize relationships. *J Gen Intern Med*. 2010;25(3):255-60.
95. Panagioti M, Richardson G, Small N, Murray E, Rogers A, Kennedy A, et al. Self-management support interventions to reduce health care utilisation without compromising outcomes: a systematic review and meta-analysis. *BMC Health Serv Res*. 2014;14:356.
96. College of Family Physicians of Canada. Best Advice guide: *Chronic Care Management in a Patient's Medical Home*. Mississauga, ON: College of Family Physicians of Canada; 2016. Available from: <https://patientsmedicalhome.ca/resources/best-advice-guides/best-advice-guide-chronic-care-management-patients-medical-home/>. Accessed 2019 Jan 22.
97. Prevention in Hand website. www.preventioninhand.com. Accessed 2019 Jan 22.
98. Kruse CS, Argueta DA, Lopez L, Nair A. Patient and provider attitudes toward the use of patient portals for the management of chronic disease: a systematic review. *J Med Internet Res*. 2015;17(2):e40.
99. Kruse CS, Bolton K, Freriks G. The effect of patient portals on quality outcomes and its implications to meaningful use: a systematic review. *J Med Internet Res*. 2015;17(2):e44.
100. Health Council of Canada. *Which way to quality? Key perspectives on quality improvement in Canadian health care systems*. Toronto, ON: Health Council of Canada; 2013. Available from: https://healthcouncilcanada.ca/files/QIRReport_ENG_FA.pdf. Accessed 2019 Jan 22.
101. Mattison CA, Wilson MC. *Rapid Synthesis: Examining the Effects of Value-based Physician Payment Models*. Hamilton, ON: McMaster Health Forum; 2017. Available from: www.mcmasterforum.org/docs/default-source/product-documents/rapid-responses/examining-the-effects-of-value-based-physician-payment-models.pdf?sfvrsn=2. Accessed 2019 Jan 22.
102. Kaczorowski J, Hearps SJ, Lohfeld L, Goeree R, Donald F, Burgess K, et al. Effect of provider and patient reminders, deployment of nurse practitioners, and financial incentives on cervical and breast cancer screening rates. *Can Fam Phys*. 2013; 59(6): e282-9.
103. Hutchison B. Pay for performance in primary care: proceed with caution, pitfalls ahead. *Healthc Policy*. 2008; 4(1): 10-15.
104. College of Family Physicians of Canada. The Practice Improvement Initiative (Pii) website. www.cfpc.ca/pii/. Accessed 2019 Jan 22.
105. Ontario College of Family Physicians. *Advancing Practice Improvement in Primary Care – Final Report*. Toronto, ON: Ontario College of Family Physicians; 2015. Available from: https://ocfp.on.ca/docs/default-source/default-document-library/hqo-final-report-advancing-practice-improvement-in-primary-care.pdf?sfvrsn=d793f489_4. Accessed 2019 Jan 22.
106. Canadian Institutes of Health Research. Strategy for Patient-Oriented Research website. www.cihr-irsc.gc.ca/e/41204.html. Accessed 2019 Jan 22.
107. Hasley PB, Simak D, Cohen E, Buranosky R. Training residents to work in a patient-centered medical home: What are the outcomes? *J Grad Med Educ*. 2016; 8(2): 226-231.
108. College of Family Physicians of Canada. *Specific Standards for Family Medicine Residency Programs – The Red Book*. Mississauga, ON: College of Family Physicians of Canada; 2016.
109. College of Family Physicians of Canada. Triple C Competency Based Curriculum website. www.cfpc.ca/Triple_C/. Accessed 2019 Jan 22.
110. Filipe HP, Silva ED, Stulting AA, Golnik KC. Continuing professional development: Best practices. *Middle East Afr J Ophthalmol*. 2014; 21(2): 134-141.
111. College of Family Physicians of Canada. Family Medicine Professional Profile website. www.cfpc.ca/fmprofile/. Accessed 2019 Jan 22.

