

THE COLLEGE OF  
FAMILY PHYSICIANS  
OF CANADA



LE COLLÈGE DES  
MÉDECINS DE FAMILLE  
DU CANADA



A VISION FOR CANADA

# Family Practice The Patient's Medical Home

SEPTEMBER 2011



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## Executive Summary



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

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

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

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

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## A Vision for Canada

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

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

Unfortunately, recent studies have indicated that compared with people in other developed nations, Canadians today are less satisfied with their access to and quality of care<sup>7</sup> and there are now worse health outcomes in Canada for several significant medical conditions.<sup>8</sup> The vision of the Patient’s Medical Home is to see the levels of satisfaction and the health outcomes of Canada’s population once again ranked among the world’s best.

# A VISION FOR CANADA

Four hands are positioned to form a house-like shape. The top two hands are held together at their fingertips, with fingers pointing downwards. The bottom two hands are held together at their fingertips, with fingers pointing upwards. The palms of all four hands are facing outwards, creating a central white space where the text is located.

**Family  
Practice**  
The Patient's  
Medical Home



## Introduction

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

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

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

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

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

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

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





## *Understanding the Patient's Medical Home*

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

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

### **WHAT THE PATIENT'S MEDICAL HOME IS NOT**

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



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

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

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



## *Family Practice: The Patient's Medical Home – Definition*

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



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

## OBJECTIVES

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

## GOALS

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

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

# Summary of Recommendations

## GOAL 1

**A Patient's Medical Home will be patient centred.**

### RECOMMENDATIONS

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

## GOAL 2

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

### RECOMMENDATIONS

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

## GOAL 3

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

### RECOMMENDATIONS

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

## GOAL 4

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

### RECOMMENDATIONS

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

## GOAL 5

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

### RECOMMENDATIONS

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

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

## GOAL 6

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

#### RECOMMENDATIONS

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

## GOAL 7

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

#### RECOMMENDATIONS

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

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

## GOAL 8

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

### RECOMMENDATIONS

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

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‡Comprehensive, focused on continuity of education and patient care, centred in family medicine.



## GOAL 9

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

### RECOMMENDATIONS

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

## GOAL 10

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

### RECOMMENDATIONS

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

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



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# Framework of the Patient's Medical Home: The Pillars



## Family Practice: The Patient's Medical Home

Patient-Centred

Personal Family Physician

Team-Based Care

Timely Access

Comprehensive Care

Continuity

Electronic Records & Health Information

Education, Training & Research

System Supports

Evaluation

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