Refreshing the Patient's Medical Home

New vision for providing exceptional care in family practice

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Dear Colleagues,

A refreshed version of the Patient's Medical Home (PMH) vision will soon be released (**patientsmedicalhome.ca**). When the PMH was originally created and launched in 2011, we believed it was important to articulate a vision for community-based care that addressed access and that took stock of evolving trends, such as changing demographic characteristics of patients and providers, increasing patient complexity, and the contribution to care of all providers in family practice. The PMH rested on 10 pillars: patient-centred care; a personal FP; team-based care; timely access; comprehensive care; continuity of care; electronic medical records (EMRs); education, training, and research; evaluation and quality improvement (QI); and internal and external supports. Eight years later, we are pleased to see that the PMH vision has been instrumental in informing and directing primary care reforms across Canada. The refreshed PMH vision takes stock of the lessons learned regionally, of opportunities for improvement that continue to be identified, and of anticipated future trends likely to affect the practice of medicine. The vision is crafted to be adaptable to provincial contexts to result in excellent community-based care that fits the needs of both patients and providers.

The 10 pillars of the refreshed PMH vision are organized into 3 themes: foundation, function, and ongoing development. *Foundation* includes administration and funding, appropriate infrastructure, and connected care. All 3 are deemed necessary for a PMH to successfully deliver the full range of potential benefits. We know from experience to date that financial and government support are essential, and that strong governance, leadership, and management are all necessary locally and regionally. The same applies to infrastructure elements such as physical space, human resources, EMRs, and other digital resources. Practice integration with other care settings, enabled by health information technology (connected care), is also a key enabler.

Function includes 5 key core pillars related to services provided by a PMH: accessible care, community adaptiveness and social accountability, comprehensive team-based care featuring FP leadership, continuity of care, and patient- and family-partnered care. In articulating these priorities, the PMH vision stresses the importance of assessing and meeting needs—be they the needs of individual patients, their families, or the communities served by the practice. These goals are closely aligned with the 4 principles of family medicine, emphasizing relationships with patients and being firmly rooted in community. The increased emphasis on community adaptiveness and social accountability is likely the single biggest change the vision has undergone since 2011.

Ongoing development includes measurement, continuous QI, and research, training, education, and continuous professional development. Continuous QI is an important CFPC priority. Through work by our Research Department and Section of Researchers, a guide is under development to assist family medicine residency programs in enhancing residents' competence in QI. Guides on practice facilitation, including advanced use of EMRs,[1] are being created to better support FPs. Robust participation in QI and research in family medicine allows us to capture the crucial contribution of family practice to primary care and to the health care system as a whole.

Katz et al[2] found that provinces are about halfway there in achieving the PMH goals, and that considerable opportunities for improvement remain. We are reminded that "during the past 15 years, new primary care funding models have been introduced without consistency in timing, key model components, or implementation strategies across provinces."[2] Our recent PMH report provides a province-by-province assessment of developments. We know that high-functioning PMHs are associated with fewer visits to the emergency department, better adherence to preventive measures, and improved chronic disease management, among other benefits.[3,4] The 2019 PMH vision takes stock of lessons learned and provides an opportunity to build on what has been achieved. If we are serious about "getting to better," we need to comprehensively address system supports necessary to achieve this vision at the micro, meso, and macro levels. We look forward to working with family physicians, other providers, our patients, and decision makers to better meet the health care needs of Canadians.

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References

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