Attribute Descriptions for a Patient Medical Home in BC

Overall goal

Patient centred, whole person-care: Care is easily navigated and centered on the needs of the patient, family, and community. Patients are empowered in optimal self-management, and contribute to the development and assessment of the practice and community care models. Care will be delivered in a culturally appropriate manner with recognition of social determinants of health and attention to marginalized populations.

Service attributes

Commitment (A personal family physician): A Patient's Medical Home (PMH) will ensure that patients have access to a personal family physician (or in some cases a NP) who will be the most responsible provider (MRP) of his or her medical care. Physicians have a defined patient panel and patients and physicians have a shared understanding of their mutual therapeutic relationship.

Contact (Timely access): Patients are able to access their own family physician or PMH team on the same day if needed. Patients know how to appropriately access advice and care on a 24/7 basis.

Comprehensive care: The PMH provides delivery of, and linkages to comprehensive services. The specific comprehensive services provided through the PMH and network of PMHs are determined by context, considering both community need and also available resources. A set of core services will be included regardless of context: I. Care of patients across the life cycle (newborn to end of life and palliative care), II. Care across clinical settings (eg ambulatory / office practice, hospital and LTC institutions, emergency care settings, care in the home) and geographic service areas (remote, rural, urban, metro), III. The full spectrum of services provided within the regulated scope of family practice (e.g health promotion and prevention, diagnosis and management of undifferentiated presenting problems, acute and chronic disease management, mental health care, maternity care) and appropriate procedural medicine.

Continuity of care: Longitudinal relationships support patient care across the continuum of patient care, spanning all settings. The enduring relationship between the patient, family physician (or NP where appropriate) and PMH team is key, and needs to be supported by informational continuity (two way communication that informs appropriate and timely care).

Coordination of care: The PMH is the hub for the coordination of care through informational continuity and personal relationships and networks with other PMHs, inter-professional team members within and linked to the practice, and linkages to speciality and specialized services across the care domains. Where services are provided outside the Patient Medical Home, simple and clear pathways will be established to support patients as they transition to and from specialized services. Patients are empowered to participate in the coordination of their care through access their own medical information and shared decision making with their physician/PMH team.

Relational enablers of care

Team-based care: The PMH generally includes more than one FP working with an expanded inter-professional team within the practice, and / or linked to the practice, with a focus on person-focused relationship-based care. Providers within the practice are working to optimized scope.

FP networks supporting practice: FPs are part of a clinical network working together to meet the comprehensive care needs of their patients and the patients of other PMHs in the community including extended hours of service, cross coverage, and/or on-call.

PMH networks supporting communities: The PMHs are networked through the Divisions of Family Practice (or other similar community care service organization where Divisions may not exist) to enable better coordination, partnership and integration with health authority and non-governmental community services (Primary Care Home), and the broader system of health care.

Structural enablers of care

Information technology enabled: Physicians, providers, and staff in the practice are IT enabled, including optimized EMR use and data collection methods to inform quality improvements in patient care and practice workflow. The EMR is able to link appropriately with other providers and parts of the system, including other community providers, pharmacies and acute care facilities. Virtual care options including access to appropriate email, telephone, and video conferencing advice/consults are used and optimized.

Education, training and research: The PMH promotes mentoring, peer coaching for continuing professional development, training and research. This will include providing support to new grads and recruits coming to the community, providing training to medical students, residents and allied health providers within the practice, participating in peer-led small-group learning sessions, and research within the PMH or as part of a network.

Evaluation and quality improvement: Physicians, other providers in the PMH, and patients are involved in clinical quality improvement activities at a professional, practice, community and system level.

Internal and external supports: The PMH has a business model which supports longitudinal, comprehensive, coordinated, team-based care, and linkages with specialized services. Practices are supported to enable this model of primary care and integrated care through provincial and regional policies and systems.