

# **Key Principles and Values for Family Physicians in Primary Care Model Development**

## **INTRODUCTION**

This document is to facilitate the development and assessment of newer models of primary care practice by outlining the key principles and values on which they should be based as viewed through the lens of family physicians and other primary care providers. During its development, Canadian and international programs of primary care renewal were reviewed and the current literature on primary care principles and values was considered. It is hoped that the information contained in this document will be beneficial to family physicians who are facing new or changing models of primary care where they are searching for the key principles and values that are important to them if they are joining a new family practice or transitioning to another.

The document was developed by a Working Group of The College of Family Physicians of Canada (CFPC). Members of the Key Principles in Model Development Working Group were: Dr. David Gass (Chair), Dr. John Brewer, Dr. Jonathan Kerr, Dr. Michael Malus, Dr. Jim Thorsteinson and Dr. John Maxted. The extra work of Ms. Lynn Dunikowski, Director of Library Services for the CFPC, is also acknowledged with thanks.

## **OVERRIDING PRIORITIES**

There are two **overriding priorities** for family physicians in considering what is valued in family practice. These are our collective commitments to QUALITY and EQUITY in the delivery of care to our patients.

### **Quality**

- Quality is a value that is given to the best care possible and usually involves a process of continuous practice improvement with attention to measuring the performance of ALL dimensions of patient-centered care.
- Quality is impacted by community, regional and provincial factors, making advocacy at those levels important in assuring quality in family practice.

### **Equity**

- Equity assures the greater good for all patients and providers and is achieved when we are able to work together with each other, with other health professionals and with our entire communities for that greater good.

Quality and Equity may be demonstrated within six areas of primary care (**Figure 1**) and within each area at the individual, family, and community levels. The six areas are:

**1) Access to Comprehensive Care**

**2) Care by Collaborative Teams**

**3) Continuity of the Patient- Doctor Relationship**

**4) Community Responsiveness using a Population Approach**

**5) Sufficient Infrastructure & Support**

**6) Support for Quality of Work Life of Professionals and Staff**

**Figure 1:**

***Relationship of Quality and Equity to Six Key Principles and Values in Primary Care Practice Model Development and Assessment***



## 1) ACCESS TO COMPREHENSIVE CARE

*“The most effective systems (clinical outcomes), and the most efficient systems (cost-revenue), with the most satisfying systems for patients and providers function with as little delay as possible.”*

– Institute for Healthcare Improvement

Canadians highly value timely access to, and continuity with their own personal physician. Evidence strongly supports better health outcomes for those in communities with better access to comprehensive services provided by family physicians working with other primary health care professionals (Starfield et al, 2002). [Comprehensive care](#) means providing a full spectrum of health services to meet the needs of patients, families, and their communities throughout the life span of the patient.

- Family practice provides each Canadian with a medical home accessible through a variety of means providing a comprehensive range of care that can be delivered by collaborative teams across many community settings.
- A comprehensive family practice includes:
  - Primary care in a variety of settings that could include family practice offices, patients’ homes, long term care institutions, hospitals, emergency departments, and maternity care settings.
  - The delivery of services to patients at all ages and stages in life for acute and chronic diseases, prevention and health promotion, support in self-care, and referral to other specialty services when required.
  - Organized [chronic disease prevention and management programs](#)
- Access to a comprehensive family practice is achieved through many channels, including the phone, email, web portals, etc. and could result in traditional office visits, group visits or home encounters.
- Family practices develop specific strategies for access to secondary and tertiary resources -
  - Specialty consultations
  - Diagnostic imaging
  - Mental health services
  - Other community services, e.g. physiotherapy and home care

### **Further Reading:**

1. American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP), American Osteopathic Association (AOA) Joint Principles of the Patient-Centered Medical Home; March 2007. [PDF](#)

2. Chan BT. The declining comprehensiveness of primary care. CMAJ. 2002 Feb 19;166(4):429-34. [PubMed](#)

3. Goroll AH, Berenson RA, Schoenbaum SC, Gardner LB. Fundamental reform of payment for adult primary care: comprehensive payment for comprehensive care. J Gen Intern Med. 2007 Mar;22(3):410-5. [PubMed](#)

4. Rachlis V. At a crossroads: the future of comprehensive care in Canada. Can Fam Physician. 2006 Nov;52(11):1375-6, 1380-1. [PubMed](#)

5. Starfield B, Shi L. Policy relevant determinants of health: an international perspective. Health Policy. 2002 Jun;60(3):201-18. [PubMed](#)

## 2) CARE BY COLLABORATIVE TEAMS

[Collaborative teams](#) that reflect community needs are important in achieving timely access to comprehensive care in family practice. A collaborative team is known to be a key component in chronic disease management. Patient relationships with their family practice home will be strengthened by concurrent provider relationships.

- The team size and composition should be flexible and adapted to community needs and values.
- Team relationships should be supported by structures that foster:
  - Clear common team goals
  - Clear role definition
  - Collegiality
  - Trust
  - Support for shared decision-making
  - Mutual respect for professional autonomy
- Teams should include a strong patient voice and support for patient self-management
- Teams should have a voice in the governance of their clinical activities in their clinic, community or hospital.

### Further Reading:

1. Fast facts. Interprofessional care. Can Fam Physician. 2007 Jul;53(7):1206. [PubMed Central](#)
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5. Scott C, Hofmeyer A. Networks and social capital: a relational approach to primary healthcare reform. Health Res Policy Syst. 2007 Sep 25;5:9. [PubMed](#)

6. Soklaridis S, Oandasan I, Kimpton S. Family health teams: Can health professionals learn to work together? *Can Fam Physician*. 2007 Jul;53(7):1198-9. [PubMed](#)

7. Wilson CR. Dream-team for optimal care. *Can Fam Physician*. 2008 Feb;54(2):317-8. [PubMed](#)

### 3) CONTINUITY OF THE PATIENT-DOCTOR RELATIONSHIP

Patients should experience integrated health care within [continuing care relationships](#) in their family practice homes as this improves quality, efficiency and satisfaction. Family practices should provide chronologic, longitudinal, informational, geographic, interdisciplinary, family, and interpersonal continuity. Family practices should be organized to optimize continuity of care across:

- Time
- Place
- Informational records
- Provider disciplines
- Family
- Interpersonal domains

Continuity strengthens the practice of the patient-centered clinical method. Continuity of care is known to improve adherence to management plans, reduce delay for necessary care, reduce utilization of lab, imaging, emergency and hospital services and improve both patient and physician satisfaction as well as the quality of care.

#### **Further Reading:**

1. Haggerty JL, Pineault R, Beaulieu MD, Brunelle Y, Gauthier J, Goulet F, Rodrigue J. Practice features associated with patient-reported accessibility, continuity, and coordination of primary health care. *Ann Fam Med*. 2008 Mar-Apr;6(2):116-23. [PubMed](#)

2. Kripalani S, LeFevre F, Phillips CO, Williams MV, Basaviah P, Baker DW. Deficits in communication and information transfer between hospital-based and primary care physicians: implications for patient safety and continuity of care. *JAMA*. 2007 Feb 28;297(8):831-41. Review. [PubMed](#)

3. Reid R, et al. Defusing the confusion: concepts and measures of continuity of healthcare. Canadian Health Services Research Foundation; March 2002 50 p. [PDF](#)

4. Rosser W, Schultz K. Promoting continuity of care should be integral to any health care system. *CMAJ*. 2007 Nov 20;177(11):1385-6. [PubMed](#)

5. Saultz JW, Lochner J. Interpersonal continuity of care and care outcomes: a critical review. *Ann Fam Med*. 2005 Mar-Apr;3(2):159-66. Review. [PubMed](#)

6. Saultz JW, Albedaiwi W. Interpersonal continuity of care and patient satisfaction: a critical review. *Ann Fam Med*. 2004 Sep-Oct;2(5):445-51. Review. [PubMed](#)

7. Turgeon J, Dumont S, St-Pierre M, Sévigny A, Vézina L. [Continuity of cancer care in Quebec: beyond the symptoms] *Can Fam Physician*. 2006 Dec;52(12):1572-3. Review. French. [PubMed](#)

#### 4) COMMUNITY RESPONSIVENESS USING A POPULATION APPROACH

One of the [Four Principles of Family Medicine](#) is 'The family physician is community-based'. When looking at a practice, consider the population(s) in the community:

- Which will your practice address?
- What are the needs?
- How and who determines the needs?
- Are there equity issues?
- How is the practice engaged with the regional health resources?
- How might the practice influence local health policies?

Family practices should:

- Participate in active [community needs assessment](#)
- Have mechanisms for community /patient input, such as [community advisory boards](#)
- Advocate to meet recognized community health needs
- Advocate for healthy public policy
- Identify cultural / racial / ethnic equity goals
- Develop working relationships with regional authorities

#### Further Reading:

##### Advocacy

1. Anderson LM, Brownson RC, Fullilove MT, Teutsch SM, Novick LF, Fielding J, Land GH. Evidence-based public health policy and practice: promises and limits. Am J Prev Med. 2005 Jun;28(5 Suppl):226-30. Review. [PubMed](#)
2. Gagnon F, Turgeon J, Dallaire C. Healthy public policy: conceptual cognitive framework. Health Policy. 2007 Apr;81(1):42-55. Epub 2006 Jun 21. [PubMed](#)
3. Genuis SJ. An ounce of prevention: a pound of cure for an ailing health care system. Can Fam Physician. 2007 Apr;53(4):597-9, 605-7. Review. English, French. [PubMed](#)
4. Martin CM. Chronic disease and illness care: adding principles of family medicine to address ongoing health system redesign. Can Fam Physician. 2007 Dec;53(12):2086-91. [PubMed](#)

### **Cultural/racial/ethnic equity**

1. Juckett G. Cross-cultural medicine. *Am Fam Physician*. 2005 Dec 1;72(11):2267-74. Review. [PubMed](#)
2. Pottie K. Misinterpretation: Language proficiency, recent immigrants, and global health disparities. *Can Fam Physician*. 2007 Nov;53(11):1899-901.01 [PubMed](#)
3. Pottie K, Hostland S. Health advocacy for refugees: Medical student primer for competence in cultural matters and global health. *Can Fam Physician*. 2007 Nov;53(11):1923-6. [PubMed](#)
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### **Relationships with regional authorities**

1. Frankish CJ, Moulton GE, Quantz D, Carson AJ, Casebeer AL, Eyles JD, Labonte R, Evoy BE. Addressing the non-medical determinants of health: a survey of Canada's health regions. *Can J Public Health*. 2007 Jan-Feb;98(1):41-7. [PubMed](#)
2. Hill A, Levitt C, Chambers LW, Cohen M, Underwood J. Primary care and population health promotion. Collaboration between family physicians and public health units in Ontario. *Can Fam Physician*. 2001 Jan;47:15-7, 22-5. [PubMed](#)
3. Morgan S, McMahon M, Mitton C. Centralising drug review to improve coverage decisions: economic lessons from (and for) Canada. *Appl Health Econ Health Policy*. 2006;5(2):67-73. [PubMed](#)
4. Teng F, Mitton C, Mackenzie J. Priority setting in the provincial health services authority: survey of key decision makers. *BMC Health Serv Res*. 2007 Jun 12;7:84. [PubMed](#)

## 5) SUFFICIENT INFRASTRUCTURE & SUPPORT

Practices have requirements for success. The physical facility is where you will spend much of your practice 'life' and where you will address your patient needs. Will the informational tools and resources work to assist you positively in serving your patients' needs? Does the practice actively focus on Quality in all its dimensions and seek to improve it? Are leadership and management valued and supported? Finally, is the [funding methodology](#) supportive of physicians, staff, and the facility?

- Does the family practice facility have:
  - Adequate common and private space?
  - Office design that supports patient flow?
  - Office design that supports team relationships and function?
  - A safe environment?
  - Suitable physical access for persons with disabilities?
- Does the [governance](#) support FP participation in management & leadership?
- Does the [information management](#):
  - Use functional electronic *or* paper records?
  - Support continuity of patient information across providers and care settings?
- Is there financial support for the overall funding of the family practice based on population needs?
- Does [physician payment](#):
  - Support the dimensions of quality?
  - Provide an income competitive with other medical specialties?
- What are the overhead costs for:
  - Facility?
  - Staff?
  - Information technology?
- Do continuous quality improvement activities support and include:
  - Measurement / evaluation / action?
  - Practice assessment?
  - Support for leadership development?

## Further Reading:

### Family practice facility

1. CMA Self Learning Module. Office Design and Layout. Available from: <http://www.cma.ca/>  
This module reviews several factors to be considered in the selection and design of your office.  
Free for CMA members and \$25 plus GST for non-CMA members
2. Jones KE, Tamari IE. Making our offices universally accessible: guidelines for physicians. CMAJ. 1997 Mar 1;156(5):647-56. Review. [PubMed](#)
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4. Peat M. Attitudes and access: advancing the rights of people with disabilities. CMAJ. 1997 Mar 1;156(5):657-9. Review. [PubMed](#)
5. Wells JE. Efficient office design for a successful practice. Fam Pract Manag. 2007 May;14(5):46-50. [PubMed](#)

### Information management

1. Adler KG. How to successfully navigate your EHR implementation. Fam Pract Manag. 2007 Feb;14(2):33-9. [PubMed](#)
2. Chaudhry B, Wang J, Wu S, Maglione M, Mojica W, Roth E, Morton SC, Shekelle PG. Systematic review: impact of health information technology on quality, efficiency, and costs of medical care. Ann Intern Med. 2006 May 16;144(10):742-52. Epub 2006 Apr 11. Review. [PubMed](#)
3. CanadianEMR. [Internet] CanadianEMR a clearinghouse for information about Canadian electronic medical records, is privately owned and based in Richmond, British Columbia. Alan Brookstone, a family physician and EMR advocate in British Columbia, serves as Executive Director. Available at: <http://www.canadianemr.ca/>
4. Health Canada. [EMR \(Electronic Medical Record\) Toolkit](#) [Internet] This resource manual and website is intended to help Canadian primary health care practices to adopt EMRs. Practices which are already using EMRs will find valuable information on EMR optimization and further benefits. Available from: <http://www.emrtoolkit.ca/>

5. Sullivan F, Wyatt JC. How informatics tools help deal with patients' problems. *BMJ*. 2005 Oct 22;331(7522):955-7. Review. [PubMed](#)

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### **Finances**

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2. Borglum K. Three steps to an effective practice budget. *Fam Pract Manag*. 2004 Jan;11(1):46-50. [PubMed](#)

3. Family Practice Management. [Family Practice Management Toolbox](#) [Internet] This journal's website offers a selection of financial management tools, many of which can be downloaded free of charge. Available from: <http://www.aafp.org/online/en/home/publications/journals/fpm/fpmttoolbox.html>

4. Kullgren J, Sibella MD. Calculating your costs per visit. *Fam Pract Manag*. 2004 Apr;11(4):41-5. [PubMed](#)

5. Naccarella L, Southern D, Furler J, Scott A, Prosser L, Young D, Swerissen H, Waters E. Primary care funding and organisational policy options and implications: a narrative review of evidence from five comparator countries. *Med J Aust*. 2008 Apr 21;188(8 Suppl):S73-6. Review. [PubMed](#)

6. Watts IT, Wenck B. Financing and the quality framework. *Aust Fam Physician*. 2007 Jan-Feb;36(1-2):32-4. [PubMed](#)

### **Continuous quality improvement**

1. Agency for Healthcare Research and Quality. [AHRQ Health Care Innovations Exchange](#). [Internet] The website is designed to support health care professionals in sharing and adopting innovations that improve the delivery of care to patients. Contents include innovative strategies and quality-related tools, classified by clinical category, patient population, setting of care, and more. Available from: <http://www.innovations.ahrq.gov/>

2. Dartmouth-Hitchcock Medical Center. [Clinical Microsystems](#). [Internet] The website offers a variety of toolkits, workbooks, videos and articles that clinical teams can use to improve the quality and value of patient care as well as the work-life of all staff who contribute to patient care. These methods can be adapted to a wide variety of clinical settings. Available from: <http://dms.dartmouth.edu/cms/>
3. Institute for Healthcare Improvement. [90-Day R&D Project](#). [Internet] A quick way to research innovative ideas and assess their potential for advancing quality improvement is described. Available from: <http://www.ihl.org/IHI/Topics/Improvement/>
4. Institute for Healthcare Improvement. [Patient Safety](#) [Internet] The website offers content — including change concepts, measures, resources, improvement stories, and downloadable tools — to help improve patient safety. Available from: <http://www.ihl.org/IHI/Topics/PatientSafety/SafetyGeneral/>
5. McMaster University Dept of Family Medicine. [The Quality in Family Practice Project](#) [Internet] The website offers assessment tools and questionnaires for family practices developed during the Quality in Family Practice Project. Available from: <http://www.qualityinfamilypractice.com>
6. Mohler PJ, Mohler NB. Improving chronic illness care: lessons learned in a private practice. *Fam Pract Manag.* 2005 Nov-Dec;12(10):50-6. [PubMed](#)
7. Robert Wood Johnson Foundation. [Improving Chronic Illness Care](#). [Internet] There is growing recognition that chronic disease management and primary care renewal are inextricably linked. This website helps to support providers who care for chronically ill patients with guidelines and specialty expertise. Available from: <http://www.improvingchroniccare.org/>

## 6) SUPPORT FOR QUALITY OF WORKLIFE OF PROFESSIONALS AND STAFF

Family physicians who feel fulfilled both at work and in their personal lives provide better care to their patients. Many resources and support systems are available in a number of areas to enable family physicians to create a healthy work-life balance.

- Flexibility
  - Special clinical interests
  - Support for personal / family responsibilities
  - Parental leave
- Collegiality
  - Mentoring opportunities
  - Availability of associates to cover
- Support for Continuing Professional Development
- Acceptable work hours / on call / vacation
- Support for family physicians in difficulty

### Further Reading:

#### Physician well-being

1. Analysis in Brief. Understanding Physician Satisfaction at Work: Results from the 2004 National Physician Survey. CIHI; 2006 Nov. [PDF](#)
2. Campbell S, Delva D. Physician do not heal thyself. Survey of personal health practices among medical residents. Can Fam Physician. 2003 Sep;49:1121-7. [PubMed](#)
3. Canadian Medical Association. [Centre for Physician Health and Well-being](#) [Internet] The website was created to help physicians, physicians in training and their families, maintain health and prevent illness, and to provide national leadership and advocacy on issues affecting the health and morale of Canadian physicians. Direct links to all provincial and territorial physician health programs are listed here. Available from: [http://www.cma.ca/index.cfm/ci\\_id/25541/la\\_id/1.htm](http://www.cma.ca/index.cfm/ci_id/25541/la_id/1.htm)
4. Cohen JS, Patten S. Well-being in residency training: a survey examining resident physician satisfaction both within and outside of residency training and mental health in Alberta. BMC Med Educ. 2005 Jun 22;5:21 [PubMed](#)

5. Goldman LS, Myers MM, Dickstein LJ. The handbook of physician health: the essential guide to understanding the health care needs of physicians; 2000. 268 p. [Amazon WorldCat](#)
6. Jensen PM, Trollope-Kumar K, Waters H, Everson J. Building physician resilience. Can Fam Physician. 2008 May;54(5):722-9. [PubMed](#)
7. Katz A et al. Summary of health status/behavior data of Canadian health professionals collected at the 2007 FMF health fair. [[Powerpoint](#)]
8. Myers M, ed. CMA Guide to Physician Health and Well-Being. Canadian Medical Association. 36 p. Topics include mental health, substance abuse, stress, burnout, prevention and recovery. Available from: <http://www.cma.ca/>
9. Sotile WM, Sotile M. The resilient physician: effective emotional management for doctors and their medical organizations. American Medical Association, 2002. [Amazon WorldCat](#)

#### **Support for Continuing Professional Development**

1. College of Family Physicians of Canada. [Mainpro](#) [Internet] The website describes Mainpro® (Maintenance of Proficiency / Maintien de la compétence professionnelle), the College of Family Physicians of Canada (CFPC) program that governs the continuing medical education (CME) requirements of its members. A [calendar](#) of Manipro-accredited events is available.
2. College of Family Physicians of Canada. CFPC eCME Resource Centre. [Internet] The website offers access to on-line educational resources that enhance the CFPC's educational programs. Available from: <http://www.cfpc.ca/local/asp/cfpc/ecme.asp>
3. Foundation for Medical Practice Education. [Internet] The Foundation for Medical Practice Education (FMPE) is a Canadian non-profit organization dedicated to the development, production, and evaluation of educational programs for community-based family medicine and general practitioners. Available from: <http://www.fmpe.org/en/about/index.htm>
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