Patient Medical Home
A Team Approach to Care

By joining Dr. Fournier's panel, you are now part of a Patient Medical Home. This means that, in addition to your primary care provider, you also have access to a team of specialized healthcare providers working together to support your well-being. This team approach means patients are not always scheduled with the doctor, yet still receive the care and support they need in a timely fashion from the team.

You may have heard this phrased as **"the right provider at the right time!"**

One example: if Dr. F doesn't have an opening for a medication refill until next week due to high demand, our clinical pharmacist may have availability today or tomorrow to discuss and renew your medication.

Primary care provider – family physician Dr. Fournier

Dr. Fournier provides comprehensive healthcare from assessment, investigations, diagnosis, treatment, and follow-up. She works closely with team members and receives an update on your condition even if you are seen by a different provider. Family physicians refer to specialists or community resources as needed and are advocates for your health.

Medical Office Assistant (MOA)

Our MOA is your point of contact for all your care at the medical home. They works with patients to determine their health needs and schedules appointments with the most qualified and timely team member available. They are also an experts in health care paperwork and can answer questions about forms, insurance, health records, and uninsured services.

Licensed practical nurse (LPN)

A member if the LPN team will see you at most visits with Dr. Fournier. They assess vitals, gather preliminary history, ensure health screening is up to date, and provide education and support. You may also see the LPN independently by appointment for review of normal results on request, blood draws, vitals checks, cryotherapy, ear flushing, or wound care.

Clinical pharmacist

Our pharmacist provides medication reviews and education, monitors meds, follows up on changes and make adjustments, provides refills, addresses coverage and barriers. They work with patients and physician to ensure meds are accessible, effective, and well understood by the patient. They will also liaise with your community pharmacy as needed.

Registered Nurse (RN), chronic care

Our RN has additional expertise in chronic care management. They follow patients for COPD, hypertension, stable diabetes, smoking cessation, and anticoagulation. They provide ongoing education and support, collaborating with the physician for management changes as needed.

Medical students, resident physicians, pharmacy students, and nursing students

We appreciate your contribution to the education of our future providers! Your care will always be overseen by their direct supervisor.

Additionally, we can call on additional team members on an as needed basis:

Physiotherapist – for assessment and treatment of musculoskeletal conditions

Social worker – for limited talk therapy and connection to further community programming

Case manager – for assistance with finances, community resources, and general assistance navigating complex medical or social situations

Contact us:
1-902-629-8841 ext. 2