PEFHT Vision:

Leaders in high-quality, patient-centred, integrated rural primary care.

Integrated Collaborative Care		
Provide effective and efficient services to those with the greatest health needs (complex, chronic conditions) that will ensure continuity of care and cross-sectoral coordination.		
Activity	**Measure/Target**	**Status/Progress**
Create a process of coordinated care planning for the most complex PEFHT patients	Implementation of Coordinated Care Program for complex patients as articulated in our MOH Operating plan.	• 93 CCP's completed to-date. • Process map completed • Inter-organizational learning circle meeting every 2 months
Co-locate in a multi-agency facility.	Process: - Articulate space program - Procure a developer - multiparty agreements completed between municipality, FHO/FHT - business model created - integrated program model established (NP role, urgent care, CDM etc.)	• RFP ready for market July 2014 • Commitment in principle from PEC for donation of 4 acre parcel of land at McFarland site. • Procurement of ongoing project management for oversight and business model creation [Fall 2014] – postponed d/t delays in creation in Offer to Lease. Business model being sketched out in advance.
Strengthen relationships with community partners through cross-sectoral Quality Improvement initiatives	Discharge Planning with QHC on key clinical pathways (COPD, CHF, DM). Ensure PEFHT coordinated pathway for complex patients post-discharge. Spread medical reconciliation project to multiple physician practices	• In process. Meeting with QHC VP's July 2014. • COPD pathway launched; • Participation in Quinte Health Links as key stakeholder in steering committee, leadership and sustainability working group, advanced chronic disease management group (CCP's); • Partnering with Prince Edward Interservices Group to provide CCP

		support for broader socio-demographic (typically low SES, literacy, education, mental health/addictions).

Patient-Centred Care		
Support 'whole-person' care and the active involvement of patients and their families in decision making about individual care plans/treatment and in the design of care models.		
Activity	**Measure/Target**	**Status/Progress**
Integrate self-efficacy as a goal and measure across all chronic disease management programs.	Establishing baseline for: Process: X # of self-efficacy scales completed Outcome: x% report an increase in self-efficacy	• All CDPM programs integrating self-efficacy as ongoing measure – March 2015 • Data collection and reporting to commence Spring 2015
Build self-management as an integral component of all chronic disease management programs.	Process: increase attendance in SM Programming	• Partnership with Regional Self-management program established for delivery of 6 programs per year. • Self-Management incorporated as a key component of all CDPM care pathways as part of ongoing program review process commencing summer 2014; • 25 Patients generated 92 Encounters in Self-management Programs; • 12 patients participated in the East Moving Program.
Engage patients and caregivers at all levels of program planning and evaluation (satisfaction surveys for all programs and patient experience engagement in all planning processes).	Process: - X number of patient surveys completed annually - Creation of patient engagement committee reporting to the BOD	• Review of patient engagement process scheduled for Fall 2014. • Patient Engagement day October 2014 • Patient engagement committee slated for implementation March 2015.

Increase Access		
Ensure that patients receive health services and education in a timely fashion (right provider, right time, right place).		
Activity	**Measure/Target**	**Status/Progress**
Explore options for multiple streams of funding creating increased access to a greater range of health promotion; health services; and social services.	Investigate governance models or partnership arrangements that would support ability to accept Trillium and other health promotion funding.	• Ongoing – Winter 2015
Devise continuous process for review of all FHT programs and services with respect to population health data to ensure resources match potential need.	Creation of program review framework to include: - Population health level data for chronic conditions - Provider survey - Partnerships with existing and potential programs/services - Recommendations for expansion/enhancements/re-alignment of resources. Pilot review process with Respiratory Programs/Services.	• Provider/staff survey completed • Respiratory program review completed Feb 2015; • Cardiac Rehab program review completed Feb 2015; • H@H program review – ongoing as part of pilot evaluation; • Other programs coming on-board for review to be staggered throughout 2014-15 fiscal year.
Conduct a needs assessment/gap analysis for patients in Long Term Care.	Cross-sectoral Meeting with LTC.	• Meeting in Spring 2015
Review the model of NP service delivery.	Cross-organizational consultations being held with goal of ensuring NP's are being used to their maximum scope and skill set in supporting the needs of PEFHT patients.	• Cross-Organizational consultation commenced January 2015. MD's/NP's meeting in March to discuss.

A Culture of Learning and Improvement		
Create and maintain evidence informed learning culture that how to learn, change, and improve. Be a recognized leader in good governance in the FHT sector.		
Activity	**Measure/Target**	**Status/Progress**
Improved data quality so as to better inform practice.	Creation of a standardized problem list (at minimum for COPD, CHF, DM) Spread the implementation of standardized list.	• In process – pending implementation of new EMR 2015
Create and implement Employee Engagement Survey.	80% participation in Employee Engagement Survey. Developed action plan in partnership with staff team on key findings of survey.	• 88% participation in survey • Survey results delivered and discussed with staff –July 2014
Develop professional development/learning plans with all PEFHT staff.	Completion of 39 plans by May 2015.	• Templated designed • Implementation commenced Feb 2015
Foster the spread of Quality Improvement initiatives across the PEFHT.	Spread the tracking of Diabetes metrics to 5 additional physician practices.	• pending
Review By-Laws to align with best practices in governance as articulated by AFHTO and upcoming federal legislation for non-profit corporations.	By-laws reviewed and amended as appropriate.	• Proposed by-law revisions presented to BOD at July 2014 meeting.
Create opportunities for relationship/team building between FHT and FHO staff.		• Social committee engaging FHO staff in summer activity.