

PEFHT Strategic Plan 2014-15

- Integrate self-efficacy as a goal and measure across all chronic disease management programs
- Build self-management as an integral component of all chronic disease programs
- 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).

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.

- Create a process of coordinated care planning for the most complex patients across the Family Health Team
 - Co-locate in multi-agency facility
 - Strengthen relationships with community partners through cross-sectoral Quality Improvement initiatives.

Integrated Collaborative Care

Provide effective and efficient services to those with the greatest health needs (complex patients, chronic conditions, etc.) that will ensure continuity of care and cross-sectoral coordination.

Vision:

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

- Explore options for multiple streams of funding creating increased access to a greater range of health and social services
- Devise continuous process for review all FHT programs and services with respect to population health data to ensure resources match patient need

Increase Access

Ensure that patients receive health services and education in a timely fashion (right provider, right time, right place).

A Culture of Learning and Improvement

Create and maintain evidence informed learning culture that knows how to learn, change, and improve. Be a recognized leader in good governance for the FHT sector.

- Improved data quality so as to better inform practice
- Develop professional development/learning plans with all PEFHT staff
- Foster the spread of Quality Improvement initiatives across the PEFHT.