Thames Valley
Family Health Team

Thames Valley Family Health Team (TVFHT)
Strategic Directions 2017-2020

As leaders and innovators in person-centred care delivery and within our team-based model of care:

Strategic Direction #1: Deliver high quality person-centred care and measure our collective impact			
Focus Area	**3 Year Outcomes** What difference will be seen 3 years from now (March 31, 2020)	**How do we measure our progress/achievement?**	**1 Year SMART Objective** What work will be done by March 31, 2018?
Build on our quality improvement foundation and foster a culture of continuous quality improvement	All of TVFHT aware of and implementing common quality principles in decision making with each team having completed at least one targeted quality improvement initiative.	Ongoing measurement and tracking of progress through the span of the strategic plan to occur through survey. Awareness and implementation of principles to be measured by survey. Targeted quality improvement initiatives to be tracked centrally by quality team.	Provide quality foundations training for each site with 60% of team[1] participating. Each team to have a quality champion identified with additional training provided to this group and Site Coordinators. Determine right relationship to, and alignment with Quality Improvement Leadership Team. Job descriptions updated to reflect a focus on quality improvement as an expectation.
Balance preventative and complex care and ensure flexibility based on diverse population needs	Every team and TVFHT as a whole to have a clear understanding of population needs and community resources.	Team awareness to be measured by survey and program proposal documentation that includes description of population needs and community resources.	Identify three Family Health Team (FHT)-wide programs (ensuring all professions are represented) that are appropriate to have a common set of parameters (best practice, outcomes, etc.) developed. Program champion and quality team to have developed plan to review and determine areas for standardization and where local customization is appropriate.

[1] Unless otherwise noted – team means physicians and FHT staff (and would be open to physician staff but not counted in measurable goals)

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	Common understanding and implementation of a preventative/complex split in TVFHT resource focus (within an acceptable range).	Method(s) developed to document and inform decision making on patterns of practice as related to focus of care.	Review program request documentation to understand how population need and community resources can be articulated with more rigour. Develop understanding of overall current preventative/complex split in FHT resource focus – work begun to define recommended future state (either organizationally, or site-by site).
Create value within the healthcare system	Fully engaged in South West LHIN Sub-Region Integration Table work to both influence direction and ensure alignment with direction. Movement to be seen on key Quality Improvement Plan indicators developed collaboratively with our partners.	Either sit on, or fully engage in processes available to influence and inform decision-making at the relevant three South West LHIN sub-region integration tables Quality Improvement Plan and/or Ministry of Health operating plan to include indicators reflective of collaborative work with partners.	Engage in South West LHIN sub-region opportunities as they arise. Development of next Quality Improvement Plan to be done with advance engagement of key partners (hospital, community care, mental health) in each of our geographical areas.

Strategic Direction #2: Foster enduring organizational alliances to build strong care pathways and processes across the health care system.			
Focus Area	**3 Year Outcomes – For Discussion/Approval in Principle** What difference will be see 3 years from now (March 31, 2020)	**How do we measure our progress/achievement?**	**1 Year SMART Objective – For Information/Discussion** What work will be done by March 31, 2018?
Build new and deepen relevant existing partnerships to create collaborative care models (such as Health Links) based on population needs (e.g., mental health & addictions, home and community care)	Relationships with key partners in each community developed to a level of clearly understood mutual commitments to collaboration and outcomes, which are not dependent on individual providers but are rather embedded organizationally in cultures. TVFHT staff, physicians and leadership actively involved in sustaining the gains made by Health Links through commitment to collaborative patient-centred care involving patients, caregivers, providers, and organizations.	Three to five well developed collaborative agreements with partners. Formal mechanism to participate in Health Links type work via tracking of Coordinated Care Plans; each TVFHT site to have documented mechanism in place to regularly identify, complete and participate in updating Coordinated Care Plans.	Review all existing programs to consider where there are community partners that we should be more formally engaged with in that program's delivery and impact. Engage in dialogue with those organizations to develop common/shared pathways and collaboration plans related to those particular programs. Identify one to two key partners in each community to explore what an "enduring organizational alliance" looks like and key success factors to achieve it, and based on this experience begin development of a process for engagement of future partners. All TVFHT providers aware of local Health Links work and actively engaging in Coordinated Care Plans when/where appropriate. Determine the success factors for enhanced collaboration with South West LHIN Care Coordinators based on the sites where it is working well. Implement (or advocate where we do not have control over implementation) those factors at remaining sites.

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Leverage system resources	Patients, caregivers, and providers reporting improved transitions to the appropriate care and/or that appropriate supports are in place to facilitate care when a specific resource is not available.	Evaluated by survey of providers and patients/caregivers to examine perceptions of care.	Mental health as year one focus – improved understanding of resources for mental health and addictions care to identify perceived and actual gaps in services. Develop two to three linkages to resolve the situations where the gap is identified but could be resolved through new means of collaboration. Improved utilization of psychiatry sessionals: 100% increase in the number of sessionals used with two to four more sites utilizing this resource.

Strategic Direction #3: Identify and implement best practices in health equity.			
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Broaden access to TVFHT resources	TVFHT resources will be used to optimal capacity, with the needs of complex patients in our catchment areas being better understood and met (either directly or through better community partnerships), and preventative/health promotion offerings being fully subscribed to by any community member that could benefit.	All regions offering some (yet-to-be-determined) degree of care to non-rostered patients in both group and individual capacities.	Groups running at average 80% of capacity. One site or service (i.e., complex care team or PINOT [People in Need of Teams] site) engaging in supporting a defined number/group of non-Family Health Team patients as a trial/pilot to understand implications of expanding access to TVFHT resources.

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Better serve those who are under-served	Those that would most benefit from Family Health Team programs and services within rostered patient population are identified and programs/services are in place to meet those identified needs. Through development of relationships with key community partners, and developing an understanding of our own capacity to do so, TVFHT facilitates or offers services to those patients most in need that do not have access to current models of interdisciplinary team-based care.	Formal process to identify and recruit patients for the appropriate TVFHT programs in place within all regions/hubs. Through agreements with community partners (see target in Strategic Direction 2), have a formal process to offer services to non-rostered patients.	Gain an understanding of patient population data (using both internal and partner data sources) to develop a profile of those TVFHT patients that may be “under-served” at four TVFHT sites (one in each county and one within London). Develop guidelines to inform the practice of home visits (e.g., effective use of resources in providing home visits) Work with other interdisciplinary team-based care organizations in our catchments to understand overall capacity and definition of populations served. Engage in any work occurring to determine/consider different processes related to aligning unmatched patients with providers accepting patients (i.e. conversations that occur at tables discussing healthcare for newcomers to Canada, any conversations coming out of health inequities report).
Embed best practices to serve culturally diverse populations	All people attending at Family Health Team sites report being received in a safe and supportive environment that responds to their diverse needs.	Evaluated by patient experience survey.	Implement a cultural competency training module to be completed by 100% of staff. Complete Health Equity Impact Assessments in London, Middlesex, Elgin and Oxford.

Strategic Direction #4: ***Optimize our resources and foster organizational excellence***			
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Share and embed internal best practices, work to scope of practice	Teams and professional groups regularly considering and making decisions on changing overall practices to align with new information about "best practice". All teams report working to optimal scope of practice considering interdependencies within the teams and with community partners (i.e., does not mean full scope of practice).	Mechanisms in place to guide practice for most common presenting conditions (mental health, diabetes, COPD)	Every site team and professional group to incorporate best practice discussions into networking meetings to facilitate information sharing between sites. Every site team to identify up to three opportunities to improve working to optimal scope of practice and develop a plan to address.
Engage staff and physicians in strategy	Organization-wide ownership of successful achievement of strategic directions.	Tools and strategies implemented at all sites to consider strategic directions regularly in their work. Evaluated by survey of TVFHT teams.	Communication plan developed and implemented that has multiple mediums for engagement. Measures of success developed and tracked that allow for all to be aware of progress towards goals and the role that they play in making it happen. Trialing of tools for strategic planning focus.
Improve internal communication and external awareness	Communication plan in place such that TVFHT staff and physicians have the information they need in a timely manner and report that honesty and transparency continue to be respected.	Communication plan in place that is reported as effective through evaluation by survey	Identification and implementation of two to three strategies to enhance communication with TVFHT staff and physicians. Explore challenges and opportunities in sharing information internally at sites at sites and ensure successful strategies are identified and implemented that promote programs and services.

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	All TVFHT programs and services are regularly promoted internally in a way that ensures access to the information is available when it is needed. TVFHT patients and partners have an improved understanding of the role that TVFHT plays in providing care in the communities we serve.	Communication plan with specific strategies regarding internal promotion of TVFHT Programs in place executed and evaluated. Defined and implemented process for staff and partners to provide care through three to five TVFHT programs	Plan developed and implemented that enhances TVFHT technology use and online presence to promote programs and services for patients and partners (both corporately and at sites).
Ensure organizational health and staff retention	TVFHT is seen as a desirable place to work as evidenced by a high staff retention/low staff turnover rate, and successful recruitment.	TVFHT staff retention rate at 90% or greater TVFHT staff positions >95% filled	Develop a definition of organizational health, and survey staff to determine what factors need to be focused on.
Ensure FHT resources align with strategy and advocate for appropriate resources to provide quality person centred care	TVFHT resource allocation completed in a manner that aligns with a defined set of criteria that considers strategic priorities and allows appropriate flexibility to respond to evolving needs within sites or professions. Have a rolling staffing/program/services advocacy plan that allows us to take advantage of any funding opportunities as they become available.	Defined process in use to guide resource deployment at all TVFHT sites. Successful acquisition of increased resources in three to five key identified areas.	Conduct a review of how TVFHT resources are currently deployed and utilized to understand the factors that should be considered in future planning. Use work completed in health equity and partner sections to develop understanding of underserved areas and create short-term priority funding asks to be used in next budget opportunity or to take advantage of other funding opportunities.