Access and Flow

Measure - Dimension: Efficient

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of clients with type 2 diabetes mellitus who are up to date with HbA1c (glycated hemoglobin) blood glucose monitoring	O	% / PC patients/clients	EMR/Chart Review / Most recent consecutive 12-month period	CB	CB	Our diabetes educators provide regular support to clients with type 2 diabetes including comprehensive assessments, nutrition counseling, foot care, and ongoing monitoring of blood work. However, the proportion of clients completing recommended blood testing has not been consistently tracked or evaluated. Establishing baseline data will help us assess current performance, identify gaps, and inform improvements to enhance the quality of diabetes care.	

Change Ideas

Change Idea #1 To improve the accuracy and consistency of diabetes documentation, the organization will implement a standardized EMR naming convention.

Methods	Process measures	Target for process measure	Comments
The Data Coordinator and Diabetes Educators will collaborate with providers to develop and implement a standardized EMR naming convention for pre-diabetes, Type 1, and Type 2 diabetes. This includes: a) Reviewing current documentation practices and identifying existing naming conventions used across providers. b)Mapping the documentation workflow leading up to the entry of a diabetes diagnosis. c)Determining the most appropriate and consistent location to document diagnosis. d)Establishing clear guidelines for how diagnoses should be entered into chart.	% of patient's with Type 2 diabetes whose charts use the standardized naming convention.	=>80% of clients with Type 2 diabetes will use the standardized EMR naming convention within 6 months of implementation and =>95% after a year.	By resolving provider documentation inconsistencies, we strengthen data integrity, build trust, and create a clearer view of our population and care delivery.

Change Idea #2	Implement a standardized process for Diabetes Educators to track patient completion of HbA1c testing and conduct timely follow-up on outstanding results according to defined timelines.		
Methods	Process measures	Target for process measure	Comments
1. The Data Coordinator will conduct quarterly EMR searches to identify patients with type 2 diabetes who are overdue for HbA1c testing and generate a tracking registry. 2. The Diabetes Educators (DEs) will review and prioritize this list based on most recent HbA1c values, contacting patients with the highest levels first. DEs will reach out to patients by phone to arrange testing, providing bloodwork requisitions via email or fax as appropriate and schedule a follow-up appointment within 2–3 weeks to review results and complete a comprehensive assessment. 3. Patients who cannot be reached will be flagged through a shared Diabetes inbox to ensure ongoing follow-up. All outreach attempts, patient responses, and relevant clinical updates (including provider input on changes in monitoring appropriateness, such as palliative status) will be consistently documented in the EMR. 4. The tracking process will be reviewed quarterly to support timely follow-up and continuous quality improvement.	% of overdue patients with at least one documented successful contact in Q2, Q3 and Q4.	>=75% of overdue patients will have at least one successful documented contact in Q2, Q3 and Q4	Formalizing process will improve patient care and bloodwork completion rates.

Measure - Dimension: Timely

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Expand access to diabetes management support services to empower individuals to effectively manage their chronic condition, reduce overall disease burden, and improve health outcomes.	C	Number / patients with diabetes, aged 18 or older	In house data collection / April 2026-March 2027	112.00	120.00	This will be achieved through enhanced program awareness, engagement strategies, and continuous evaluation over a multi-year period.	

Change Ideas

Change Idea #1 Develop and implement a comprehensive communications and promotion strategy for all diabetes-focused programs.

Methods	Process measures	Target for process measure	Comments
1. Program Coordinator to develop a quarterly overview of diabetes programs being offered. The overview will be: Displayed in provider offices (in response to client feedback preference), Shared in waiting rooms (print and digital formats), Promoted through social media and during key campaigns (e.g., Diabetes Awareness Month), and Distributed to community partners, pharmacies, communication boards, and relevant stakeholders. 2. Program Coordinator will create a comprehensive distribution list and will track quarterly to monitor reach and engagement.	1.The number of participants attending programs quarterly. 2. Quarterly analysis of referral data to identify high-performing sources to optimize communication strategies and adjust accordingly.	1. Q2-50% of attendance target is reached for diabetes focused programs and 75% of target is reached at Q3. 2. Post-program surveys achieve a =>75% completion rate, with participants identifying their referral sources.	By increasing program awareness, we aim to boost enrollment and ensure consistent attendance throughout the year.

Change Idea #2 Enhance Program Evaluation tools

Methods	Process measures	Target for process measure	Comments
1. Program Coordinator to refine evaluation tools and develop targeted questions, deepening insights into participant experiences to drive improvements in program design, delivery, and effectiveness. 2. Program Assistant to collect post-program client surveys to assess and track satisfaction, experience, and perceived value.	The % of participant's that identify improvements in confidence and knowledge related to diabetes self-management.	=>75% of participants identify improvements in confidence and knowledge related to their diabetes self-management.	

Equity

Measure - Dimension: Equitable

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Completion of sociodemographic data collection	O	% / Patients Active patients aged >=13yrs	EMR/Chart Review / Most recent consecutive 12-month period	39.00	65.00	Given that we did not meet the target last year and were unable to implement any of the change ideas due to staffing challenges we are keeping the same target of 65% as identified by the Alliance for Healthier Communities.	SGBOHT, Alliance for Healthier Communities

Change Ideas

Change Idea #1 Co-create a "Strive for Completion" process with the clinical team and reception staff to educate clients about the questionnaire to increase engagement and completion rate.

Methods	Process measures	Target for process measure	Comments
1. Host three meetings to create the "Strive for Completion" process. a)First meeting will focus on current practices at reception-successes, barriers, opportunities-and staff led brainstorming of what the data can help the CHC change or implement. b)Second meeting will focus on the co-creation of the process at reception to support clients to complete the questionnaire, and the tools and resources needed to support their capacity. c) Third meeting will focus on the creating and implementing a monitoring schedule with regular check ins.	Q3-Review % of clients completed questionnaires, Q4-Review % clients with completed questionnaires.	Q3-50% of clients have completed questionnaire, Q4-65% of clients have completed questionnaire	We were unable to implement the strategy due to staffing pressures and shortages; however, we believe it remains a strong improvement plan and intend to reinitiate it this year.

Measure - Dimension: Equitable

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	O	% / Staff	Local data collection / Most recent consecutive 12-month period	92.59	100.00	Given that 100% is the benchmark target, and the organization's committed to strengthening staff capacity to provide equitable and inclusive services.	Mamaway Wiidokdaadwin Indigenous Interprofessional Primarcy Care Team (Barrie Area Native Advisory Circle)

Change Ideas

Change Idea #1 Complete a formal evaluation and comparison of training completion rates across the organization to identify gaps in access, participation, and or tracking.

Methods	Process measures	Target for process measure	Comments
The Workplace and Community Equity Committee (WACEC) will: 1. Review mandatory EDI-AR and Indigenous trainings offered to new hires during orientation. 2. Audit the methods used to monitor and track training compliance at orientation. 3. Analyze training completion metrics for both new and existing staff to identify participation gaps. 4. Identify relevant EDI-AR educational opportunities through partnerships with local Indigenous Leaders. 5 Develop a structured, annual training calendar for EDI-AR education for all employees. 6. Establish a system for tracking training to monitor completion rates across the organization. 7. Provide alternate, but equivalent learning options for staff unable to attend in-person sessions.	% of new hires that completed mandatory trainings within probation period. % of existing employees that completed mandatory trainings in the past 12 months.	100 % of staff including management level will complete relevant EIDA-R education every 12 months.	Given this is a benchmark target, the organization is confident that an enhanced orientation process, supported by an annual EDI-AR training schedule and improved tracking, will enable achievement while strengthening staff capacity to deliver equitable and inclusive services.