SAMPLE: COMMON PLANNING APPROACH

Program Plan for Diabetes

Goal - Objective - Service - Outcome - Indicator

GOAL: Optimize the prevention and management of Type II Diabetes

> **Objective:** to achieve optimal glycemic control in patients referred to the FHT diabetes program
>> **Service:** 1) Dietary/lifestyle management (including nutrition assessment, medical nutrition therapy, lifestyle modification, nutrition/health education)
>>> a. Group Class
>>> b. Individual counselling
>> **Service:** 2) Pharmacological management
>>> a. Individual assessment/follow-up with NP
>>> b. Medication review with Pharmacist
>>> **Outcome:** Patients referred to the FHT diabetes program will achieve target HbA1c
>>>> **Indicator:** 60% patients referred to FHT diabetes will achieve target HbA1c

> **Objective:** To manage/prevent complications and comorbidities of patients referred to the FHT diabetes program
>> **Service:** Annual Lipid Profile
>>> **Outcome:** Patients will have a lipid profile completed annually
>>>> **Indicator:** 70% of patients will have a lipid profile completed annually
>> **Service:** Annual Eye Exam
>>> **Outcome:** Patients will have eye exam completed annually
>>>> **Indicator:** 70% of patients will have an eye exam completed annually
>> **Service:** Annual Foot Assessment
>>> **Outcome:** Patients will have foot assessment completed annually
>>>> **Indicator:** 70% of patients will have a foot assessment completed annually
>> **Service:** Annual eGFR
>>> **Outcome:** Patients will have an eGFR completed annually
>>>> **Indicator:** 70% of patients will have an eGFR completed annually
>> **Service:** Annual ACR
>>> **Outcome:** Patients will have an ACR completed annually
>>>> **Indicator:** 70% of patients will have an ACR completed annually

GOAL: Program Metrics

> **Objective:** To determine service capacity
>> **Service:** Tracking the demand (referrals) and service capacity (patients and encounters) of the diabetes program
>>> **Outcome:** Patients, encounters and referrals to the Diabetes Program are tracked
>>>> **Indicator:** Number of patients seen in the Diabetes Program in the quarter
>>>> **Indicator:** Number of patient encounters in the Diabetes Program the quarter
>>>> **Indicator:** Number of referrals to the Diabetes Program