



Logic Model: Diabetes Type II Gaps of Services in Fort Bend County PCT 2

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Overview

- Diabetes in Fort Bend Co. PCT 2
- Gaps in Current Interventions
- Intervention Introduction
- Logic Model
 - Program Implementation
 - Program Planning
 - Evaluation Planning
 - Indicators
- Issel's Criteria for Good Interventions
- Conclusion



Diabetes in Fort Bend County Precinct 2

- 6.8% prevalence in Precinct 2
- In 2002 diabetes was the 4th leading caused of death in FBC
- 343,000 Texans have undiagnosed DM
- Pct 2 spends \$66 million in excess health care dollars per year for diabetic population


Existing Interventions

	<u>Description</u>	<u>Acceptability</u>	<u>Feasibility</u>
Fort Bend County Health Department	Screening tests in Rosenberg	Underutilized	Fair No public transportation, lack of outreach
Texas Cooperative Extension	6 session DM workshop for prevention and control	Materials not culture- specific	Good church-based population eager to participate
Kelsey-Seybold Clinic in Fort Bend County	Referrals when diagnosed & re-referred HgbA1C is >9.7 referrals made again	Fully integrated within the hospital system	Covers insured only
Methodist Sugarland	Referrals made when diagnosed	Fully integrated within the hospital system	Covers insured only – assistance available to uninsured through the Hospital ⁴



Gaps in Intervention Services

- Lack of coordination among existing programs
- Insufficient programs
- Lack of culturally sensitive material
- Uninsured population are not screened
- Lack of services for underserved populations
- Lack of services for at risk population groups

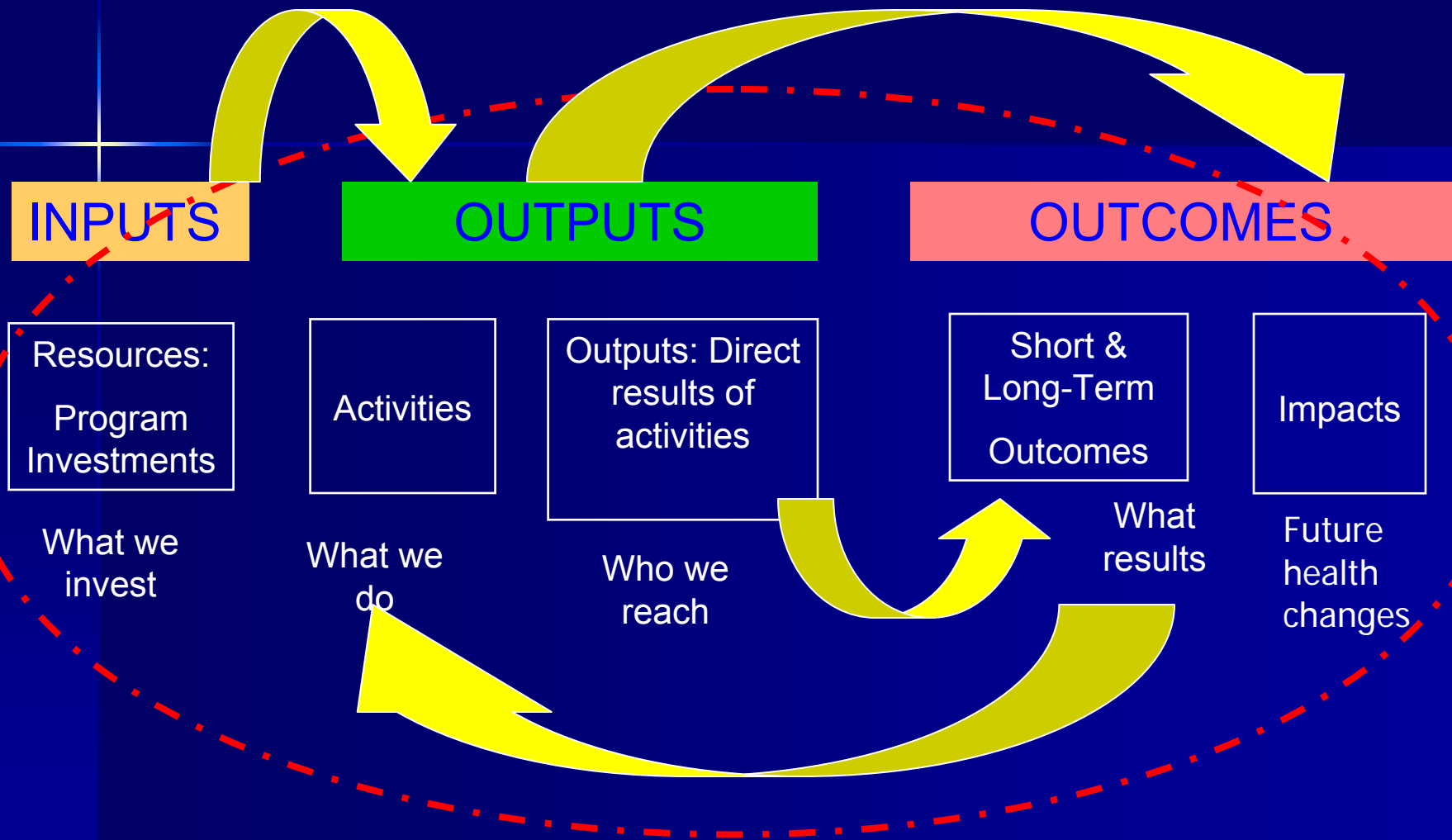


Proposed Intervention: Screening & Referral to Disease Management

Screening & referral to disease management programs

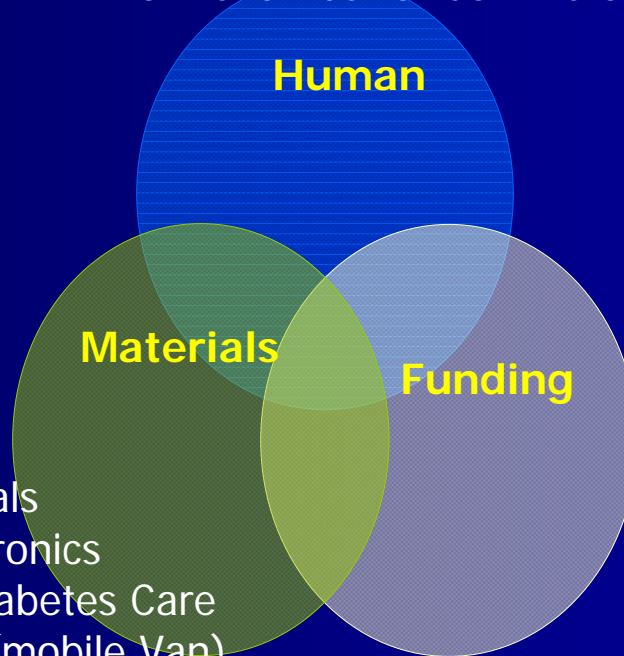
- Coordination among existing programs
- Culturally sensitive educational material
- Focus on the uninsured and underserved populations
- Targets at risk population groups

Diabetes Intervention Program not Linear



Program Implementation: RESOURCES

1. Recruiting/training staff
2. Endorsement Medical Ctr.
3. TDC/TCE/ADA
4. Collaborative Comm. Liaison representation
5. FOHC
6. Chamber of Commerce



1. Space
2. Training materials
3. Computer/electronics
4. K-S Model of Diabetes Care
5. HD equipment (mobile Van)

1. States & local agencies
2. Grants
3. Donations
4. Budgets

Program Implementation: ACTIVITIES

Partnerships

Collaboration w/stakeholders

Provide leadership & Participation Among partnerships

Attend Regional state/local meetings

Provide Tech. Assistance

Conduct local need assessment

Assess & Develop Training

Evaluation Plan

Do needs Assess.

Monitor needs Assess.

Perform system Change

Description of services provided

Financial stability

Expand marketing

On-going fiscal performance

Seek Additional funding

Staff Methods of learning & training

Develop Competency Based Framework

Modified tools (surveys, Referrals forms, HIPAA) and Processes (screening To referral)

Develop, Deliver & evaluate trainings

Modify current Curriculum based on competencies & Cultural modalities

Prioritized trainings based on evaluations

Develop an inventory of training products (lifestyle survey)

Underserved/ Unserved populations

Establish a collaborative Group between stakeholders

Identify joint projects, Trainings

Establish means for identifying uninsured

Convene a Community consensus conferences (town hall)

Program Implementation: OUTPUTS



Program Implementation: Short & Long Term OUTCOMES

Resources

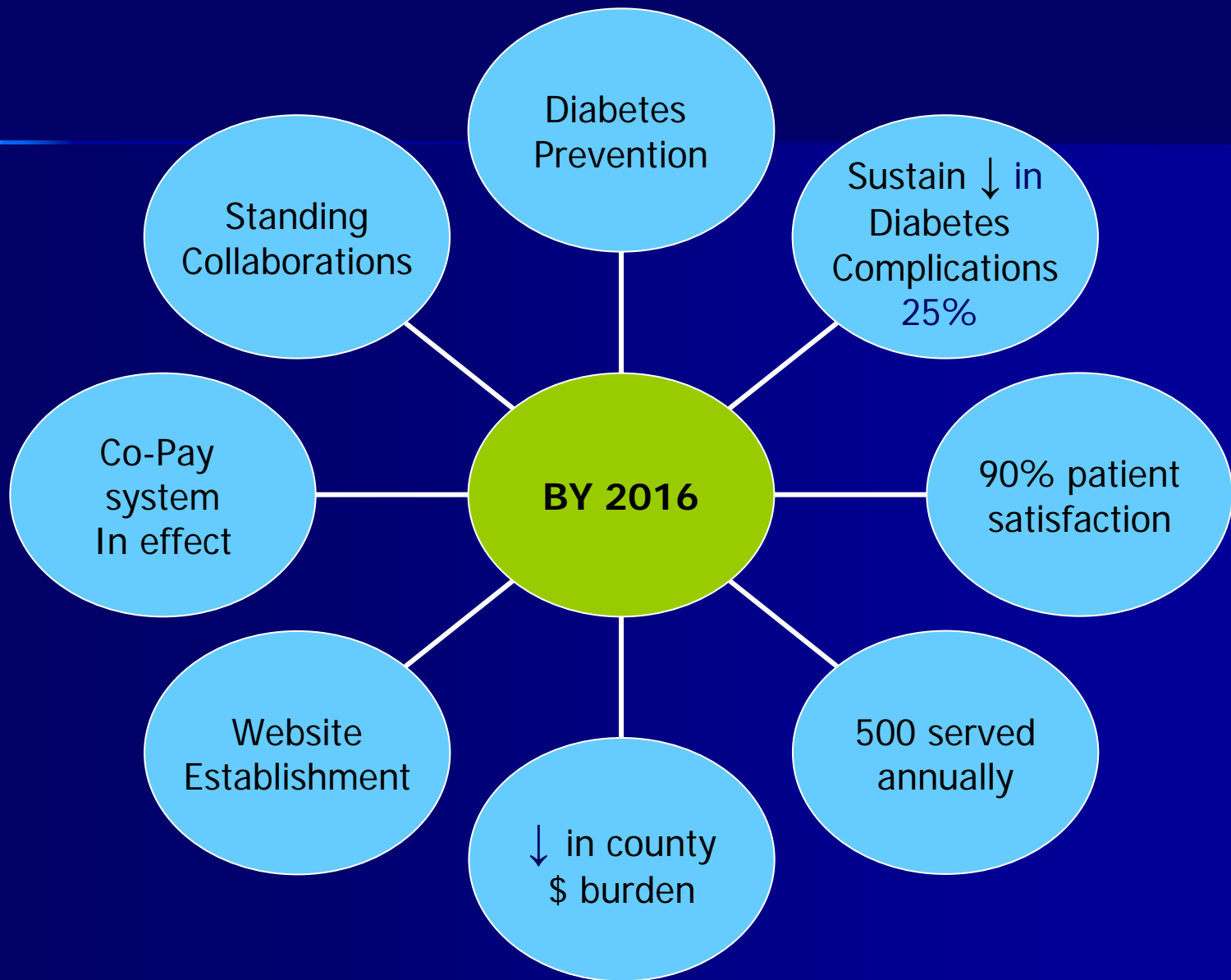
Activities

Outputs

Impact

1. Collaborative Agreements
2. Referral
3. Change comm. attitude
4. Disease management lifestyle
5. ↓ Hospital admissions
6. ↑ # uninsured screened + served
7. Up to date need assessments
8. Modified current material to fit cultural sensitive population
9. Local training strategies implemented
10. ↑ collaboration for efficiency & effectiveness
11. ↑ resources
12. Improved link
13. ↓ diabetes incidence
14. ↑ Educational programs
15. Improved outreach

Program Implementation: IMPACT



Diabetes Program Implementation: Intervention based on needs assessment

RESOURCES

- 1. Human
- 2. Funding
- 3. Materials

PARTNERSHIPS

ACTIVITIES

Partnerships

Assess and Develop Training

Financial Stability

Staff Methods of Learning & training

Develop, deliver & Evaluate trainings

Underserved/unserved populations

OUTPUTS

1. # meetings
2. # policies
3. # screened
4. # referred
5. # educated
6. # retained in program
7. # visits
8. # staff/participants training session (multi agencies)
9. # referred for appropriate medical care
10. # inquires into program
11. # hours tech. assistance
12. # courses developed for participants
13. # annual meetings
14. # needs assessments
15. # Identified stakeholders
16. Completed marketing plan
17. Development Board (fund raising)
18. Marketing plan
19. Completed frameworks
20. # tools and processes used and documented;
21. # competency-based courses conducted
22. Evaluation completed
23. Priorities implemented
24. Inventory established and updated

SHORT/LONG-TERM OUTCOMES

1. ↑ referral by X%
2. Disease management lifestyle
3. ↓ by X% diabetes related admissions to hosp.
4. ↑ # uninsured screened + served
5. Up to date need assessments
6. Modified current material to fit cultural sensitive population
7. Local training strategies implemented
8. ↑ collaboration for efficiency & effectiveness
9. ↑ resources
10. Improved b/w training staffs and stakeholders
11. ↓ diabetes incidence
12. ↑ training based on public demand
13. Improved plan for subsequent years of training
14. Improved outreach to unserved/ underserved

IMPACT

1. > Efficient leadership among stakeholders
2. Co-pay system in effect
3. 90% patient satisfaction
4. Sustain ↓ in diabetes complications (25%)
5. X # served annually
6. Diabetes prevention (pre-diabetic state)
7. Decrease in county financial burden

INFRASTRUCTURE

Diabetes Program Planning

Strategies

- Collaborations w/stakeholders
- Refer screeners to agencies
- Long-term plan for uninsured

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Assumptions

- Will to Collaborate
- Availability of funds
- Neighborhood involvement
- Identified participation
- Staff available

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Influential Factors

- Save \$8000/Prevented case
- Stakeholders Strong interest
- HD interest in ↓ Cases+complications

Problem or Issue

- # of uninsured cases
- # of unidentified cases
- Lack of coord. among screening & providers
- \$ for treating complications

1

2


Community Needs/Assets

- HD provides screenings
- Treatment + education
- Need coll. b/w identification & treatment
- Lack services for uninsured
- Need uninsured identification

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Desired Results

- ↑ (+) Referral to Care & education
- ↑ HD screening capacity
- ↑ uninsured prevention & treatment
- Provide cultural sensitive material
- ↓ \$ spend in complications
- ↓ # of admitted inpatients
- Stakeholders advisory committee



Results is the name of the game!

“The important question any constituent needs to ask is whether or not the program achieves results.”

President Bush, NPR news, 2-7, 05

Diabetes Evaluation Planning

FOCUS AREA: RELATIONSHIPS

AUDIENCE	QUESTIONS	USE
FUNDERS/ DONORS	Program Cost effectiveness? Patient/Staff satisfaction? Program budget? Cost savings (cost/visit)	Quality Assurance/Planning Program evaluation cycle Cost benefit analysis Cost benefit analysis
STAFF	Patient/Staff satisfaction? # of screened? Referral process/promotional approach?	Evaluation/program promotion Program evaluation cycle Evaluation and /or improvement
CLIENTS	Perceived quality care; Improvement in Health status? Ease of access to services	Program improvement & planning Program improvement & planning
STAKE- HOLDERS	How is collaboration working? How often are stakeholders meeting? How is the program perceived & accepted among the community	↑ participation/communication Meeting minutes Focus groups

Diabetes Evaluation Planning

FOCUS AREA: PROCESS

AUDIENCE	QUESTIONS	USE
FUNDERS/ DONORS	<ul style="list-style-type: none">•Is process functional and efficient•Does the process meet the needs of the pop. i.e. are program goals being met?•How many people are being served?	<ul style="list-style-type: none">•Analysis of cost per capita•Survey data, employee input•Quality improvement reports/ screening logs
STAFF	<ul style="list-style-type: none">•Are tools available to do the job?•Will training be sufficient?•Are policies and procedures clear?	<ul style="list-style-type: none">•Staff survey•Training logs, training feedback•Staff survey; review of policy & procedures manual
CLIENTS	<ul style="list-style-type: none">•Is it easily accessible?•Can I give feedback?•Is it family-centered??	<ul style="list-style-type: none">•Client survey•Client survey / feedback forms•Family centered curriculum
STAKE-HOLDERS	<ul style="list-style-type: none">•Is administration responsive to staff and community concerns?•Are clients being followed over the long term once screened? (high-risk)	<ul style="list-style-type: none">•Client satisfaction surveys/ staff feedback formsClient / Staff satisfaction surveysFocus groups•Client tracking reports

Diabetes Evaluation Planning

FOCUS AREA: OUTCOMES

AUDIENCE	QUESTIONS	USE
STAFF	<ul style="list-style-type: none"> • Reaching target population (uninsured, culturally sensitive) ? • Efficacy of screening process/referral 	<ul style="list-style-type: none"> • Annual reports: % patients with uncontrolled diabetes • Annual reports: % patients with uncontrolled diabetes
CLIENTS	<ul style="list-style-type: none"> • Improvement in health status • Are services accessible? 	<ul style="list-style-type: none"> • Annual reports: % of pre-diabetics/ not converting • Patient survey
STAKE-HOLDERS	<ul style="list-style-type: none"> • Missing pieces in referral/ treatment/education • Health Status of participants • Is funding sufficient? • Is DM II being prevented among the pre-diabetic population? • Are diabetes complications ↓? 	<ul style="list-style-type: none"> • Staff survey / patient survey/ referral agency input • Media Advocacy • Fundraising Training/Budget reports • Long-term tracking of clients Reports from referral agencies • Hospital admissions/specialist referrals/ data tracking
FUNDERS DONORS	<ul style="list-style-type: none"> • Is the program reaching targeted goals? • Is the uninsured population being served? 	<ul style="list-style-type: none"> • Annual reports/Grant evaluation instruments • Program results

Diabetes Indicators Development

FOCUS AREA: RELATIONSHIPS

QUESTIONS	INDICATORS	TECHNICAL ASSISTANCE NEEDED
Is clinic establishment viable?	Funds stakeholder participation	Contractual agreement analysis of financial statements/Fundraising
Satisfaction with screening & referral programs	Patient & employee surveys	Analysis of surveys
Reaching targeted population	% uninsured screened vs. % total uninsured in the community	Data Analysis
Is the program cost effective?	Cost Analysis (yearly)	Data Analysis
What is collaboration input to program?	Survey of collaboration advisory board Analysis of annual reports	Data Analysis

Diabetes Indicators Development

FOCUS AREA: PROCESS

QUESTIONS	INDICATORS	TECHNICAL ASSISTANCE NEEDED
Is the process functional, efficient & effective?	Cost-Benefit Analysis	Data Analysis
Are the tools available to properly do the job? Are policies & procedures clear?	Staff Survey/Employee Manuals	Data Analysis
Is it easily accessible (location, time offered)?	Client Surveys	Data Analysis
Is it family-centered?	Client Surveys	Data Analysis
Are clients being followed over the long term once screened?	Client Tracking Reports	Data Analysis

Diabetes Indicators Development

FOCUS AREA: OUTCOMES

QUESTIONS	INDICATORS	TECHNICAL ASSISTANCE NEEDED
Improvement in health status?	Collection of program results through collaborative agencies	Data Analysis
Does the program reduce type II diabetes?	Compare % screened & diagnosed pre-diabetic to % of pre-diabetics who convert status	Data Analysis
Does the program reduce complications of type II diabetes?	Patient HgA1C levels; Hospital admissions (ICD-9 codes); # referrals to specialists	Data Analysis
Is the uninsured population being served?	Client demographic information analysis	Data Analysis



Issel's Criteria for Good Interventions

1. Technologically feasibility
2. Health gains must result
3. Politically feasibility
 - ✓ Target population
 - ✓ Funding agencies
 - ✓ Stakeholders
4. Address societal priorities
5. Manipulability
6. Reasonable cost



Accountability Era

- What gets measured gets done
- If you don't measure results, you can't tell success from failure
- If you can't see success, you can't reward it
- If you can't reward success, you're probably rewarding failure
- If you can't see success, you can't learn from it
- If you can't recognize failure, you can't correct it.
- If you can demonstrate results, you can win public support.

Osborne and Gaebler, 1992

References

Issel, Michele L. (2004.) Health program planning and evaluation: A practical, systematic approach for community health. Sudbury, MA: Jones and Bartlett Publishers.

W.K. Kellogg Foundation. (2004.) W.K. Kellogg Foundation Logic Model Development Guide. Battle Creek, MI: W.K. Kellogg Foundation.

Taylor-Powell (2005.) Logic Models: A framework for program planning and evaluation. University of Wisconsin-Extension-Cooperative Extension.

Questions?