NCACH Care Transformation Workgroup Logic Model_version 2

Project Title: Diabetes Education Survey **Date: 7/21/2015**

Project Description: Conduct targeted surveys of patients, healthcare providers & health plan providers in relation to existing NCACH-region Diabetes Self-Management Education (DSME) programs to 1) determine knowledge & skills retention & self-management compliance, 2) to identify service gaps and 3) identify barriers to access, participation & referrals.

Inputs	Strategies	Reach	Outputs	Short-Term Outcomes	Intermediate Outcomes	Long-Term Outcomes
To accomplish our strategies, our team will need:	To make improvements or address existing health problems, our team will:	Our strategies target the following audience(s):	Once accomplished, our team expects to produce the following:	Expected changes in 1 – 3 years: (often related to learning)	Expected changes in 4 – 6 years: (often related to actions)	Expected changes in 7 - 10 years: (often related to conditions)
1. Workgroup participation. 2. ACH Governing Board support (serve as champion for workgroup). 3. Time. 4. Funds for marketing, translation services, postage, interpretive services, & survey participation incentives. 5. Regional & national partnerships. 6. Marketing/media contacts. 7. Research/best practice survey examples. 8. Electronic & paper survey delivery mechanism (Survey Monkey, ipad/ iphone) & processes. 9. Defined survey demographic data. 10. Defined survey geographic area. 11. Institutional Review Board (IRB) application approval. 12. Tribal involvement. 13. Inventory of DSME programs offered in 4-county region.	1. Develop survey tools to: • identify patient knowledge & skills post DSME • identify DSME service gaps, access & participation barriers, & compliance barriers from patient perspective • identify DSME service gaps, access & referral barriers, & compliance barriers from provider perspective • identify service gaps or barriers from health plan perspective 2. Conduct a pilot to gain additional survey input & assess data. 3. Translate the patient survey to Spanish. 4. Maintain cultural sensitivity towards Hispanic & Native American residents. 5. Obtain data via: • Patient interviews (face-to-face or phone interviews) conducted by volunteers, diabetes educators, dietitians • Webbased survey • Paper survey	1. Type I & Type II diabetic patients who have, within the past 2 years,: • been referred to a DSME program • attended a DSME program • completed a DSME program • been newly diagnosed but not referred to DSME 2. Regional healthcare providers who support diabetic patients: Physicians, PAs, Nurse Practitioners, Dietitians, Diabetes Educators. 3. Health plan providers who support regional diabetic patients.	1. A list of target population knowledge & skill gaps, service gaps, access gaps, compliance barriers & service barriers by PCP, delivery site, city &/or region from which a targeted plan can be developed. 2. A list of DSME access & referral barriers by PCP, delivery site, city, &/or region from which a targeted plan can be developed. 3. A community health improvement project metrics/evaluation template that can be modified for use by future teams. 4. # of target patients who participate. 5. # of target healthcare providers who participate. 6. # of target health plans who participate.	1. Well-publicized, readily accessible regional DSME program information. 2. Increase patient, provider and health plan awareness of regional DSME courses & enrollment processes. 3. Implement a tailored, targeted plan that addresses service gaps & barriers to access & participation. 4. Increase patient awareness of diabetes management testing requirements & frequency.	1. Increase the proportion of patients with diagnosed diabetes who complete a DSME program. 2. Increase the proportion of patients with a diagnosis of diabetes who have at least: • an annual dental exam • an annual foot exam • an annual dilated eye exam • a twice-a-year glycosylated hemoglobin measurement. 3. Increase the proportion of patients with diabetes who perform self-blood glucose-monitoring at least once daily.	