November 2011

Diabetes Education Centre

York Region Program Logic Model

Process | **Outcomes**

1.0 Admin Supports/ Inputs/ Enablers

- 1.1 Staff
- 1.2 Management support
- 1.3 Collaboration/ partnerships
- 1.4 Training activities
- 1.5 Assessment/ educational tools and resources
- 1.6 Marketing
- 1.7 Families, caregivers
- 1.8 Access/facility
- 1.9 Linguists, translators
- 1.10 Communications
- 1.11 Funding
- 1.12 Case management model

2.0 Program Implementation, Process

- 2.1 Intake assessment
- 2.2 Assessment of client/family/caregiver knowledge
- 2.3 Identification of client needs
- 2.4 Creation of education plan and goal setting based on client ability and need
- 2.5 Care coordination with other programs and specialists for service delivery
- 2.6 Provision of educational services and materials based on client needs.
- 2.7 Ongoing case management based on client factors and needs
- 2.8 Support access to care based on cultural requirements of client population
- 2.9 Monitoring of clinical tests and values
- 2.10 Follow up

3.0 Outputs

- 3.1 Referrals received
- 3.2 Coordination of care and provision of appropriate education based on client needs
- 3.3 Education plans developed
- 3.4 Education sessions conducted based on client/family need
- 3.5 Provision of case management based on client needs
- 3.6 Improved client/family self-care knowledge and lifestyle practices
- 3.7 Improvement in clinical test values
- 3.8 Client/family satisfaction
- 3.9 Ongoing support based on client needs

4.0 Short-Term Outcomes (within 3 mos)

- 4.1 Client identification of self-care educational needs
- 4.2 Educational priorities implemented based on client needs
- 4.3 Improvement in initial client clinical test values
- 4.4 Integrated approach to client care
- 4.5 Evidence of improvement in client self-care and lifestyle practices

5.0 Intermediate-Term Outcomes (6 – 12 months)

- 5.1 Improved client understanding about diabetes
- 5.2 Improved diabetes self-management and control
- 5.3 Prevention of complications of diabetes among groups with diabetes
- 5.4 Ongoing improvement in client self-care practices
- 5.5 Ongoing improvement in clinical test values
- 5.6 Improved client quality of life
- 5.7 Prevention of further diabetes complications
- 5.8 Knowledge sharing of program successes and improvements

6.0 Long-Term Outcomes (12-18 months)

- 6.1 Improved client and family awareness of risk factors related to diabetes
- 6.2 Increased awareness of strategies for managing diabetes
- 6.3 Clients empowered to be self-directed in the management of their care
- 6.4 Improvement in health care providers' understanding of diabetes control and management based on dissemination of program findings and processes
- 6.5 Creation of health policies that improve quality of access to diabetes care