Waterloo-Wellington Diabetes Regional Coordination Centre

A Framework for the Development and Provision of Diabetes Outreach Services

A tool for Diabetes Educators to support them in developing an effective Outreach Program

August 2011

Stand up to Diabetes

Langs Farm Village Association
Building a Healthy Community

Langs Farm Village Association is the host organization for the Waterloo-Wellington Diabetes Regional Coordination Centre

Contents

Goal of Outreach Services Framework:

To provide a tool and guide for planning and developing diabetes outreach programs in your community.

Objectives of Framework:

1. To provide ongoing direction to support outreach service provision in a form appropriate to communities
2. To ensure that people with diabetes who live in diverse communities and rural and remote areas receive appropriate and timely support and treatment
3. To strengthen connection between the DEP and communities

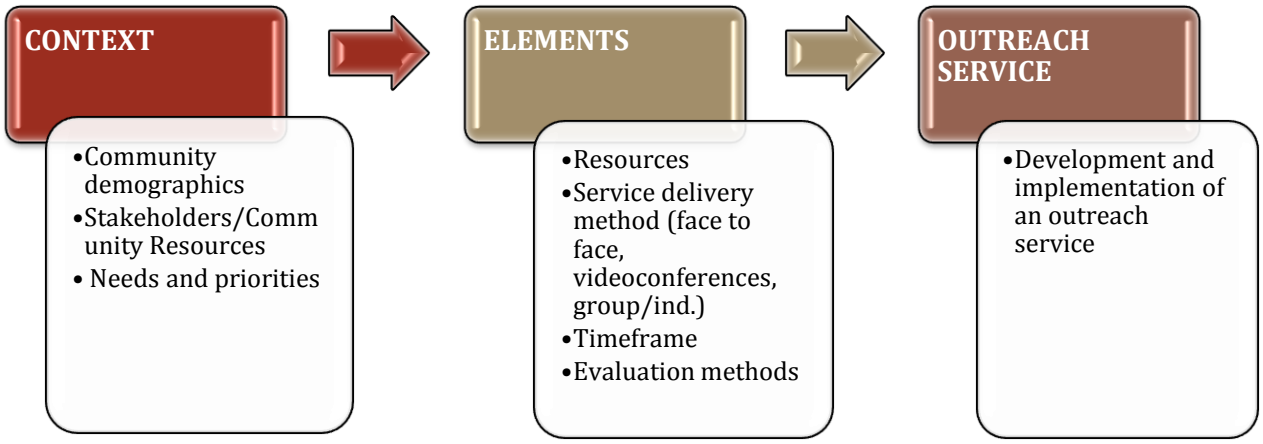
Definition of Outreach

"Outreach" is a term that is often used, but can be interpreted differently by many. The following are some definitions or ideas for outreach services:

1. The act or process of reaching out
2. Clinical outreach services to high risk populations
3. Knowledge transfer to providers re: best practice
4. A service that offers information or advice in a location remote from a central management function and site
5. Partnerships and networks with other service providers to deliver and promote
6. Marketing and promotion of services to increase utilization

3 components to this framework:

Information to be considered at each stage:



Context Stage: Analysis of the community

- **Demographics**

The demographics of a community refer to the geographical situation of the community and the general characteristics of the population within the community .

- **Key stakeholders/community resources**

Key stakeholders/ community resources refer to the people and organizations within the community who are interested in or considered to be supports in the delivery of outreach services. Examples may include: primary care practitioners (PCPs), Family Health Teams (FHTs), allied health professionals (chiropodists, dentists, optometrists, pharmacists etc.) or organizations (Long Term Care (LTC) Centres, immigrant communities, community health centres (CHCs), employee workplaces etc.).

- **Needs and priorities**

Needs and priorities of the community refer to how well the relative health status of the community is and whether services and supports are in place to meet their needs.

Demographics:	Our community
Population (eg. How large is your community; is it urban or rural?)	
Isolated community within driving distance of major health service (eg. How far do people have to travel; is it accessible by public transit; is there free parking?)	
Age distribution (eg. Is there a specific age category that should be targeted?)	
Social and economic status (eg. What level of socio-economic status is this community?)	

Primary industry/level of unemployment (eg. Is this a low industry area with high levels of employment; is this a farm area with self-employment?)
Education level: (eg. What level of education did most of the community reach?)
Health Status: (eg. Is there a high prevalence of diabetes; obesity; hypertension; smoking; mental health?)
High risk population: Immigrants,Ethnic groups (eg. What ethnic groups are prevalent in this community?)
Key Stakeholders/Community Resources
Community leaders (eg. Who is a recognized leader in this community?)
Agencies/Organizations (eg. What agencies or organizations are in this community?)
Health professionals (eg. Which HCP or allied health professionals in this community might be interested in outreach?)
How do we build relationships with these stakeholders? (eg. Meet and greet, open house etc?)
Needs and priorities:
Identified need for this community:
Are there customs or beliefs unique to this identified community?
Demands for services (eg. Where are similar services currently being offered in this community?)
How will the community benefit from this service?
How will the stakeholder benefit from this service?

Elements Stage: Identifying resources

This step determines which additional resources and elements are required to develop outreach service.

Resources
What staff are involved? (Nurses, Dietitians, Health promoters, volunteers, administrative support etc.?)
Where can this service be provided? (Community centre, employee workplace, physician's office etc?)
What space is required? (Office, meeting room, kitchen etc?)
What equipment is needed to provide service? (Lap-top computer, projector, screen, flip-chart, cell-phone, carrying-case, food models, teaching tools etc.)
What hand-out materials/literature is required? (CDA materials, developed materials?)
Budget? (What costs are involved eg. Start-up: equipment; Ongoing: rent, travel, food?)
Marketing and Promotion
How will the program be marketed? (Brochures, newspaper advertisement, letter to patients, etc?)
How will individuals be booked for program? (Sign-up sheet, telephone #, Referral etc.?)
Service Delivery Method
Will it be a group or individual contact?
Will it be a didactic presentation or facilitated presentation?
Timeframe
When will program start?(Date, time, length of time etc.?)
How often will it be provided?(Weekly, monthly etc?)
Documentation/Data Collection
Do we need a signed agreement with organization?
How will we document care?(EMR, outreach file etc.?)
How will we capture data?(Tracking sheets, data-base etc?)
How will we arrange follow-up care? (Schedule for future appointments, refer to DEP?)

Evaluation Methods
How will we know the program was effective? (Pre/post tests of knowledge, evaluation of program, measurable outcomes—goal setting; A1C; waist circumference etc.)
How will we collect data? (Written evaluation forms; show of hands; verbal feedback, lab data etc?)
How will we record data? (Excel spreadsheet to collate data, flow-sheet in patient chart etc?)
When will we review data? (After every program; in 3 mo; in 6 mo etc.?)

Outreach Service Plan Development

This is the final stage of the planning process, prior to implementation. It provides a clear written plan and vision for all involved in the program. It should be kept in your records (eg. Policy and Procedures book; Programs) as well as shared with the host organization or community.

Project Name:

Purpose of Program:
Why are you doing this program—keep it one simple statement.

Description of Program:
Provide overview of program and reason for the program.

Objectives:
State clear objectives

Location/Date/Time of Program:
Specify location, date, and time of program

Responsibilities of Outreach Program:
Outline the role of the outreach program eg. Marketing program, booking patients, documenting, tracking,

Responsibilities of Host:
Outline the role of the host eg. use of space, recruitment of patients

Evaluation:
How and when do you intend to evaluate? Will you share findings with the host?

Summary

This framework tool was developed as a tool to assist you with planning your diabetes outreach services. Methodology and strategies outlined in this framework were gathered from the literature on outreach services as well as experience with program planning. There are many resources available, but we hope this tool serves as a guide to support you in your program development.

References

Public Health Agency of Canada (2008). *A Tool for Strengthening Chronic Disease Prevention and Management.* http://chronicdisease.cpha.ca

Whitehead M. and Dahlgren G., (2007). *Concepts and principles for tackling social inequities in health: Levelling up Part 1 and 2.* The Regional Office for Europe of the World Health Organization.

Brennan Ramirez LK, Baker EA, Metzler M. *Promoting Health Equity: A Resource to Help Communities Address the Social Determinants of Health*. Atlanta: U.S. Department of Health and Human Services, Centres for Disease Control and Prevention; 2008

LHIN Community Engagement Guidelines and Toolkit, (February 2011), http://www.waterloowellingtonlhin.on.ca/Page.aspx?id=1958&ekmensel=e2f22c9a_72_250_btnlink

Engaging Primary Care Physicians in LHIN Process: "Primary Care Physician Engagement Resource Guide & Toolkit", (December 2010) http://www.waterloowellingtonlhin.on.ca/Page.aspx?id=7328&ekmensel=e2f22c9a_72_250_7328_3

Community Legal Services Guidance for Outreach Services to the SQM, http://www.asauk.org.uk/fileLibrary/pdf/sqmoutgd.pdf

Glazier et al (2006). *A Systematic Review of Interventions to Improve Diabetes Care in Socially Disadvantaged Populations.* Diabetes Care, Vol 29, 7, 1675-1688

Eigennmann C, Colagiuri R. *Outcomes and Indicators for Diabetes Education – A National Consensus Position.* Diabetes Australia, Canberra 2007.

American Association of Diabetes Educators. *AADE Position Statement – AADE7™ Self-Care Behaviours*. The Diabetes Educator Vol 34, Num 3 (2008).

MCLennan et al (2006). *Capacity building and complex communication needs: A new approach to specialist Speech pathology Services in rural Victoria*. Australian Journal of primary Health 12 92) 66-74

Western Australia Allied health Review group (2003). A *Framework for the development and provision of allied Health Outreach services.* Produced by Next Challenge Consultancy

Battye K and Taggart K (2003). *Development of a model for sustainable delivery of outreach services to remote north-west Queensland*. Rural and remote health 3 (online) no 194

Wooley et al (2005). *Measuring what counts: evaluating outreach Allied Health organisation service delivery.* National SARRAH conference 2008

Dewson S, Davis S, Casebourne J. (2006). *Maximising the Role of Outreach in Client Engagement*, Research Report DWPRR 326. Department for Work and Pensions.