# Section III

## Building your program – Step 4, 5, 6, 7

- Introduction
- Service/Program Feasibility Review
- Logic model for program planning
- Checklist: Initiating a Health Care Program
- Application Q&A's

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You are now ready to build your program. The following questions can be used as an exercise to think through the elements, linkages, business implications, appropriateness, and feasibility of the program or service plan.
Tools to assist with program development include:

- **Service/Program Feasibility Review (Step 4)**: explores the scope and appropriateness of the potential program. Chart the client journey, especially services accessed by the client, to ensure that your client receives consistent messages and interventions from all services (See example).

- **Logic Model for Program Planning (Step 5)**: provides a template, with supporting information, to develop a program plan and evaluation, using the logic model design.

- **Initiating a Healthcare Program Checklist (Step 6)**: reviews the key plan elements necessary for a comprehensively designed program that is congruent with the CDPM Framework. Completion of this tool identifies any gaps in the draft program plan, and supports the final plan content.

**Revision of the Logic Model (Step 7)**

- After you have completed the above tools revise the logic model as required

**Need more help – Check out the questions, answers and examples at the end this section of the tool kit**.

# CHRONIC DISEASE MANAGEMENT PROGRAM FRAMEWORK
# SERVICE/PROGRAM FEASIBILITY REVIEW

**Proposing Organization(s):**

**Organizations' mandate(s):**

- What is the title/focus of the initiative?

- What level of population management does it reflect?
    - Health promotion
    - Level 1___ 2___ 3___

**Initiative's scope:**

- What is the target population?

- What data supports the need/gap being addressed by the proposed initiative?
    - Research evidence
    - Benefits/deficiencies
    - Population health needs justification

- How does the program "fit" with the promotion, primary, secondary, or tertiary role of the organization(s)?

- What integration opportunities and partnerships are available to move the initiative forward?

**Program/service development/maintenance overview:**

- How long might it take to develop the program/service?

- What are the potential developmental resources?

- What are the potential funding resources?

- How does the program/service fit with the defined continuum of care as reflected in the framework?

- How does it link with existing and/or future services/resources/programs?

- Using the roles/activities matrix and model element definitions of the CDM model, define (high level) activities/deliverables/objectives that are within the scope of the program/service.

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**Logic Model Planning**

It is necessary to be explicit in describing your program and its goals. Being explicit helps others to understand your program's purpose but it also allows for your program to have an evaluation framework. Logic models are one way to achieve this explicitness. See Appendix B for Innovation Network, Inc. (2005) Logic Model Workbook to assist you in developing a logic model

According to Brian Rush of the Towards Evidence Informed Practice Program (TEIP) of the Ontario Heart Health Resource Centre, program logic models:

- Articulate the program structure (functional components of a program)
- Articulate the program logic (the relationship between program activities/process and expected outcomes)
- Guide what needs to be measured and why – activities/process and /or structure

Brain Rush suggests the following process steps to build a logic model

1. Review and write down the needs that led to your idea/plan/project
2. Review and write down the "theory" underlying your idea/plan/project Why A → B →C
3. Then the logic model will connect the dots between the activities and outcomes

The TEIP Program has established a process for planning, implementation and evaluation health promotion programs. Logic Models assist this process. TEIP has a number of suggestions to assist in development of logic models:

- Use a simplified logic model template
- Use stickie notes for each item – they can be easily moved as you play with how to organize the information
- Logic models can be built from the topdown or the bottom up but top down is often recommended for evaluation of existing programs
- Identify the main components (activities/resources)
- For each component identify implementation/process objectives (what the program will do)
- Under each process, identify anticipated short-term outcome objectives (the effect of the program)
- Identify intermediate and long term objectives arising from the short-term objectives
- When information is organized on the stickies transfer to the template.

(TEIP, Logic Model Workshop, 2006)

Check out the TEIP tools for planning, implementation and evaluation of your own health promotion programs at http://teip.hhrc.net

## Logic Model Template

**Program Name:**

<table>
<tr><td colspan="5">Problem Statement:<br><br>Program Goal (s):</td></tr>
<tr><td colspan="5" align="center">Resources<br>What resources do we have to work with?</td></tr>
<tr><td align="center">Activities<br>What happens in our organization?</td><td align="center">Outputs<br>What are the tangible products of our activities?</td><td align="center">Short-term Outcomes<br>What changes do we expect to occur within the short term?</td><td align="center">Intermediate Outcomes<br>What changes do we want to see occur after that?</td><td align="center">Long-term Outcomes<br>What changes do we hope to see over time?</td></tr>
<tr><td></td><td></td><td></td><td></td><td></td></tr>
</table>

<table>
<tr><td>Rationale(s):<br>The explanation of a set of beliefs, based on a body of knowledge, about how change occurs in your field and with your specific clients (or audience).</td><td>Assumptions:<br>Facts or conditions you assume to be true.</td></tr>
<tr><td></td><td></td></tr>
<tr><td colspan="2">External Factors:</td></tr>
</table>

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**Initiating a Healthcare Program Checklist**

| 1 (Not In Place); 2 (Under Development); 3 (Fully Implemented); N/A (Not Applicable) | | | | |
|---|---|---|---|---|
| | 1 | 2 | 3 | N/A |
| **1. DELIVERY SYSTEM DESIGN** | | | | |
| An interdisciplinary team | | | | |
| A focus on health promotion and wellness | | | | |
| Planned interactions and active follow-up | | | | |
| The capacity to tailor services to meet identified needs | | | | |
| The capacity to provide culturally competent care | | | | |
| Innovative Practices | | | | |
| Surveillance systems | | | | |
| **2. PROVIDER DECISION SUPPORT** | | | | |
| Education and training | | | | |
| Clinical Management Tools | | | | |
| Access to expertise | | | | |
| Performance measurement system | | | | |
| **3. INFORMATION SYSTEMS** | | | | |
| Information technology systems that connect team members, sites and data | | | | |
| Electronic health records | | | | |
| Registries | | | | |
| Interactive tools and software | | | | |
| Health information for individuals and families | | | | |
| **4. PERSONAL SKILLS and SELF-MANAGEMENT SUPPORT** | | | | |
| Shared decision-making | | | | |
| Education and skills development | | | | |
| Behaviour modification program | | | | |
| Counseling and support services | | | | |
| Links to community resources | | | | |
| Follow-up | | | | |
| **5. HEALTHY PUBLIC POLICY** | | | | |
| Legislation and regulations | | | | |
| Fiscal policies | | | | |
| Guidelines | | | | |
| Organizational policies | | | | |
| **6. SUPPORTIVE ENVIRONMENTS** | | | | |
| Supportive physical environments | | | | |
| Supportive social environments | | | | |
| Community engagement/mobilization | | | | |
| Community partnerships/coalitions | | | | |

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**Questions to help the planning process –** Answering these questions may help in conceptualizing your program and producing data and information for your planning**.** We have included an example.

*Example: The ACME health service has identified a need to increase prevention and risk modification to individuals with CD or those individuals at risk of CD. CD is a grouping of symptoms resulting from eating high fat foods, being inactive, smoking and drinking large quantities of alcohol. It is usually managed through lifestyle interventions and therapeutic interventions such as medications. Where does ACME team start?*

✓Chart the individual with CD typical journey.
✓Star areas of contact or influence.
✓For each contact, remember to list all providers – some contacts such as CCAC may have multiple providers.
✓Remember the key messages: The client always encounters a client-focused approach and consistent messaging about CD.

Charting the journey – An Example

Not feeling well →Seeks information on the internet and at the library*. → Unable to get comprehensive answer so visits the doctor*. Doctor prescribes medication to reduce symptoms and improve some impact of CD.→ Referred to ACME for risk modification counseling* and goes to the pharmacist for medication*. →Acme suggests enrolling in a healthy weights program at the clinical nutrition clinic*, arranges for a personal trainer at the Y*, and a smoking cessation course with public health*. →Client asks that the family be involved.* →Client delays initiating the program until after the summer holidays and falls following a party and is admitted through the local ER* and has a 2 day stay in hospital*.→Due to injuries suffered, he is referred to CCAC*. →Returns to ACME to resume self-management plan but wants to add an evaluation of drinking through the local addictions centre*. Client works well with follow up on the established goals for 6 months. Suddenly following a death in the family he feels he is regressing and is depressed. →Returns to the family doctor and is referred to the mental health program*. Depression begins to improve and the client returns to working on his goals.

List the contact points *.

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## *Questions?*

1. What type of initiative is planned? (Strategy, project, program, research, guideline, policy, education, communication, marketing, collaboration- networking)

*Notes:*

***Example**: Acme is looking at starting a collaborative network of health and community providers to ensure consistent messaging and approaches to CD.*

2. What is the scope of the initiative? What does the initiative hope to achieve? (management of disease, health promotion, prevention, capacity building)

*Notes:*

***Example**: Acme hopes to build capacity within the health and community system to effectively and efficiently manage and prevent CD.*

3. Do similar initiatives exist? Locally? Distance?

*Notes:*

***Example**: Yes. There are initiatives for obesity in children and an alliance for health promotion and prevention.*

4. If yes, how would Grey Bruce benefit from this initiative?

*Notes:*

***Example**: It would be concentrated on a large risk population in Grey Bruce who are not managed well. It would ensure a move to consistent messaging and best practice. Could be the start of a large coalition to address similar conditions?*

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5. Referring to the Health Promotion and Prevention Pyramid, what is the level of involvement for this initiative?

*Notes:*

***Example****: Primary and secondary prevention primarily.*

6. Should my organization be involved in the levels this initiative is designed to address? (Examine the mandate of your organization.)

*Notes:*

***Example****: Yes. Our mandate is to assist in the modification of risk factors on an individual level.*

7. Is my organization ready for the change in practice which would result from this initiative?

***Example****: ACME is frustrated with the status quo and has committed to changing the current, fragmented approach to CD.*

8. Who is the target audience/client/consumer? (Example: public, risk populations, individuals, providers, families)

*Notes:*

***Example****: Though the improved practice would assist individuals with CD the collaboration is targeting health and community service providers.*

9. What partners need to be involved to achieve the goals of this initiative? (Example: community agencies, public health, hospitals, LHIN, advocates)

*Notes:*

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***Example****: The list of contacts as indicated on the journey plus initiatives which would also benefit due to similar risk factors and shared populations – Cardiac rehab, Regional Diabetes, District Stroke Centre, First Nations Health, Active 2010*

10. What are the roles and responsibilities of my organization in this initiative?

*Notes:*

***Example****: Initiate the gathering of the stakeholders, get buy in, facilitate a planning process, lead the planning process until a coalition/network is formed.*

11. What outcomes fit my organization's mandate?

*Notes:*

***Example****: Having consistent messaging and approaches from each provider influencing an individual with CD should result in better health outcomes and a reduction in risk behaviours.*

12. At what levels– health promotion, prevention, secondary prevention or tertiary prevention - are outcomes defined?

*Notes:*

***Example****: Most of the outcomes will be defined at the prevention and secondary prevention level but for consistency the tertiary level needs to be part of the coalition.*

13. Are the outcomes measurable? (SMART)

*Notes:*

***Example****: The outcomes are defined and measurable. Timelines may be optimistic.*

14. Can areas of misunderstanding or "Fuzziness" in your initiative be identified? Can these areas be made more explicit?

*Notes:*

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***Example**: Need to ensure a clear understanding of the initiative and the advantages of consistency. Do not want participants to think we are on their territory.*

15. Do you know who to ask to help you with this process?

*Notes:*

***Example**: We know to contact the Grey Bruce Health Network CDPM task team for help.*

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