LWD PLM BUILDING BLOCK 3

OUTPUTS

What we do (activities) and who we reach in LiveWell Diabetes

| Patients First: LWD reaches Children to 18 years and Adults and their families within SHR & throughout the province. |
| Connecting to LWD through self-referral, MD-referral or through outreach (going to high risk populations). |
| Participating individually in one on one consultations (inpatient & outpatient); in community programs (Aim 4 Health, Fitness Food Fun, Preventing Diabetes and Heart Disease, Discovering Diabetes, First Step, Cardiac Rehab Program); or in specialty clinics (Diabetes In Pregnancy, Pediatric & Transition, Adult Interdisciplinary) that also serve the province. |
| Located in Saskatoon urban and rural sites a) inpatient hospital settings, b) outpatient settings including Primary Health Centres and physician offices, c) community settings for groups, d) First Nations communities, e) and in client homes (Aim 4 Health). |
| Offered by an Interprofessional team with advanced training in diabetes management (nurse clinicians, dietitians, exercise therapists, health educators, outreach workers, social workers, pharmacists, peer leaders) and accessible medical specialist support. Includes intensive diabetes management in complex cases with other care providers such as Mental Health, Home Care, Acute & Emergency Care etc. |
| Providing culturally-appropriate clinical assessment care & management, self-management support, risk assessment/targeted screening initiatives and follow-up (phone, fax, email, face to face). |
| Facilitated and supported by point of care tools/technology (Electronic Medical Record). Quality Improvement Initiatives (Plan-Do-Check-Act) and client data surveillance information systems. |
| Partnering/Collaborating with formal and informal community support groups/organizations/services/programs to share what LWD knows, advocate for, and take action on healthy public policy and determinants of health (health equity, food security, social isolation, transportation, poverty). |

2014/2015 Indicators Tracked

# total LWD clients; by age, diagnosis (if new), postal code, gender, immigrant
#% clients self-reported ethnicity
#% client experience survey/responses
LWD common program referrals
# urgent referrals on non-service days
# days from referral to 1st contact
#% reached/attended community displays, Health Fairs, education events
# clients reached thru ‘curbside counselling’/where
# outreach visits: hospital; home; SW
# individual LWD consultations
# LWD programs & sessions conducted; participation rates for each
# of specialty clinics held; participation rates; appointment status
# individual visits with pregnant women
# cancellation/no show rates
LWD location sites: urban & rural
# physician practices supported by on-site LWD diabetes services
#% family physicians engaged in LWD
# medical specialists working with LWD
# clinical health psychology residents
# of interprofessional team members / program staff /community peer leaders
# team education/training events
# joint nurse clinician / dietitian appointments for med referrals
# follow-up contacts or review, # by email, phone or face to face
# First Nation people screened for prediabetes/diabetes [CANRISK]
#% completed Risk Assessment & brief education/counselling
# foot assessments
# >18 yrs transferred to adult program
# pediatric new diagnosis ED visits/ SHR admission/reasons/follow-up
# with ehealth viewer access privilege
#% staff attended Safety Days
#% staff attended Kaizen Basics
#% team huddles/frequency
# Visibility walls/huddle boards/DVM
# type Quality Improvement initiatives (PSDA)
# type of LWD working committees
# health activities, screening,education events in partnership with other organs
# external collaborative community-based partnerships
# external partnerships funding support