# Case study example: The *Health Connect* Logic Model

| Inputs | Outputs | | Outcomes | | |
|---|---|---|---|---|---|
| | Activities | Participation | Short-term | Intermediate | Long-term |
| **What resources are needed to implement the activities?** | **What specific activities will you undertake?** | **Whom are you trying to reach through your activities?** | **What changes do you expect to see in the short term?** | **What changes do you expect to see as a result of achieving the short-term outcomes?** | **What will be different if you are successful?** |
| • Staff time (CHW and staff at partner agencies)<br>• Funding through partners: food bank, community center, community clinic<br>• Partner organizations receiving referrals<br>• Technology (e.g., referral system to track CHW clients)<br>• Information and resources (e.g., health education materials, lists of community resources)<br>• Internal processes (workflow and forms for tracking individual client progress)<br>• CHW training (skill development, diabetes content knowledge)<br>• Facilities (community center, clinics, food bank) | **Program development**<br>• Promote CHW program in community<br>• Develop & implement referral processes between key partners<br>• Train CHWs<br>**Client services**<br>• Enroll clients in assistance programs (e.g., WIC, SNAP, health insurance)<br>• Connect clients with programs at key partners (food bank, clinic services, and physical activity programs at the community center)<br>• Provide referrals to other social services (e.g., housing assistance)<br>• Provide information on healthy meal preparation and opportunities to increase healthy eating & physical activity<br>• Collaboratively develop goals with clients and action plans for self-management<br>• Follow-up and provide support around achieving self-management goals | • Low-income residents with diabetes, focusing on those with poor access to food, health care and/or opportunities to be physically active<br>• CHW partners:<br>Community clinic providers<br>Food bank staff<br>Community center staff | • Increased awareness and utilization of CHW by low-income residents with diabetes<br>• Improved referral processes & linkages between key partners<br>• Increased enrollment in assistance programs<br>• Increased referrals to other social services<br>• Increased access to healthy food options, heath care services, and physical activity programs<br>• Increased confidence in ability to obtain and prepare healthy foods<br>• Increased awareness of opportunities and accessible ways to increase physical activity<br>• Establishment of self-management goals and action plan<br>• Increased participation in self-management activities (e.g., healthy eating, physical activity, regular primary care visits) | • Increased food security<br>• Improved health behaviors, i.e.,<br>  • Increased healthy eating (fruit and veggie consumption)<br>  • Increased physical activity<br>• Increased number of clients with a medical home<br>• Decrease in unmet social service needs<br>• Progress toward or achievement of self-management goals | • Improved diabetic health measures<br>• Decreased diabetic complications<br>• Increased quality of life |