Logic Model as Community-Engaged Research Planning Tool:

A Conversation

Presenters:

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Team St. Louis, C6 (Kia Davis, Cara Pugh, Tiffany Young)

Community Agreements

- Be respectful
- Active listening
- Be constructive
- Lean into discomfort
- Share from experience
- Step up; Step back
- No judgments during brainstorming

Session Objectives & Format

Objectives:

1. Showcase lived experience using logic models for community-engaged research projects on structural racism
2. Be motivated to maximize what the tool has to offer

Format:

1. Team KnoxHEAL and Team St. Louis Conversation (25 min)
2. Q&A with everyone (15 min)

Conversation Topics

1. What is your team's research project? Share how you used logic model to help shape your project.

2. Your thoughts on logic-modeling, **before** and **after** the proposal completion, and during research implementation?

3. Logic model as a community engagement tool – Can you share your thoughts?

LOGIC MODEL: Team Knox H.E.A.L. (#110975)

Need / Problem: Develop evidence to drive policy and process change

Goal: Change policy, change CHS climate, improve health outcomes for BIPoC patients, share with national group of FQHC

INPUTS (What We Invest)	ACTIVITIES (The Actual Tasks that we do)	OUTPUTS (Direct, immediate, measurable product of activities)	SHORT-TERM OUTCOMES (1 year or less)	MEDIUM-TERM OUTCOMES (1-3 years)	LONG-TERM OUTCOMES (3-5 years)
Time	Policy analysis of all policies and operations guides	Playbook	Identify specific institutionally racist policies, practices, and functions	Changes to CHS policy, practices, and functions that uphold institutional racism	10% Improvement in BIPOC patient satisfaction with healthcare quality
Resources: FTE from Winford, JJT, Laughter	provider/staff training	Identification of institutional racism in CHS Policies, practices, and procedures	Identify the relationship between policies, practices, and functions and health outcomes of BIPOC patients		10% improvement in BIPOC patient's Charlson index scores
Technology	patient treatment and navigation	Relationships between policy and patient satisfaction	Identify the relationship between policies, practices, and functions and quantitative climate assessment and patient satisfaction assessment		
Relationships with patients	patient access to resources	relationships between policy and patient Charlson index scores			
Relationships with employees/staff	patient communication				
Buy in from Administrative leadership	Interviews with employees and patients regarding institutional racist pathways				
Space	employee ratings of CHS climate				
Staff for abstracting HER	testing associations between policy and Charlson index				
Money for participant compensation	interviews with staff;				
GAs for data collection and recruitment	interviews with patients				
Office supplies					
Recruitment materials					
Email, Phones, Laptops					

Assumptions:

1. Racism exists within CHS policy and healthcare processes
2. We will be met with resistance

External/Contextual Factors:

1. Administrative buy in
2. White supremacist sentiment is prominent in Knoxville

TEAM STL LOGIC MODEL

Need/Problem: In the US, structural racism has created and maintained neighborhoods that are racially and economically segregated from legislation in the 1860s to current housing market discrimination. The subsequent health-damaging effects of these segregated neighborhoods have been well documented. What has not been well documented or tested are solutions to alleviate the disproportionate burden of poor health outcomes repeatedly observed in these segregated neighborhoods. This proposal fills this gap by answering whether innovative economic justice policies like CBAs can mitigate the impact of structural racism via residential segregation on communities of color.

Goal: To understand the extent to which community benefits agreements (CBAs) alleviate the multigenerational impact of structural racism on the health of historically oppressed communities.

        Aim 1: Quantify the health impact of CBAs on historically oppressed communities where they have been implemented

        Aim 2: Understand how the implementation and community context influence CBA impacts and ultimately health.

Resources critical to program success	High level list of tasks/activity areas	The direct, measurable, results of program activities	Measurable changes, over time, to the environment the program operates in, and/or the performance or perceptions of people served by the program/research		
Inputs (What we invest)	**Activities** (The actual tasks that we do)	**Outputs** (Direct, immediate, measurable product of activities)	**Short-term outcomes** (1 year or less)	**Medium-term Outcomes** (1-3 years)	**Long-term outcomes** (3-10 years)
RWJF IRL staff & external mentorship support	Scoping/targeted literature review on CBAs and their implementation across the nation	Quantitative results indicating the impact of CBAs	Increase stakeholders' knowledge about CBA impacts	Increase disenfranchised communities of color awareness of CBAs as an economic intervention across the U.S.	Increase in CBA ordinances is disenfranchised communities of color across the U.S.
Consultants (statistician, community organizer, community assistant, qualitative data collectors & analyst)	Collaborate with community partners to revise/edit AIM 1 indicators & deep canvassing questions	Qualitative results that describe the implementation context and impacts of CBAs	Increase stakeholders' knowledge of best practices for implementing a CBA	Improve stakeholders' attitudes toward/about CBA	Increase adoption of CBAs as an economic intervention
Washington University postdoctoral fellows & graduate students	Quantitative analysis (select intervention like St. Louis and control communities, define unit of analysis (census tracks, zip codes?) Conduct the	Published policy brief/executive summary	Increase stakeholders' knowledge about the range/types of CBAs		Inclusion of global measures of health in CBA interventions
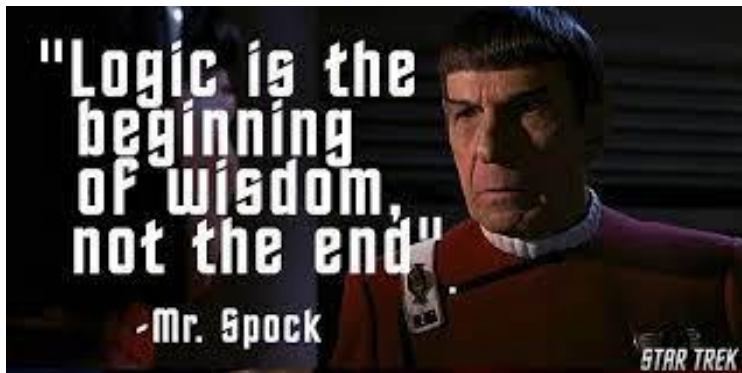
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