The Logic Model was developed by the W.K. Kellogg Foundation to aid program planning, implementation, and evaluation. It is highly versatile, generally outlining three main features of programs—inputs, outputs, and impacts—and their interrelation. The Model includes a sequence of activities from which individual, community, and system changes are expected to occur to impact health. It may be useful in community-oriented primary care programs.

To generate the FLLP logic model, we identified resources—both monetary and human expertise—and stakeholders whose contributions would enrich the process. Among the stakeholders were course instructors, graduates of the training program, funders, and health agencies. We reached consensus on the assumptions and expectations for the nutrition problems addressed: if people acquire food and nutrition information (short-term impact), they will adopt health-promoting behaviors and share their success with others (medium-term impact). The long-term impact would be a healthier community.

For programs already in place, outlining activities is straightforward. For each activity, short-term (knowledge and attitude change), intermediate-term (behavior change), and long-term (health status change) outcomes are stated. Linking activities to expected impacts helps determine if planned activities are sufficient to meet stated impacts. If not, the model needs examination to determine why expected outcomes are not occurring. For FLLP, we found the food and nutrition knowledge gain (short term) and behavior change (medium term) and the ability to transfer this knowledge (medium term) were not occurring as predicted.

When planning the evaluation scheme based on the Model, the evaluation methods need to be examined. For FLPP, we were collecting data about individuals’ pre-FLPP and post-FLPP nutrition and physical activity behaviors and course evaluations. These data were not able to give us the entire picture of program effectiveness. For our final evaluation plan, we integrated the results from a new survey of past participants, volunteer records, course evaluation forms, and available data on physical activity and nutrition behaviors.

Our experience with the Logic Model helped us see other ways it can be used in family medicine. In an era of shrinking resources and increasing demands for clinical productivity, teachers of family medicine can also use the Logic Model to assure that curriculum innovations or alterations have been considered from all aspects and highlight the value of change. Analysis of existing programs against the Model may show where value can be added or more efficient use of resources can be made. Likewise, in the community, clear statements of plans with outcomes achieved makes funding more likely for future projects. In addition, use of the Model makes evaluation substantive to the desired outcomes, versus student opinion surveys, the more typical data available to faculty for professional documentation toward promotion.

Developing the Model was a useful tool even with a 5-year-old program. It described FLLP to our funders and stakeholders and allowed adjustment of training content and methods to create the desired impacts. We were able to efficiently determine strengths and weaknesses of FLLP and define recommendations for change and improved sustainability. We recommend the Model to clearly delineate responsibilities, activities, and how impacts will be evaluated in community-based health improvement programs.

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REFERENCES


Family Medicine Residents and Home Visits

To the Editor:

Background

By 2030, one in five Americans will be older than age 65, many of them with some kind of disability. A significant number will utilize home care and community services to accommodate their needs.

The family medicine residency at Jefferson Medical College, Thomas Jefferson University, has had a home visit program since 1981. The residents are required to participate in home visits with attending physicians. The residents average approximately 44 home visits by the end of their training. To investigate the impact of the current home visit program, we surveyed the family medicine residents’ attitudes and knowledge on caring for elderly, homebound patients.

Methods

We surveyed first-, second-, and third-year residents (n=27) in the fall of 2003. The survey consisted of two parts. The first section was
15 questions based on a Likert scale that assessed attitude and knowledge on caring for elderly, homebound patients. The second part consisted of two open-ended questions: (1) What is the most challenging or difficult aspect(s) in the care of an elderly home visit patient? (2) What is the most rewarding aspect in the care of an elderly home visit patient?

Results
All 27 residents returned the survey, for a response rate of 100%. Thirty percent of residents experienced a sense of frustration when dealing with elderly home visit patients with chronic diseases. Most of the residents believed that elderly home visit patients are capable of improving their health (93%), make informed decisions or choices (96%), and can be educated on preventive measures to improve their health (81%). Most of the residents (96%) believed that understanding the caregiver of a home visit patient will help in the medical care of that patient. Only 37% of residents believed that home visit patients take medications as prescribed. The majority of residents (93%) depended on social workers, nurses, and therapists to care for home visit patients. Forty-one percent of residents understood how to utilize the different services provided by home health care. Forty-four percent of the residents did not feel comfortable managing the medical problems of home visit patients. First-year residents were much less comfortable (89%) compared to third-year residents (33%). Seventy-eight percent of residents expressed interest in the care of these patients, and 81% would like to continue to care for home visit patients in the future.

The residents responded that the most challenging or difficult aspects in the care of elderly home visit patients were lack of access to ancillary and specialty services and infrequent contact with the patients. The most rewarding aspects in the care of elderly home visit patients were the ability to see the patients’ home environment and being cared for by loved ones, the ability to provide access to care for homebound patients, and patient appreciation.

Conclusions
Most of the family medicine residents are interested in caring for elderly, homebound patients. They report visiting patients in their home environment rewarding and talking with caregivers valuable. The residents realize that providing medical care at home requires an interdisciplinary team that includes social workers, nurses, home health aides, and therapists. They cite lack of access to ancillary health care services and fewer resources as barriers to caring for homebound patients. The problem is that many residents are not aware and do not fully understand how to utilize the scope of home health care services in the community. We need to train our residents better on how to manage these resources to assist in the medical care of our patients in the home.

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