**Project mHEALTH**

**Yale University School of Medicine AIDS Program**

**Liberty Community Services  
Connecticut Department of Correction**

**Logic Model**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **If we have this:** | **We can do this:** | **And then this:** | **Which will lead to this:** | **And then this:** |
| **Peer Navigator**  **(LCS)** | **Facilitate access to and retention in medical care, affordable housing and other support services** | **Schedule visits and provide transportation to appointments with PCMH providers** | **Improved stabilization of basic needs** | **Will result in increased ability to address medical care, drug treatment and support services** |
| **CJS Referrals Coordinator (CTDOC)** | **Facilitate coordination first with EIS Services and then with the Peer Navigator and Network Navigator** | **Linkage to community based Intensive case management, treatment for HIV, substance use disorders and mental health** | **Improved linkage to and retention in HIV care and other community services** | **Improved housing stability, HIV treatment outcomes, social support and reduced recidivism** |
| **Network**  **Navigator/Hou**  **sing**  **Coordinator**  **(LCS)** | **Coordinate housing, medical, mental health and addiction treatment and link to social service agencies in the RW Consortium of Care (PCMH)** | **Eventual transition to medical case managers and a community-wide network of services Coordinate activities with HOPWA-funded agencies and other housing service providers** | **Stabilization of HIV, substance abuse and mental health outcomes** | **Improved linkage to and retention in HIV care; Improved HIV treatment outcomes – adherence, viral suppression, reduced HIV transmission** |
| **Early**  **Intervention**  **Services**  **(CHCV)** | **Referral to a Patient Centered Medical Home with primary care, case management, and treatment of mental illness and substance abuse** | **Access to care for PLWHA who are out of care or newly diagnosed; lack of disruption of treatment services and continuity of care** | **Better HIV outcomes, reduced relapse, reduced criminal activity, reduced addiction severity** | **Stabilization of housing, relationships, mental health, employment and health care** |
| **Directly**  **Administered**  **Antiretroviral**  **Therapy**  **(CHCV)** | **Promote retention in care, ART adherence and self-efficacy through medication supervision** | **Continue to engage the client in his/her care through daily interactions and education and training** | **Improve adherence to ART and promote retention in care** | **Result in viral suppression, improved health-related quality of life and management of other comorbid conditions** |

*This publication is part of a series of manuals that describe models of care that are included in the HRSA SPNS Initiative* Building a Medical Home for HIV Homeless Populations*. Learn more at* <http://cahpp.org/project/medheart/models-of-care>