**LOGIC MODEL FOR OPERATION LINK**

| **LEVEL** | **INPUTS** | **ACTIVITIES** | **OUTPUTS** | **OUTCOMES** | | |
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| Short-Term | Intermediate | Long-Term |
| **CLIENT** | -Mobile Care Unit  \*Care Navigator  \*Peer Counselor  \*Medical Care Coordinator  -Network of Service Providers | -Recruit Clients  -Enroll Clients  -Conduct Needs Assessment  -Develop Coordinated Care Plan  -Implement Care Navigation  -Conduct Peer Support and Encouragement  -Conduct Medical Care Coordination (Provided In-kind)  -Transport Clients to Appointments  -Collect Outcome Data | -Number of Outreach Contacts  -Number of Project Enrollees  -Number and Type of Network Service Providers in the Network  -Number of Client Trips to Appointments  -Number of Care Navigator Contacts  -Number of Peer Navigator Contacts  -Number of Medical Care Coordinator Contacts | -Number of Clients  Entering HIV/AIDS Treatment  -Number of Clients Entering Mental Health Treatment  -Number of Clients Entering Substance Abuse Treatment  -Number of Clients Entering Temporary Housing  -Number of Baseline Collections: Beck Depression Inventory  -Number of Baseline Collections: CD4 Cell Counts  -Client Satisfaction with the Project and Services | -Increased No. of Clients in HIV/AIDS Treatment at 6-Month Intervals  -Increased No. of Clients in Mental Health Treatment at 6-Month Intervals  -Increased No. of Clients in Substance Abuse Treatment at 6-Month Intervals  -Increased No. of Clients in Temporary Housing at 6-Month Intervals  -Improved Outcomes on Beck Depression Inventory at 6-Month Intervals  -Improved CD4 Cell Counts (annual) Yrs. 2-5  -Increased No. of Negative Drug Screens  -Increased No. of Client Referrals to the Project | -Clients have a Medical Home  -Increased Adherence to HIV/AIDS, Mental Health, and Substance Abuse Treatment  -Improved and Stable Client Housing  -Improved Medical and Behavioral Health Outcomes |

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| **CONTEXTUAL CONDITIONS AND RIVAL EXPLANATIONS** |

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| **LEVEL** | **INPUTS** | **ACTIVITIES** | **OUTPUTS** | **OUTCOMES** | | |
| Short-Term | Intermediate | Long-Term |
| **MOBILE CARE UNIT** | -Truck and Trailer (Provided In-kind)  -Truck Maintenance and Gas  -Two Tablet Computers and Portable Printer  -Staffing for Mobile Care Unit  -Staff Training  \*Patient-Centered Medical Home (PCMH) Training  \*Class C Driver’s License  \*Ongoing Professional Development | -Identify and Visit Outreach Locations on Set Dates/Times  -Recruit & Enroll Clients into Project  -Implement Care Navigation & Peer Support  -Implement HIV Testing and Other Medical Services (Provided In-kind)  -Transport Clients to Appointments  -Schedule and Coordinate Client Appointments  -Distribute Incentives (Food, Clothing, etc.)  -Collect Outcome Data | -Monthly Calendar for the Mobile Care Unit  -Mileage of the Mobile Care Unit  -Number of Project Enrollees  -Number and Type of Network Service Providers  -Number of Service Provider Contacts (Appointment Scheduling, Client Consultation, etc.)  -Number of Care Navigator and Peer Counselor Contacts with Clients  -Number HIV Tests and other Medical Services (Provided In-kind)  -Number of Client Trips to Appointments  -Number and Type of Incentives | -Number of Scheduled Community Stops (Monthly)  -Number of Clients  Entering HIV/AIDS Treatment  -Number of Clients Entering Mental Health Treatment  -Number of Clients Entering Substance Abuse Treatment  -Number of Clients Entering Temporary Housing  -Number of Kept/Missed Appointments  -Number of Clients Referred Using Mobile Unit | -Increased No. of Scheduled Community Stops (Annually)  -Increased No. of Clients in HIV/AIDS Treatment at 6-Month Intervals  -Increased No. of Clients in Mental Health Treatment at 6-Month Intervals  -Increased No. of Clients in Substance Abuse Treatment at 6-Month Intervals  -Increased No. of Clients in Temporary Housing at 6-Month Intervals  -Number of Clients Using Referral Services | -Institutionalization of Scheduled Community Stops  -Increased Adherence to HIV/AIDS, Mental Health, and Substance Abuse Treatment  -Improved and Stable Client Housing |

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| **CONTEXTUAL CONDITIONS AND RIVAL EXPLANATIONS** |

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| **LEVEL** | **INPUTS** | **ACTIVITIES** | **OUTPUTS** | **OUTCOMES** | | |
| Short-Term | Intermediate | Long-Term |
| **NETWORK OF SERVICES** | -Project Staffing:  \*Care Navigator  \*Medical Care Coordinator  \*Project Director  \*Case Manager  \*Peer-to-Peer Mentoring  -MOUs between PPHD and Network Service Providers | -Identify Appropriate Service Providers and Enroll Clients in Treatment/ Services  -Coordinate Client Services Within and Across Providers  -Schedule and Monitor Client Appointments  -Maintain Ongoing Contact with Client Service Providers and Conduct Problem-Solving  -Schedule and Facilitate Quarterly Network Provider Meetings | -Number and Type of Service Providers in the Network  -Number of Service Provider Contacts (Appointment Scheduling, Client Consultation, etc.)  -Quarterly Network Provider Meetings | -Number of Clients Enrolled in Services/Treatment  -Number of Clients Entering Temporary Housing  -Number and Type of New Providers in the Network  -Number of Provider Representatives at Quarterly Network Provider Meetings | -Increased No. of Clients in Services/ Treatment at 6-Month Intervals  -Increased No. of Clients in Temporary Housing at 6-Month Intervals  -Development and Dissemination of a Network Provider Directory  -Development and Dissemination of a Network Procedures Manual | -Increased Client Adherence to HIV/AIDS, Mental Health, and Substance Abuse Treatment  -Improved and Stable Client Housing  -Enhanced Relationships and Coordination Between Network Providers  -Enhanced and Improved Network (Number of Providers and Breadth of Services)  -Shared Responsibility for Care Navigation Among Network Service Providers (i.e., Institutionalization) |

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| **CONTEXTUAL CONDITIONS AND RIVAL EXPLANATIONS** |

*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>