**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>