**LOGIC MODEL FOR OPERATION LINK**

| **LEVEL** | **INPUTS** | **ACTIVITIES** | **OUTPUTS** | **OUTCOMES** |
| --- | --- | --- | --- | --- |
| 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** |

**(Continued)**

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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** |

**(Continued)**

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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>

**Project mHEALTH**

**Yale University School of Medicine AIDS Program**

**Liberty Community Services
Connecticut Department of Correction Logic Model**

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| --- | --- | --- | --- | --- |
| **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** |

## Theoretical Model

Health Hope and Recovery was developed to serve the needs of HIV positive people diagnosed with mental health and/or substance abuse and who are chronically homeless, at risk of homelessness or fleeing from domestic violence.

### Background

1. Given the complex needs of HIV positive individuals with a diagnosis of mental health and/or substance use disorders who are homeless and/or at risk of homelessness, the system of care must be operated within a highly supportive culture that fosters engagement and retention in services.
2. Engagement and retention will be most effective when the system of care is supported by staff that has the skills to work with the population and is able to use evidenced-based strategies to help clients develop and achieve their own goals regarding engagement in care and treatment.
3. There are discernible differences in the needs of the three different priority populations: a) literally homeless; b) unstably housed; and c) those fleeing from domestic violence and lacking housing resources.

The program utilizes specific strategies to effectively engage members of the priority population and keep them engaged over a sufficient duration of time to enhance their own motivation to get treatment and thereby to achieve health, hope and recovery. Core outcomes are linkage to and retention in HIV care, adherence to medical care and treatment leading to viral suppression, and linkage to, retention in and adherence to mental health and/or substance use disorder treatment.

### Evidence Base

The service model draws on evidence-based practices related to medical care for HIV positive people, engagement of homeless and substance-abusing persons in services, motivational enhancement approaches within a stages of change framework, integrated mental and substance abuse treatment, and care coordination approaches specifically designed for those who are HIV positive, homeless, and have mental health and/or substance use disorders.

***Primary Care – Co-Occurring Mental and Substance Use Disorders Integration*** - The evidence base for the integration of mental health and substance abuse services into a primary care medical home is found in the variety of models developed for the integration of primary care and psychiatric services (Unützer et al., 2008; Areán et al., 2005; Katon et al., 2006). The integration of mental health and substance abuse services with HIV care in a medical home is a highly desirable goal (Willenbring, 2005).

***Primary Care and Multiple Chronic Conditions Medical Home*** – Walkup and colleagues (Walkup et al., 1999) note the lack of a system of care in the U.S. for people living with HIV/AIDS (PLWHA) and co-occurring substance abuse and mental illness and more generally the lack of systemic integration of care for PLWHA who are doubly or triply diagnosed with other chronic conditions. Two broadly-accepted conceptual models with clearly defined principles provide guidance for the design and implementation of care service delivery to persons with complex chronic conditions: 1) the primary care model (AAFP et al, 2007) and 2) the chronic care model (CCM) (Wagner et al., 1996), were developed for a different purpose but build on each other sequentially. The *patient-centered* medical home (NCQA, 2008; PCPCC, 2011) stresses the participation of patient and family in creating and implementing the care plan. There is good evidence that medical homes improve care and patient satisfaction (Rosenthal, 2008).

The *chronic care model*, built on the platform of primary care, is focused on system changes to guide quality improvement and disease management activities for chronic illness (Wagner et al., 2001; Bodenheimer et al., 2002). A clinical team in a physician-directed system, quality and safety tools, and quality improvement and performance measurement are aspects of effective care delivery systems. The *Multiple Chronic Conditions* strategic framework - Another Step Forward, issued by the U.S. Department of Health and Human Services (DHHS, 2010), provides a broad framework for health care service delivery design and implementation. Patient-centered medical home and chronic care model approaches are expected to reduce costs directly by avoiding redundant or unneeded tests, imaging, procedures and medications – collectively called, ‘unnecessary services.’ A second expectation is to improve the quality of care by maintaining comprehensive clinical information on the care patients receive in order to improve diagnosis and treatment decisions.

***Care Coordination*** – There has been increasing attention to the importance of ***care coordination*** for effective service delivery within a patient-centered health care delivery system. Antonelli and colleagues (2009) clarify a multidisciplinary framework for care coordination and provide excellent analysis of the literature, offering guidance for implementation.

***Critical characteristics*** include: 1) **Patient- and Family-Centered** (links patients and families to an accessible, community-based primary care medical home); 2) **Proactive, Planned, and Comprehensive** (supports anticipatory, proactive, continuous, and longitudinal care; builds on family strengths and is guided by a comprehensive, standardized assessment of needs; supports and relies on team care; facilitates the care-planning process including consultation, referral, testing, goals – jointly developed and shared, monitoring, and follow-up; and plans for the transition of youth from pediatric to adult systems of care); 3) **Promotes Self-Care Skills and Independence** (ensures the provision of patient/family education to build self- management skills; equips families with the skills needed to navigate a complex healthcare system); and 4) **Emphasizes Cross-Organizational Relationships** (builds strategic relationships across a community that support integration of care and patient/youth/family self-management skills; ensures effective communication and collaboration along the continuum of care).

***Care Coordination Competencies*** include: 1) ability to develop partnerships; 2) proficient communication; 3) ability to use assessments for intervention; 4) facility in care planning skills; 5) ability to integrate all resource knowledge; 6) ability to stay goal/outcome oriented; 7) capacity to work with adaptability and flexibility; 8) continuous learning; 9)  team-building skills; and 10) ability to use information technology.

***Care Coordinator Functions*** are to: 1) conduct care coordination interactions; 2) manage continuous communication; 3) complete/analyze assessments; 4) develop care plans; 5) manage/track tests, referrals, and outcomes; 6) coach patients/families; 7) integrate critical care information; 8) support/facilitate care transitions; 9) facilitate team meetings; and 10) use health information technology effectively.

The program draws upon several evidence-based practices:

1. ***Patient Navigation*** – the process of helping patients to effectively and efficiently use the healthcare system. Sofaer (2009) describes four major challenges patients face when navigating a complex healthcare system: 1) choosing, understanding and using health coverage or applying for assistance when uninsured; 2) choosing, using, and understanding different types of health providers and services; 3) making treatment decisions; and 4) managing care received by multiple providers. A report from the National Cancer Institute’s Patient Navigator Research Program (Freund et al., 2008) defines patient navigation as support and guidance offered to vulnerable persons with the goal of overcoming barriers to timely, quality care. Primary outcomes are 1) time to diagnostic resolution; 2) time to initiation of treatment; 3) patient satisfaction with care; and 4) cost effectiveness of treatment. The preponderance of literature focuses on patient navigation in the cancer care setting because it was first utilized in this arena but it is increasingly applied to a broad spectrum of health conditions. Ferrante and colleagues (2010) studied services offered by patient navigators in primary care settings and found these services valuable for patients who have complex needs and also identified barriers to integrating these services in primary care settings.
2. ***Engagement and Motivational Enhancement*** – Effective engagement of staff with homeless individuals, particularly those with mental and/or substance use disorders, is both a basic principle and a specific competency. The effectiveness of this engagement determines the ability of service programs to involve and retain individuals in services and to achieve positive outcomes. The conditions of homelessness, HIV positive status and mental illness and/or substance abuse compound the engagement task (Owen et al., 1997). The treatment literature provides important principles regarding engagement. The staged approaches to structuring services for the population emphasize the need to engage the person in a trusting relationship and to enhance motivation as a necessary first step to participating in treatment or recovery-oriented activities.
3. ***Brief Strengths-Based Case Management for Substance Abuse*** (SBCM) (Rapp et al., 2008), recognized by the Substance Abuse and Mental Health Services Administration (SAMHSA) as an evidenced-based practice (NREPP, 2012a), is called a case management model but is ideally suited for achieving the goals of improved engagement of patients in treatment for substance abuse disorders and is utilized for this purpose by the program. SBCM is a one-on-one social service intervention for adults with substance use disorders designed to reduce the barriers and time to treatment entry and improve overall patient functioning. The intervention is time-limited (90 days) and differs from conventional case management. SBCM is delivered in a maximum of five 90-minute sessions that focus on helping patients develop and implement a personal, patient-driven plan that improves the individual's overall functioning and/or addresses specific barriers to linking with treatment.
4. ***Motivational Interviewing*** – Research has demonstrated that motivational interviewing (Miller & Rollnick, 1991; CSAT, 1999) is the evidence-based practice of choice for achieving the core objectives of motivational and life style change that are basic to the goal of engaging homeless HIV positive adults with co-occurring mental or substance use disorders and managing continued engagement in recovery. The approach is associated with greater participation in treatment and positive treatment outcomes (Landry, 1996; Miller et al., 1995; Miller & Tonigan, 1996; Prochaska & DiClemente, 1982). Many homeless individuals with substance use disorders are not ready for abstinence-oriented programs (Oakley & Dennis, 1996). They also may lack the motivation to engage in active treatment, which is often true in the case of mental illness or being HIV positive. Motivational interventions that emerged in the substance use field (Miller & Rollnick, 1991) have been adapted for people with serious mental illnesses and/or co-occurring disorders, as well as for people who are homeless. Motivational interviewing sets forth both principles and techniques for moving clients, sensitive to their state of readiness and at their pace, towards greater commitment to change-focused services. The motivational interviewing literature provides practical guidance for helping an individual to progress through the stages of change.
5. ***Stages of Change*** - Motivational enhancement approaches are matched to the client’s stage of recovery and often integrated as part of the Transtheoretical Stages of Change Model (Prochaska & DiClemente, 1992), which describes predictable stages of change for people with substance use disorders. These stages have clear applicability to engaging persons who are homeless, mentally ill, or HIV positive. The model as applied to behavior change involving substance use (Prochaska, DiClemente & Norcross, 1992) conceptualizes the following five-stage process that clients must move through:
* **Stage I - Precontemplation** - there is no intention to change or engage in treatment
* **Stage II - Contemplation** - there is an awareness of the problem and the individual weighs the pros and cons of action (this stage usually lasts about six months)
* **Stage III - Preparation** - combines the intention to change with behavioral criteria; the individual has decided to act and makes plans to do so in the near future
* **Stage IV - Action** - the individual modifies his or her behavior, experiences or environment to overcome the problems
* **Stage V - Maintenance** - the behavior that occurred in the action stage is maintained.

The value of staged interventions for individuals such as the project priority population, coupled with engagement strategies and motivational interviewing techniques, has been well documented (Mueser & Noordsy, 1996). The Community Support Program projects administered under SAMHSA have found that many individuals with co-occurring disorders are not ready for abstinence-based programs. One of the most significant contributions of the program was the discovery that individuals with serious mental illness require stage-wise substance use interventions that engage clients in treatment first and then provide them with the motivation needed to change (Mercer-McFadden et al., 1997).

1. ***Seeking Safety*** (Najavits, 2002a, 2002b; Morrisey et al., 2005) The model provides concepts and interventions that can guide trauma-informed services for the project and has been shown to be effective in dealing with alcohol, drug, mental health, trauma/injuries, PTSD and recovery for adult males or females 18-55 who are American Indian or Alaska Native, Asian, Black or African American, Hispanic or Latino, or White (NREPP, 2012b).
2. ***Integrated Dual Disorders Treatment***, providing mental health and substance abuse treatment simultaneously – ideally in one system of care – has been endorsed by the Center for Mental Health Services as an evidence-based approach for persons with co-occurring mental and substance use disorders, irrespective of age, gender or race/ethnicity (SAMHSA, 2009; Drake et al., 1998, 2004). CSAT (2001) provides specific guidance related to substance abuse treatment for persons with HIV/AIDS.

**Theoretical Model Narrative Citations**

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