Logic Model – Vancouver Native Health - TAHAH

Target groups:

Aboriginals with multiple barriers and lack of connection to community and health services

Inputs	1.0 FTE Medical Office Assistant / LPN with POP / TAHAH	1.0 FTE Nurse (Case Management)	1.0 FTE Intensive Case Manager (AIDS VAN)	4 x 4 hours / week Community Health Advocates	.2 FTE Elder	
Activities	Client referred by POP team	Assess support needs Re: social determinants of Health: - Housing - Income - Food security	Support client in applying for supports based on eligibility	Assess health, Mental health and Addiction support needs	Refer & accompany client to care, treatment, community services	
	Client is offered support from Community Health Advocate	Elder provides support as needed	Education / outreach to address social determinants of health	Health and social advocacy	Access provided to Traditional Medicine and Aboriginal culture practices	
Outputs	Client engages with TAHAH staff	Disability housing & other applications submitted	Client has a primary care physician	• Increased ARV uptake • Increased ARV Adherence ≥ 95%	Client has connection with specialized services as relevant (e.g., MH & addictions)	Client has increased connection to aboriginal culture and to community
Short-term Outcomes (March 2013)	Client has improved CD4 Count & Reduced viral load	Client receives disability income	Client has more stable housing	Client has improved food security	Client is satisfied with services	
Intermediate Outcomes	Client is reconnected to community and has improved journey					
Long-term Outcomes	Reduction in new HIV infections	Decreased client morbidity & mortality				