Operation Link

City of Pasadena Public Health Department, Pasadena, CA

Providing vital care navigation and outreach to individuals who are experiencing homelessness and living with HIV in the San Gabriel Valley

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OPERATION LINK AT A GLANCE

City of Pasadena Public Health Department

Geographic description: The Los Angeles basin has the largest population experiencing homelessness in the country—almost 90,000 individuals, of which 1,165 live in Pasadena. Of this population, it is estimated that more than 2,700 people experiencing homelessness are living with HIV, 22,500 suffer from severe or persistent mental illness, and 31,500 suffer from some sort of addiction. The basin has the second largest number of HIV cases in the country.

Main challenges: To create a medical home for a population that was not being served adequately by the system of care. The enormity of the geographic area and limited affordable housing resources present additional barriers to service for individuals who are homeless.

Focus population: People in the San Gabriel Valley who are experiencing homelessness, living with HIV, and diagnosed with mental health and/or substance use disorders. Operation Link targeted individuals newly released into the community from treatment programs, shelters, or incarceration.

Description of the model: An intense case management/system navigation program designed to engage individuals who are experiencing homelessness, living with HIV, and diagnosed with mental health and/or substance use disorders into medical homes that provide HIV primary care, behavioral health, housing, and care coordination services.

Medical home model staff: 2 peer care navigators, an RN case manager, a project director, a project coordinator, a clinical supervisor, and a project assistant

Clients served: 107

Impact 107 clients served, of whom 67 successfully graduated. Operation Link staff and the Public Health Department overall gained a better understanding of the needs of the population experiencing homelessness in Pasadena and the surrounding area. This ultimately has led to the expansion of Operation Link's scope to include individuals who are experiencing homelessness and diagnosed with mental health and/or substance use disorders who are not living with HIV.

ABOUT THE SPNS INITIATIVE

Building a Medical Home for Multiply Diagnosed HIV-Positive Homeless Populations, 2012-2017

People who are experiencing homelessness are disproportionately affected by HIV, and those who are also living with HIV are more likely to delay entering care, have poorer access to HIV care, and are less likely to adhere to antiretroviral therapy. In 2012, the Health Resources & Services Administration (HRSA), HIV/AIDS Bureau through the Special Projects of National Significance (SPNS) Program* funded a national initiative with the goal of building a medical home for a vastly underserved population: those who are experiencing homelessness or unstable housing, living with HIV, and who face challenges of mental health or substance use disorders. Nine clinic and community-based organizations and one multisite coordinating center were funded to implement and evaluate service delivery models for this population. The two main goals of the models were to 1) increase engagement and retention in HIV care and treatment; and 2) improve housing stability. While each model was tailored to the environment in which it existed and the needs of the specific population served, the nine models all created a role of care coordinator/patient navigator who worked with clients to access a networked system of services among HIV, housing, and behavioral health care providers. To measure achievement of project goals, the nine programs conducted a longitudinal multi-site evaluation study of the models.

The City of Pasadena Public Health Department was one of the nine demonstration sites funded under this initiative. This manual describes their experience implementing and evaluating the Operation Link project.

For more information about the initiative, visit http://cahpp.org/project/medheart/

*The Special Projects of National Significance (SPNS) Program is charged with the development of innovative models of HIV treatment, in order to quickly respond to emerging needs of clients served by Ryan White HIV/AIDS Programs. SPNS advances knowledge and skills in the delivery of health and support services to underserved populations diagnosed with HIV infection. Through demonstration projects such as the initiative that gave rise to the Operation Link project, SPNS evaluates the design, implementation, utilization, cost, and health-related outcomes of treatment models, while promoting dissemination and replication of successful interventions. Learn more at https://hab.hrsa.gov/about-ryan-white-hivaids-program/part-f-special-projects-national-significance-spns-program

INTRODUCTION

Challenges Faced in Pasadena and Surrounding Area

In the popular imagination, the City of Pasadena (population 137,122) and the Los Angeles basin (estimated population 29 million) is what we see on television: beaches, Hollywood, rich and famous people, the Tournament of Roses Parade, blue skies, gleaming and glittering cities, and happy shiny people with endless opportunities. However, the region has another side that is overshadowed by that popular notion. Sadly, the basin is home to the largest population experiencing homelessness in the country (almost 90,000 individuals with 1,165 living in Pasadena) and the second largest number of HIV cases in the country (11,323 cases).[1] While estimating the actual number of people affected by homelessness, HIV/AIDS, mental illness, and substance use (combined) may be challenging, it is estimated that there are over 2,700 individuals experiencing homelessness and living with HIV/AIDS, 22,500 suffer from severe or persistent mental illness, and 31,500 suffer from some sort of addiction in the entire Los Angeles basin.[2]

The enormity of the geographic area that includes Pasadena, the San Gabriel Valley and Los Angeles County, coupled with a high cost of living and rent, also present barriers to services for individuals who are experiencing homelessness.

About Operation Link

The City of Pasadena Public Health Department (PPHD) developed and implemented Operation Link, an intense case management/system navigation program designed to engage HIV+, homeless, multiply diagnosed individuals in care. Operation Link is a part of a multisite evaluation, funded by a Health Resources and Services Administration, Special Project of National

[1] California Statewide Coordinated Statement of Need, September 2009, p. 16.

[2] Estimates by the National Coalition for the Homeless give an indication of the extent of the problem: at least 3 percent of the homeless population live with HIV disease, approximately 20-25 percent suffers from some sort of severe and persistent mental illness (NCH Fact Sheet #3: Koegel et al., 1996) and 30-35 percent suffers from some sort of addiction (NCH Fact Sheet #6).

Significance (SPNS) grant (see page 5 for more about this initiative). It focuses on engaging and retaining individuals who are experiencing homelessness, living with HIV, and codiagnosed with a mental health or substance use disorder into medical homes that provide HIV primary care, behavioral health, housing, and care coordination services. Operation Link primarily utilized a Mobile Care Unit (MCU) for initial recruitment purposes, as well as providing basic services, such as care navigation, in the field. As the program developed, peer care navigators (PCNs) began working with clients to find established medical homes throughout the Los Angeles County area that would be both accessible from the clients' primary place of residence (i.e., shelter, sober living facility, or newly acquired housing through Operation Link) and able to meet the clients' medical, mental health, and substance use needs.

Pasadena, the San Gabriel Valley, and Los Angeles County at large have several service providers to treat HIV/AIDS, mental illness, and substance use, as well as to address homelessness. However, the geographic areas in question are vast, with the San Gabriel Valley at 200 square miles and Los Angeles County at 4,000 square miles. The enormity of the geographic area presents a barrier to service for individuals whoare experiencing homelessness. While there are services available, the services are spread out over a large area, making access an issue. Operation Link identifies the closest and most appropriate service provider(s) for the individual, coordinates the scheduling of appointments, and provides transportation assistance in the form of bus tokens, commuter rail passes, taxi vouchers, etc. In addition, a bus stop is located directly in front of the PPHD building in Pasadena. Operation Link also emphasizes the need to meet clients "where they are," which often requires the peer care navigators to make visits to shelters, parks, or other easy meeting areas, such as a coffee shop.

Additionally, while Operation Link cannot begin to tackle the high cost of living and rent in the Los Angeles basin, it does have the ability to match various transitional, short-term, and longer-term housing programs with clients' needs. The program includes a toolkit of housing choices, including Section 8 Housing Choice Voucher and

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> - Operation Link staff

Operation Link goals

- Provide peer support and advocacy for multiply-diagnosed PLWHA people who are experiencing homelessness, living with HIV, and diagnosed with mental health and/or substance use disorders within the San Gabriel Valley and greater LA area, in order to identify and remove barriers to treatment adherence
- Increase clients' adherence to treatment to improve medical status
- Implement "mobile" care-coordinated services, i.e., meeting the clients where they are, be it on the streets or in a shelter, to ensure linkage to care
- Improve the stability or status of clients' housing

HOPWA Programs offered through the City of Pasadena Housing Department, temporary shelter through the Emergency Shelter Grants from HUD, transitional shelter facilities through Union Station, and in-patient substance use care through IMPACT, an organization that provides residential and outpatient substance use treatment, as well as transitional living.

About the City of Pasadena Public Health Department

The City of Pasadena Public Health Department was uniquely positioned to implement Operation Link, due to its years of experience creating and supporting programs for underserved populations from a public health standpoint. At the start of Operation Link's implementation, PPHD ran the Andrew Escajeda Comprehensive Care Services (AECCS) clinic, providing medical, mental health, and substance use care for those living with HIV/AIDS. The AECCS utilized the Patient-Centered Medical Home (PCMH) model and was therefore well acquainted with the standards of care for medical homes. The Medical Home model also aligns with the mission and core values of PPHD as it addresses needs at the individual- and patient-centered level, ensuring that the person will have greater access to health, wellness, and social services to help them make healthy choices and remain adherent to their care and treatment. The AECCS has been serving people living with HIV/AIDS for over 20 years, and takes a patient-centered approach to providing ongoing comprehensive and well-coordinated care that is delivered by a multidisciplinary team led by a medical provider. Coordination and integration across the treatment continuum are key components of the program, and the program supports the delivery of high-quality, cost-effective care. Quality and safety are the primary focus, and they are supported by the provision of a patient-friendly scheduling system, which facilitates interactive communication between medical providers and patients. Over the course of Operation Link's existence, AECCS's management has changed from PPHD to the Wesley Health Center, a Federally Qualified Health Center with decades of experience working with people living with HIV/AIDS, those experiencing homelessness, and other specialized populations. (See the sidebar on the right.) However, AECCS remains to be one of the many providers in the network that work with Operation Link clients and their PCNs.

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Under new management

At the start of Operation Link, the City of Pasadena operated a safety net HIV clinic. The enactment of the Affordable Care Act meant that many previously uninsured clients receiving HIV services at the clinic had access to coverage—coverage that did not include City of Pasadena services because the clinic was not a federally qualified health center. So the City transferred the clinic over to another organization that was able to accommodate the new insurance billing structure: Wesley Health Center (WHC), a not-for-profit federally qualified health center with a strong track record of providing HIV services and care for the homeless. WHC hired many of the City of Pasadena staff and moved into the same facility, so client care was minimally affected. Operation Link continued as a program within the City of Pasadena and often links clients with WHC for HIV treatment.

SETTING UP THE MEDICAL HOME MODEL

Background and Theoretical Model

Operation Link's intervention and models of care are based on the following evidence-based methods: 1) Critical Time Intervention (Herman et al., 2007); 2) Seeking Safety (Najavits, 2007); and 3) Illness Management and Recovery (Mueser et al., 2006). While each of these models has been studied and shown to be effective in its own right, Operation Link brings these three approaches together as part of a new innovative Medical Home approach for the target population. These three models are described below.

Operation Link's on-the-street, proactive, and assertive outreach method to engage, recruit, and provide navigation services was based on the theoretical constructs of the Critical Time Intervention (CTI) model. The CTI model is a client-level approach that is based on the belief that timing of the intervention is of the utmost importance for individuals experiencing homelessness who are at high risk of poor health outcomes. The CTI model suggests providing intensely focused models of care during the critical transitional period when a client is placed in the community from shelters, emergency rooms, in-patient treatment for substance use or mental health, etc. (Herman et al., 2007).

The CTI model's focus on timing is based on observations and studies that show that a large proportion of individuals placed in homeless shelters become homeless again after shelter discharge, despite having discharge plans and assistance after their release. Research found that the critical period after release from a shelter (or treatment or an institution) must be seized upon to overcome the "natural discontinuity in support" these individuals tend to experience when they are returned to the community (Herman et al., 2007). The Operation Link approach included proactive and focused engagement of targeted individuals newly released into the community. Initial outreach conducted with the Mobile Care Unit (MCU) drew from the project's supporting partners, which included Huntington Hospital's emergency services department, IMPACT Drug & Alcohol Treatment Services' in-patient substance use treatment, and the Pasadena Police Department's Prisoner Reentry Program, which provides services to parolees.

Operation Link also provides services to individuals of focus following models of care that have been shown to be effective with individuals battling multiple diagnoses. Seeking Safety is a treatment model that is based on the belief that surrounding a client with the feeling of safety

is critical to engagement and retention in services (Najavits, 2007). Research has consistently shown high rates of substance use disorders co-occurring with post-traumatic stress disorder (PTSD), and that various subgroups have particularly high rates of substance use disorders and PTSD, including people experiencing homelessness, people who are gay/lesbian/transgendered/bisexual persons, people who are incarcerated, and veterans (Najavits, 2006). Individuals with the dual diagnosis of substance use disorder and PTSD have worse treatment outcomes, more positive views of substance misuse and other high-risk behaviors, higher HIV risk, more legal and medical problems, lower work and social functioning, and increased rates of future trauma (Najavits, 2007). Seeking Safety is a patient- and present-focused care model that seeks to first and foremost establish the client's sense of safety. In this context, "safety" includes the following elements: safety from substances, safety from dangerous relationships (including drug-using friends and domestic violence); and safety from extreme symptoms such as disassociation and self-harm.

The Seeking Safety model helps clients free themselves from negative behaviors and move toward freeing themselves from trauma at a deep emotional level. Operation Link emphasizes the components of Seeking Safety by focusing on present-centered, positive, and encouraging conversations and interactions, and avoiding at all costs having clients recount their "trauma story" (with the exception of collecting brief client profile information). For example, a client can relate the age that they first used drugs or alcohol without recounting the details of that incident. Following the Seeking Safety model will enhance the client's sense of safety and provide the emotional and psychological room needed to focus on coping with today's issues and tomorrow's recovery.

Finally, Operation Link incorporates components of the Illness Management and Recovery (IMR) model, which teaches illness self-management strategies that lead to improved outcomes and recovery (Mueser et al., 2006; SAMHSA, 2009). The model is based on the belief that recovery occurs when people discover (or re-discover) their strengths and abilities for pursuing personal goals, and develop a sense of identity that allows them to grow beyond their diagnosis (or diagnoses). In the broader health field, evidence supports the value of teaching illness self-management for improving chronic medical conditions such as diabetes, arthritis, and asthmas (Mueser et al., 2006); however, most individuals with HIV/AIDS, substance use disorders, and mental illness still need help managing their illness, collaborating with service providers, and pursuing recovery. The model helps people set and pursue personal goals and implement action strategies in their everyday lives. The IMR model incorporates research-based strategies for teaching illness self-management, and these include: 1) psychoeducation about the client's diagnoses, symptoms, triggers, and treatment; 2) cognitive behavioral approaches to medication adherence (e.g., incorporating cues into daily routines to remind a client to take their medication; 3) developing a relapse prevention plan; 4) implementing social skills training to help strengthen social support systems; and 5) coping skills training for the management of persistent symptoms and behavioral triggers (Mueser et al., 2006). Operation Link emphasizes the components of the IMR model by ensuring

> "Three evidence-based models—Critical Time Intervention, Seeking Safety, and Illness Management and Recovery—include common themes that have been woven into the basic interface between Operation Link and the clients, and serve as the framework of the program.
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> - Operation Link staff

that the client's customized care plan is patient-directed and includes the client's personal goals and the project team's strategies for helping to achieve success.

The three evidence-based models described above include common themes have been woven into the basic interface between Operation Link and the clients, and serve as the framework of the program. Operation Link is innovative and unique for two reasons: first, each of the three models is empirically supported as a stand-alone approach, but the melding of these models as the framework for the program is a new approach. "One size fits all" will not work for the population of focus, but a customized, multifaceted approach serves to enhance the basic services provided. Second, Operation Link utilizes peer care navigators (PCNs), which is a unique approach combining traditional case management services with the additional support and comfort provided by a peer.

Operation Link focuses on building a "medical home" for the client by providing care navigation, supported by peer counseling and medical support. As an example, the traditional HIV/AIDS mobile unit might provide testing, HIV counseling, basic acute medical care, and medical referrals, but Operation Link addresses a much broader array of issues that affect the whole person, including HIV/AIDS, homelessness, substance use, and mental illness. The peer care navigator is the key to being able to address this broad array of issues. The PCN locates and works with each service provider needed to address the client's issues, coordinates and arranges appointments, provides intensive follow-up to ensure the client is retained in treatment, and coordinates across providers to ensure that treatment is consistent across providers and consistent with the framework of the proposed project. In addition, as a peer support aspect, the PCN provides empathy and first-hand experience with HIV/AIDS, homelessness, substance use disorders, and/or mental illness. This important support further assists the client to remain engaged in the project, and thus adhere to treatment. Whether the client needs someone to accompany them to an appointment, an advocate for services, or just someone to talk to, the PCN is there for the client.

Operation Link's support of their clients is further supported at a broader structural level by the formal creation of a network of service providers. At the start of the program, Operation Link primarily worked with PPHD's internal HIV/AIDS clinic, named Andrew Escajeda Comprehensive Care Services (AECCS), for medical and mental health referrals and linkages. However, as the project evolved, Operation Link's staff realized the importance of meeting the clients where they feel most comfortable and allowing them to choose a clinic that is best for them. For example, a newly housed client who now lives several miles from PPHD may find it difficult to remain in care at this particular

> "Because of the lack of affordable housing in LA county, it wasn't an easy thing to house a client in Pasadena and bring them to the clinic here at Pasadena Public Health Department. We ended up working with clinics throughout the county so when a client moved into a new apartment, the person was linked into a nearby clinic and there wouldn't be an additional transportation barrier in staying in care. These new relationships were established as part of Operation Link.
>
> - Operation Link staff

clinic, due to transportation and other barriers; therefore, the Operation Link PCN would work with this client to find a new clinic in their area and ensure linkages to all necessary services.

Staff Recruitment and Hiring

The core Operation Link team is comprised of a project director, a project coordinator, a clinical supervisor, an RN case manager, peer care navigators, and a project assistant. At the start of the project, Operation Link had a social worker on staff, but later replaced this position with the clinical supervisor and RN case manager.

PPHD works with the City of Pasadena Human Resources (HR) Department for recruitment and hiring purposes. Job descriptions are created in partnership with the HR Department and open positions are posted on to the City of Pasadena website. For the purposes of Operation Link, a specialized job description was created for the peer care navigator position, which specified that the ideal candidate would have personal experience with HIV/AIDS, homelessness, and/or substance use or mental health issues. In addition to the City of Pasadena open recruitment website, which is updated weekly, open positions for Operation Link were announced at partner agency meetings and through email blasts.

Per the City of Pasadena guidelines, candidates were screened by the HR Department for eligibility. The top applicants were invited to a panel interview, conducted by individuals with experience in HIV/AIDS programs and/or with similar job duties to the open position. Those who received the top scores from this interview were then referred to PPHD for final interviews and selection.

Operation Link currently has two peer care navigators, each with their own personal experiences and qualifications in the HIV/AIDS field. In order to provide culturally sensitive and linguistically appropriate services, one PCN is bilingual in English and Spanish, helping to ensure the comfort of the program's many monolingual Spanish-speaking clients.

The following is a list of standard duties for each position:

• Project Director

- o Responsible for technical and scientific aspects of the grant, including providing oversight and expertise for sub-studies
- o Represents the City of Pasadena/Operation Link at various HRSA, Ryan White, LA County Department of Public Health, Division of HIV/STD Programs (DHSP), HIV Commission, and other related meetings/conferences
- o Works with evaluator and project coordinator to monitor project progress to ensure that goals and objectives are met in a timely manner
- o Meets with executive directors/managers of community organizations and network providers to secure and finalize partnerships for Operation Link
- o Establishes long-term vision and goals for project
- o Provides technical assistance and guidance to Operation Link team to develop outreach and other strategies
- o Conducts annual employee evaluations; communicates success and lessons learned of demonstration project at industry meetings/conferences
- o Submits journal articles
- o Provides final approval of grant expenditures and budget modifications
- o Reviews/audits cases to ensure referrals and care are appropriate
- o Assists clients as needed through the delivery of brief interventions focused on substance misuse, mental health, risk reduction and disclosure/partner notification
- o Handles client grievances
- o Reviews case files and provides guidance to peer care navigators on the development of customized care plans
- o Reviews evaluation information.

• Project Coordinator

- o Responsible for programmatic aspects of the grant, including overseeing day-to-day project activities and ensuring that all activities are completed per the yearly work plan
- o Completes HRSA and/or BU-required forms, progress reports, budget modifications, and non-budgetary change requests (changes/additions to personnel, overall goals, etc.)
- o Troubleshoots programmatic issues and recommends corrective action plans
- o Participates in programmatic HRSA conference calls and in-person meetings
- o Performs work related to the execution, administration, and close-out of cooperative agreements
- o Ensures that grant funds are expended appropriately and works with project director and management analyst IV on any needed budget modifications
- o Ensures that all project activities are in compliance with both HRSA and City of Pasadena policies and protocols
- o Works with project director on HR issues, such as evaluations
- o Ensures staff are appropriately trained to meet cultural and linguistic needs of clients
- o Conducts weekly staff meetings

• Clinical Supervisor

- o Provides clinical supervision to peer care navigators on a weekly basis in both a group and individual setting
- o Provides training to include suicide assessment, domestic violence, and substance use issues
- o Acts as a consultant on particularly problematic cases
- o Provides non-scheduled contacts with peer care navigators in times of stress or crisis

• RN Case Manager

- o Working with peer care navigators, project director, and clinical supervisor, acts as medical lead to ensure the clients' needs are met and their care is coordinated

Supporting the peer care navigator

The City of Pasadena team determined that their navigators needed to have lived experience and knowledge of the HIV care system in the area to link people who are experiencing homelessness and living with HIV with the services they needed. "Of all the categories of services in LA County—those addressing homelessness, mental health, and substance use, for example—the HIV care system is the most difficult to navigate," explained Matt Feaster, the City of Pasadena's Epidemiologist. "It's also highly stigmatized. That's why it is important to hire a peer that understands what it's like to live with HIV and knows what resources are available."

Operation Link peer care navigators provide case management and system navigation services to clients. But just as important as logistical support, PCNs provide the emotional support that nurtures and sustains clients as they work to improve their well-being.

In the beginning, turnover among the PCNs was high. One PCN had excellent navigation skills, but found the emotional support role challenging. Another came from a nonprofit organization with a strong advocacy component and found the position within a government organization restrictive. "As part of the City of Pasadena, we are paid with taxpayer money. That limits the social advocacy we can do," explained Erika Davies, Operation Link project coordinator. "Peers who come from a community activist background find that frustrating."

Working intensively with this population is stressful—seeing clients living on the streets and unable to get what they need puts a lot of pressure on those who are trying to provide support in an imperfect world. To strengthen the support provided to navigators, the Operation Link team hired a clinical supervisor. "I am the direct supervisor for day-to-day activities, the administrative supervisor," said Erika. "But now, we have a clinical supervisor who can take the time to meet regularly with each peer care navigator and be available when there is a need to talk things through. Someone who can help the navigator set appropriate boundaries with clients, who can respond supportively to the unique challenges of the work and each person's particular life circumstances as a peer."

- o Assists clients as needed through the delivery of brief interventions focused on patient education, treatment adherence, managing side effects, medical nutrition therapy, co-infections, and preventative care
- o Conducts general health screenings
- o Conducts a limited range of immediate health services (e.g., taking vitals and treating wounds)
- o Advises the project director and peer care navigators in matters related to the client's health and medical status
- o Conducts medical case management related to clients' health status and medical needs
- o Helps identify appropriate network providers who can assist with medical care needs.

• Peer Care Navigator

- o Conducts client care coordination, follow-up and data entry
- o Conducts outreach and HIV testing (when applicable) to target population
- o Informs community organizations and partners about Operation Link services, and provides guidance on how to refer new clients to Operation Link
- o Builds and manages a client case load of 25-30 annually
- o Ensures that all appropriate forms and releases are signed
- o Assists clients as necessary with receiving benefits, i.e., General Relief, health insurance through Affordable Care Act, etc.
- o Conducts needs assessments and creates customized care plans, with input from project director and RN case manager
- o Supports and encourages clients when they are first tested HIV positive (when applicable), who are lost to care, or who are at risk to become lost to care
- o Builds trusting and supportive relationships with clients
- o Schedules medical, mental health, housing, substance use treatment, and other appointments as required per customized care plan
- o Accompanies clients to appointments if necessary
- o Assists clients with paperwork, obtaining government-issued ID, and navigating through benefits system
- o Links clients into care and other supportive services
- o Monitors progress and follows up on the clients' customized care plans
- o Re-evaluates and updates care plans as needed

• Project Assistant

- o Manages both internal and external referrals for enrollment, confirming eligibility of referred clients, collecting and storing client contact information, and assisting with follow-up.
- o Assists with data entry
- o Assists with chart review
- o Assists with preparing mobile care unit for outreach events (set up, re-stock supplies, etc.)
- o Office support, including preparing materials for meetings or general distribution, answering phone calls, taking messages, making appointments for peer care navigators and/or nurse case manager
- o Assists during outreach events as necessary

Training and Supervision

Operation Link provides individual and group clinical supervision on a weekly basis. The purpose of clinical supervision in Operation Link is to provide a method of support for peer care navigators, the project assistant, and other staff who work directly with clients. The overall aim of clinical supervision is to improve staff's job performance by providing tools and methods to enhance proficiency and efficiency in their work, as well as to increase knowledge relative to the fields of HIV, substance use, and mental health. Clinical supervision also helps to prevent transference and countertransference issues that frequently arise within peer-based and other case management models. By helping Operation Link staff to acknowledge and process countertransference reactions in both individual and group settings, clinical supervision ensures that the interventions utilized by the program are effective and promote positive outcomes for the clients. All staff participating in clinical supervision should be clear that sessions are meant to develop professional effectiveness and are not meant to be used as personal counseling or therapy sessions.

In an individual setting, the clinical supervisor provides one-on-one guidance and support to Operation Link staff, including, but not limited to, the following:

- Review and discuss individual client cases, including assessments, treatment plans, progress notes, and goals; co-sign treatment plans as needed
- Regularly review staff's progress and direct services performance and provide feedback and suggestions as needed
- Allow opportunities for staff to discuss and process their personal issues as they affect the workplace and/or client interactions, such as issues around self-awareness, defensiveness, transference, and countertransference. Provide guidance and feedback as to how to handle these situations and to maintain appropriate boundaries with both clients and coworkers
- Provide referral to Employee Assistance Program (EAP) if discussed issues go beyond scope of clinical supervision

In a group setting, the clinical supervisor provides additional support to Operation Link staff, including, but not limited to, the following:

- Review and discuss particularly difficult client cases in a case conference setting, acting as a moderator for discussion and providing expert behavioral health advice as appropriate
- Provide opportunities for group discussion around workplace tensions and how to maintain appropriate boundaries with both clients and coworkers

Additionally, during group supervision, the clinical supervisor provides professional development training around topics such as trauma-informed care, motivational interviewing, crisis intervention, suicide assessment, domestic violence, and substance use. This particular setting allows for the peer care navigators to delve in-depth into the trainings, working closely with the clinical supervisor to openly ask questions and practice scenarios.

Clinical supervision has been critical in Operation Link, as there had been some early staff turnover due to stress, transference, countertransference, and lack of strong boundaries. The first PCNs in the program experienced high levels of anxiety when they were unable to connect with or immediately assist clients, feeling a great personal burden. The incorporation of weekly individual and group supervision has vastly improved morale and the ability to maintain strong boundaries, as well assist in the PCNs' professional development through customized trainings.

In addition to clinical supervision, Operation Link staff are required to complete a minimum of 16 hours of HIV/AIDS, mental health, or substance use related training each year. Furthermore, several trainings are available throughout the year from the City of Pasadena HR Department in various topics, such as Everyday Ethics, Conflict Management, Leading a Strengths-Based Life, and Stress Management.

Logic Model

Operation Link's logic model (included in *Resources* section) is a tool that has been used to record the implementation of the project. The logic model is updated annually, and the evolution of the logic model has mirrored the evolution of the project. The project's logic model includes inputs, activities, outputs, and outcomes, as well as contextual conditions and rival explanations. These last two logic model components are critical to understanding why the project worked as expected or did not work as expected. Contextual conditions can be positive (e.g., the project received additional in-kind support) or negative (e.g., staff turnover). Rival explanations, while not necessarily negative, can help explain an outcome that occurred due to a force or activity outside of the project (e.g., budget cuts).

RECRUITING CLIENTS INTO THE PROGRAM

Eligibility Criteria

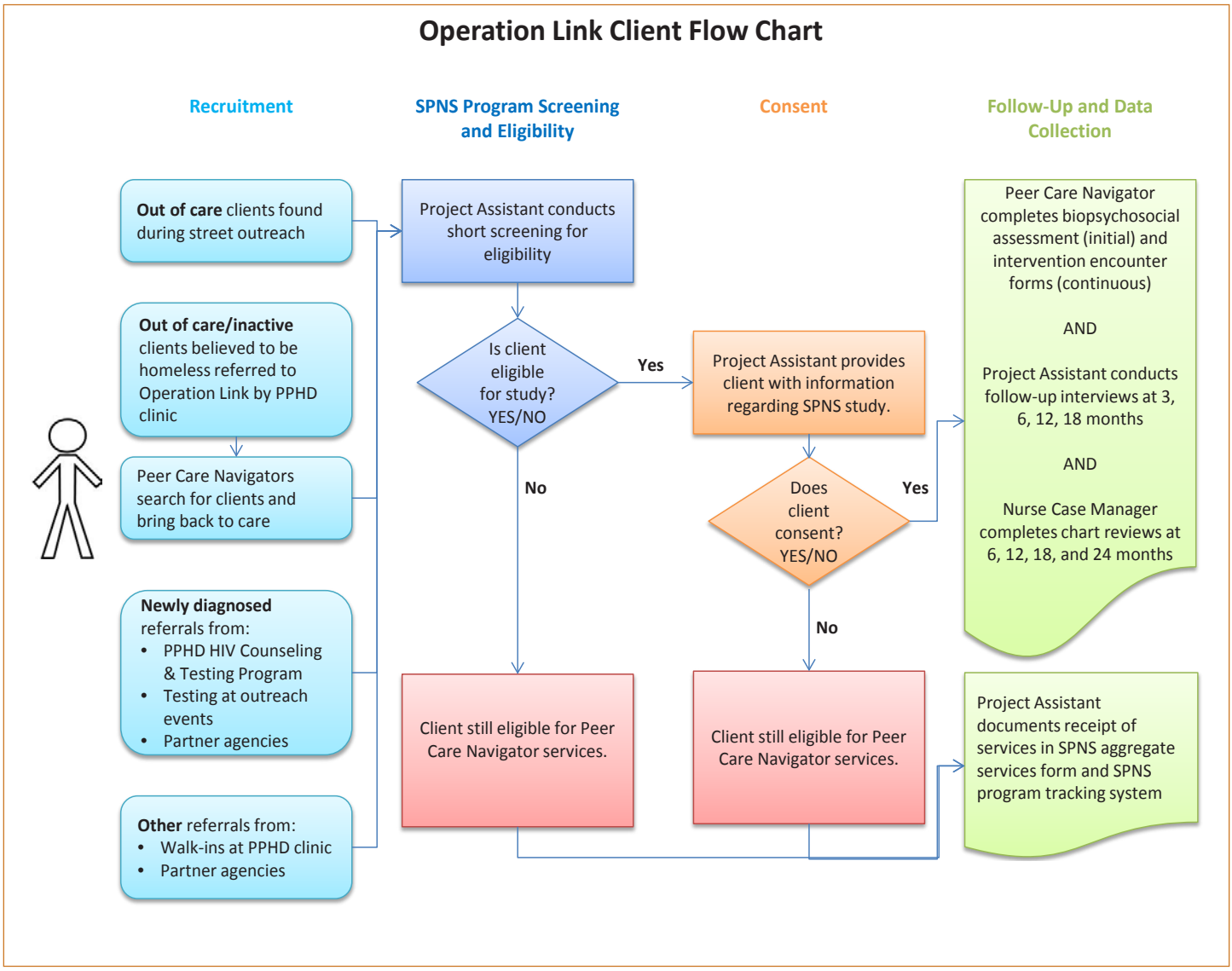
Individuals living with HIV aged 18 or older in the greater Pasadena area and who meet the following criteria are eligible for Operation Link services. A potential client:

- Is out of care, newly diagnosed, or otherwise not adherent to medical care
- Has multiple and complex psychosocial issues (such as mental health, substance use, homelessness, etc.) that negatively affect a client's health status.
- Is experiencing homelessness or unstable housing, defined as one of the following:
  - o Literally homeless: an individual who lacks a fixed, regular, and adequate nighttime residence
  - o Unstably housed individual who:
    - Has not had a lease, ownership interest, or occupancy agreement in permanent and stable housing with appropriate utilities (e.g., running water, electricity) in the last 60 days; **OR**
    - Has experienced persistent housing instability as measured by two moves or more during the preceding 60 days; **AND**
    - Can be expected to continue in such status for an extended period of time.
  - o Is an Individual fleeing domestic violence who:
    - Is fleeing, or attempting to flee, domestic violence;
    - Has no other residence; and
    - Lacks the resources or support networks to obtain other permanent housing.

Recruitment and Screening Procedures

To begin recruitment at the start of the project, peer care navigators (PCNs) were responsible for conducting outreach in targeted locations where homeless individuals are known to congregate. Examples of such locations included, but were not limited to, homeless shelters, parks, transitional living facilities, and community centers.

Peer care navigators also worked with local officials and community organizations to inform and educate about Operation Link services, as well as work on a referral system, preferably via a Memorandum of Understanding (MOU). (A sample is included in the *Resources* section).



The PCNs recruited the first individuals into the Operation Link program by conducting frequent and regular (i.e., the same day/time each week) outreach, utilizing either the mobile care unit or foot outreach, depending upon location and availability to set up the mobile care unit. During outreach, peer care navigators were able to provide food and hygiene kits as incentives for individuals experiencing homelessness to be tested for HIV and/or screened for eligibility into Operation Link services. The food and hygiene kits included a schedule of locations, dates, and times where the mobile care unit will be located on a monthly basis.

The PCNs also worked with Andrew Escajeda Comprehensive Care Services (AECCS) (now under management by Wesley Health Center) to identify former clients who are believed to be homeless or at risk for homelessness and have been out of care for 6 months or more. Peer care navigators then attempt to reconnect these clients by reaching out to them and attempting to locate them at their last known locations.

As awareness about the project spread, community partners such as homeless shelters and external HIV/AIDS clinics in the area began referring clients to Operation Link. Though formal written agreements were not formed, Operation Link would generally take any client referrals that met the eligibility criteria, as long as there was availability on the PCNs' caseload. Operation Link's project assistant conducts a short screening for program eligibility, as described in the *Enrollment* section on the next page.

Listening to the people you serve

When the Operation Link program was set up in Pasadena, it was planned as a mobile model where the City of Pasadena mobile van would provide HIV treatment services for clients who were experiencing homelessness, with additional services provided at the HIV clinic. But external factors led them to modify the plan, including the reactions of people experiencing homelessness to the mobile van: The mobile van is large and brightly colored. This is good for creating awareness of City of Pasadena health services and conducting outreach events, but turned out to be a barrier when trying to engage with the homeless community. "When they learned that we were with the City of Pasadena, it scared them," said Angélica Palmeros, Operation Link project director. "They thought we were working with the Police Department to run them out."

Enrollment

As noted above, Operation Link specifically focuses on individuals who are experiencing homelessness and living with HIV, with current or history of substance use and/or mental health diagnoses. The project assistant conducts a brief screening to ensure that these criteria are met before referring the case to the project director or project coordinator, who then assigns the case to a peer care navigator. Clients are assigned a PCN based upon case load openings/availability, language, culture, client needs vs. PCN's expertise, and potential compatibility (i.e., if the client "clicks" with the PCN).

Upon enrollment, clients are requested to sign a Client Contract, which outlines the responsibilities of both the PCN and the client. This ensures that the clients understand that they must make efforts to adhere to their care plan in order to make progress towards better health outcomes and housing (See the sidebar on the right for details). A copy of the client contract is included in the *Resources* section.

In general, PCNs are required to contact a new client within 3 business days after the case has been assigned. More often than not, however, contact is within the same day and in person, as homeless clients may not be in a location where phone contact is possible.

Referrals

Operation Link provides care coordination for its clients, including internal and external referrals. Care coordination includes communication, information sharing, and collaboration, and occurs regularly between the peer care navigators, project director, project coordinator, clinical supervisor, and RN case manager.

Setting expectations with clients: The Operation Link client contract

The Operation Link Client Contract was a result of the peer care navigators' first experiences working with clients in the project. Due to the urgency of the clients' various situations, especially when it came to housing, the PCNs worked diligently to create customized care plans in collaboration with their clients. However, they quickly realized that some clients were not as motivated to participate in their care and often left the PCNs waiting at doctors' offices or were no-shows to housing appointments, despite receiving transportation assistance. The PCNs also found the need to clearly state that Operation Link was a short-term program, designed to stabilize a client until he or she was ready to transition to standard care. Therefore, the PCNs worked to create the client contract, which was used as a tool to outline and manage expectations. "The client contract helped us to encourage clients to actively participate in their care," Precious Jackson, Operation Link peer care navigator, said. "They knew what to expect from us and what we needed from them in order to get them the help they needed."

> When we switched gears from using the mobile unit, our peer care navigators ended up doing traditional foot outreach—they would walk around with hygiene kits or food packs and get to know everybody and gain their trust that way. Local shelters were important partners who referred clients. As we started working with other clinics, they would refer people to us when they had clients that were high acuity. Our peers would help them stabilize and get housing and get them back into that clinic for care.
>
> - Operation Link staff

Coordination activities may include accompanying clients to appointments, arranging access and/or transportation to various appointments, reducing barriers to obtaining services, assisting with paperwork completion, establishing linkages, and other activities. Due to the specific population for this project, it is especially important for the Operation Link team to meet the clients where they are whenever possible and needed. It is also critical for the peer care navigators to accompany clients to appointments as needed in order to assist with paperwork, advocacy, and/or emotional support.

Whenever possible and convenient for clients, the peer care navigators have linked clients to care at the Andrew Escajeda Comprehensive Care Services (AECCS) Program, which is managed by Wesley Health Center and located in the same building as Operation Link. This allows the Operation Link team easier access to assist the client through every step of enrolling into a medical home. Operation Link staff work closely with AECCS staff in assisting the client to access all available services, such as medical, dental, mental health, substance use treatment, food pantry, transportation, and benefits specialty. AECCS staff also invite Operation Link staff to case conferencing when an Operation Link client is scheduled to be discussed.

When it is not possible for a client to enroll into services at AECCS, peer care navigators, working with the RN case manager, will help the client enroll into services at a more convenient location. If it is not possible for a client to enroll in a "one-stop shop," the Operation Link team will integrate methods in the client's Individual Service Plan (ISP) to reduce barriers to access. In certain circumstances, the mobile care unit may act as a client's medical home, insofar as receiving case management services and basic medical care with the RN case manager or other providers that are available through AECCS.

Client Involvement

Clients are encouraged to actively participate in the process of creating an Individual Service Plan (ISP) with goals that resonate with them. PCNs work closely with their clients to ensure that the goals are achievable, and help clients understand that their dedication and commitment are required in order to meet these goals. The client contract (included in the *Resources* section and described in the sidebar to the right on page 18) was developed as a means to solidify the idea that both the PCNs and the clients have their roles to play in the success of the clients. Additionally, PCNs reported clients not wanting to graduate from Operation Link due to fear of change, bonding with the peer care navigator, or other reasons. The client contract was implemented to set roles and boundaries from the beginning and establish graduation from the program to be a positive

and important accomplishment and a goal or something to look forward to. Clients who were still reluctant to graduate were given extra time to adjust to their transition plan and to get to know their long-term case managers.

Furthermore, prior to the transition of management of PPHD's HIV/AIDS clinic to the Wesley Health Center, Operation Link utilized AECCS's Client Advisory Board as a means to receive feedback regarding the program. The Client Advisory Board was open to all clients of PPHD's HIV/AIDS programs and provided a forum to provide guidance and suggestions for improvement. Since the transition of the clinic to the Wesley Health Center, Operation Link has received feedback from clients in the form of follow-up interviews.

Managing Flow of Participants

Each peer care navigator is limited to a caseload of 25 clients at any one time. Though the initial goal had been a caseload of 40-50 clients, Operation Link staff quickly realized that the time and effort required to assist one client in a meaningful and impactful manner would limit the PCNs to a smaller caseload.

After the initial eligibility screening conducted by the project assistant, the project director, project coordinator, and/or the clinical supervisor are responsible for assigning the cases to the PCNs. Though several factors may determine the assignment, the major aspects include the PCNs' caseload availability (i.e., how many "openings" there are), cultural and linguistic needs, and the client's immediate needs.

During group supervision with the clinical supervisor and during case conferences, client cases and progress are discussed. In addition to particularly difficult cases, any clients that have been lost to follow-up or are ready for "graduation" (further described in the *Transitioning to Standard Care* section on page 22) are reviewed. In the case of those lost to follow-up, PCNs are required to have documented at least five attempts to reengage the client, including in-person efforts and contacting emergency contacts. If these attempts have not resulted in reengagement, the client may be disenrolled; however, if the client reemerges and is seeking services, he/she would be reenrolled.

"Though the initial goal had been a caseload of 40-50 clients, Operation Link staff quickly realized that the time and effort required to assist one client in a meaningful and impactful manner would limit the peer care navigators to a smaller caseload.

- Operation Link staff

In the case of those who are ready for graduation, the clinical supervisor verifies that all Individual Service Plan goals have been achieved and the PCN discusses the concept of graduation with the client to ensure that the client feels comfortable transitioning to standard care. Once graduated, the client is removed from the PCN's active caseload. However, PCNs also follow up with graduated clients once a month in case any additional emergent needs have risen.

SERVICE DELIVERY MODEL

Peer care navigators, with supervision from the clinical supervisor and nurse case manager as appropriate, complete biopsychosocial assessments (Included in the *Resources* section) for each client. Based upon this assessment, an Individual Service Plan (ISP) will be created (included in the *Resources* section). Acuity levels for each client will be determined by the Operation Link team, and peer care navigation services will occur, *at a minimum*, per the following guidelines:

- **Severe:** Client has complex and ongoing challenges that greatly impair their ability to manage medical care and treatment, such as chronic homelessness, addiction, and mental health disorders. Client is frequently or currently in crisis. Immediate and intensive intervention is necessary.
  - o Comprehensive assessment and service planning every 30 days
  - o Provision of brief interventions (see the next page for description) – weekly or as needed
  - o Ongoing follow-up
  - o Case conference – weekly

- **High:** Client has episodic or ongoing concerns that interfere with medical and other care and treatment. Large gaps exist in the client's ability to cope with and manage health and housing status.
  - o Comprehensive assessment and service planning every 60 days
  - o Provision of brief interventions – twice a month or as needed
  - o Ongoing follow-up
  - o Case conference - monthly

- **Moderate:** Client needs assistance in resolving barriers to HIV medical services with health education, risk reduction, skills building or other brief intervention. Client requires some assistance in accessing resources and/or social service referrals.
  - o Comprehensive assessment and service planning every 90 days
  - o Provision of brief interventions – monthly or as needed
  - o Follow-up – weekly or as needed
  - o Case conference - every 90 days

- **Self-Managed:** Client is stable, and capable of managing their HIV medical, dental, and behavioral health care with no or intermittent need for assistance. Client is stably housed and is able to demonstrate basic life skills to ensure continued housing. Client is able to follow up on referrals independently. Self-managed clients aren't actively followed but screened once a month to determine whether the client's acuity has changed.
  - o Once a client is at the self-managed acuity, the peer care navigator should work with the social worker and nurse case manager to determine if this client is a candidate for graduation from Operation Link.

Though it is expected that most SPNS project clients will come in with a severe or high acuity, it is the team's joint goal to reduce the acuity to moderate or self-managed over the time of the project. In case of crisis, the Operation Link team acts in accordance with the Crisis Flow Chart included in the *Resources* section.

Individual Service Plans (ISP) are to be conducted in partnership with the client and the Operation Link team. Goals should be SMART (Specific, Measurable, Achievable, Realistic, and Timely) and should be updated as frequently as needed.

Brief Interventions

The Operation Link team provides brief interventions to clients as required. Brief interventions are those practices that aim to identify a problem and motivate an individual to do something about it. Single or multiple sessions of motivational discussion focused on increasing the individual's insight and awareness regarding specific health behaviors and their motivation for change.

- Patient education
- Treatment adherence (must be delivered by RN case manager)
- Risk-reduction counseling
- Disclosure assistance
- Other interventions- includes interventions that relate to clients' treatment adherence and risk behavior that may not directly relate to the other intervention categories (e.g., social support, intimate partner violence, psycho-social issues, and life skills)

Communication/Case Conferences

Case conferences can be used to identify or clarify issues regarding a client's status, needs, and goals; to review activities including progress and barriers towards goals; to map roles and responsibilities; to resolve conflicts or strategize solutions; and to adjust current service plans.

Case conferences occur during group supervision and regularly once a month with the AECCS team. For the clients who have been enrolled in clinics outside of PPHD, case conferences are arranged by the PCNs as often as possible. Due to the unique structure of the Operation Link program working with several external clinics, it has proven difficult to schedule regular case conferences with these agencies. However, the PCNs remain in constant communication with the partner agencies providing services to Operation Link clients.

Graduation - Transitioning to Standard Care

Once a client is at the self-managed acuity, the peer care navigators work with the clinical supervisor and nurse case manager to determine if this client is a candidate for graduation from Operation Link. Criteria include, but are not limited to:

- Adherent to medical and behavioral health care, including medication and consistently attending appointments
- Understands and is able to navigate through systems (i.e., benefits, medical care, etc.) independently and/or knows how to seek assistance outside of the Operation Link staff
- Stable housing situation
- Able to demonstrate basic life skills, such as grocery shopping, budgeting, and bill payment, to ensure continued success
- Able to follow up on referrals independently
- Individual Service Plan goals completed, with no further concerns from the client

If the peer care navigator, clinical supervisor, and nurse case manager agree that the client is ready for graduation, a transition plan is created with the client to ensure continuity of care at their chosen medical facility.

Clients are also informed that, should the need for assistance arise, they are welcome to contact the Operation Link program again. Upon graduation, clients receive a Certificate of Completion (included in the *Resources* section) with a customized message from their peer care navigator and a housewarming gift.

One particular barrier in the ability to graduate clients from the program has been the lack of affordable housing in Pasadena. As such, Operation Link has been working with housing agencies outside of Pasadena, in various parts of Los Angeles County. The peer care navigators then work with the client to find a medical home near their established housing.

Another challenge was the lack of basic life skills training for housed clients. Though these types of trainings had once been readily available through homeless serving organizations in the past, the funding in Los Angeles County for these services has been virtually eliminated. In order to address this issue, peer care navigators have incorporated some basic life skills training for their clients, with the assistance of the clinical supervisor.

Documentation

Operation Link currently utilizes paper charts for clients. Each chart contains the client's intake forms, biopsychosocial assessment, Individual Service Plan, progress notes (cosigned by the clinical supervisor or the project director), copies of referrals made, and notes from case conferences. PPHD did not have an electronic medical record system implemented during the development of the program, but is preparing to move to an electronic system within the next year.

Graduation: Celebrating success

The graduation process was the result of the peer care navigators wanting to celebrate and congratulate their clients on their hard work to stabilize their medical, mental health, substance use, and housing situations. The PCNs recognized the significant efforts of each client to succeed in completing their goals, especially in the face of a housing market with less than ideal numbers of affordable housing units.

"When a client is stable and housed, it's exciting," Alex Lozano, peer care navigator, said. "We want them to know that we're proud of them for coming so far."

Example of a housewarming gift upon graduation

Introducing... Some of our graduates

Allen (not his real name) is a 56-year-old Caucasian male who has been living with HIV for 11 years. He went from being an independent contractor with the State of California as a construction manager to being laid off when the economic downturn hit in 2008. He went through his savings and attempted to find jobs, but was unsuccessful. He became homeless, sleeping in his car because he didn't have enough income to stay self-sufficient.

Allen enrolled in Operation Link in November 2014. With the help of our benefits specialist, he was able to obtain Social Security, but that still wasn't enough to cover all of his expenses. The PCN worked with him to obtain housing by connecting him with Coordinated Entry Services. Working with the PCN, he was proactive in looking for housing and in December 2014, found an apartment within a senior living complex.

Bess is a 45-year-old African-American female who has been HIV positive for 14 years. She became a client of Operation Link in September 2014, as she had been unstably housed for several years, sleeping in the doorway of the hallway at her sister's home. The client had also been mistreated by her sister with emotional and verbal abuse. In addition to linkage to services, Bess's PCN provided strong emotional support. Because of this connection, the client was empowered to verbalize how her sister's behavior made her feel. Once Bess stood up for herself, her sister stopped the bullying.

> "[My peer care navigator] was very helpful, extremely knowledgeable, and professional. It wasn't like going to a clinic – I would go see him for whatever I had to do, but it was like going to see a friend. [My PCN] was the best thing that has happened to me since I was diagnosed with HIV.
>
> - Graduated Client, 2016

> "A couple of years ago, after I found out [that I was diagnosed with HIV], I lost my job, my boys…it was a nightmare. My PCN is one of the most wonderful, sweetest people. From day one, she's been there to advocate for me. She's even gone to the hospital with me. She's always there. She's the most amazing person to have come into my life.
>
> - Graduated Client, 2016

Bess applied for a Los Angeles County Section 8 application and was proactive in keeping her appointments so she could obtain a Section 8 certificate. She received her L.A. County Section 8 certificate in December 2014 and moved into her new apartment in February 2015.

Carl is a 49-year-old undocumented Latino male who came to Operation Link with an addiction to crystal meth and a history of depression. Prior to enrolling in Operation Link, he was unstably housed and was referred through the Tarzana Treatment Center, who enrolled him in their inpatient program. With the help and support of his PCN, the client was stably housed after completing treatment and is now working part-time and is adherent to medical care.

Dave is a 29-year-old Caucasian male diagnosed in 2012 with an addiction to marijuana and other drugs. Before becoming an Operation Link client, he was not in stable care or housing. He was referred by PPHD's Medical Care Coordination team and was thereafter referred to an outpatient program for his substance use issues. After becoming substance free, his PCN assisted in his housing search through HOPWA. After months of searching, the client found a housing unit in nearby Glendale and has remained substance free, housed, and compliant with care. He is now a full-time student.

OPERATION LINK IMPACTS

Over the course of its 5 years under the HRSA-funded project, Operation Link served 107 clients, exceeding the program enrollment goal of 100 clients. As of the writing of this manual, 67 of these clients successfully graduated, 17 were lost to follow up, and 3 were deceased.

Through the implementation of this project, staff became more aware of and sensitive to the needs of the population experiencing homelessness, especially in the case of providing immediate care to prevent loss to follow up. By providing the Operation Link team with training on trauma-informed care and through extensive partnership and outreach, the program was able to assist dozens of previously unstable clients receive critical health and dental care, mental health and substance use services, and housing.

Operation Link has brought to light the necessity of intensive case management and peer support for individuals who are experiencing homelessness, living with HIV, and diagnosed with mental health and/or substance use disorders. The formidable impact of the program is shown in that, following the grant period, Operation Link expanded its scope to include individuals not living with HIV. A PCN has been partnered with an LCSW to provide case management services, based out of two public libraries within the City of Pasadena. Operation Link in its new capacity is funded partially by the City of Pasadena Library Services Department, which recognized the importance of this type of intervention for the individuals experiencing homelessness that frequent the public libraries. The Pasadena Public Health Department is currently exploring other funding sources, including Medi-Cal and Medicare, to continue to sustain and expand the program.

RESOURCES

The following resources from the [Program name] model can be found on the Center for Advancing Health Policy and Practice website. All resources from the initiative Building a Medical Home for Multiply Diagnosed HIV-Positive Homeless Populations can be found on the web at http://cahpp.org/project/medheart/resources

- Logic Model for Operation Link (.docx)
- Sample Memorandum of Understanding (MOU) (.doc) with community partner
- Client Contract (.docx) outlines peer care navigator and client roles and responsibilities
- Biopsychosocial Assessment Form (.docx): a needs assessment on which the Individual Service Plan is based.
- Individual Service Plan Form (.xls) used by the client, peer and social worker to outline client goals for well-being, steps to reach those goals, and target dates
- Operation Link Client Flow Chart (.pptx) illustrates the movement of clients through the Operation Link program
- Sample Certificate of Completion (.pptx) given to the client to celebrate the milestone of graduating from Operation Link

PASADENA
PUBLIC HEALTH DEPARTMENT

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