PASADENA
PUBLIC HEALTH DEPARTMENT

OPERATION LINK INTERVENTION MANUAL

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OVERVIEW

The City of Pasadena Public Health Department (PPHD) developed and implemented Operation Link, an intense case management/system navigation program designed to engage HIV+ individuals experiencing homelessness in medical care, housing, and employment. Operation Link is a part of a multisite evaluation, funded by a Health Resources and Services Administration Special Project of National Significance (SPNS) grant. The program focuses on engaging and retaining HIV positive homeless or unstably housed individuals who are unemployed or underemployed into housing, employment, and health care services. Operation Link previously began in 2012 as a project targeting people living with HIV who were experiencing homelessness and substance abuse or mental health issues, then expanded to include all people experiencing homelessness. With the award of this SPNS grant targeting people living with HIV who are homeless and looking for employment, Operation Link shifted focus to this new variation, working to find housing and employment opportunities for clients.

GOALS

Improve HIV health, housing, and employment outcomes, for low-income, uninsured, and underinsured people living with HIV (PLWH) in racial and ethnic minority communities

Enhance and improve partner service coordination for clients

Enhance project team's knowledge and skills to provide superior service delivery

TARGET POPULATION

- HIV+ individuals aged 18 and over who:
    - Are out of care, at risk of falling out of care, newly diagnosed, not virally suppressed, or otherwise not adherent to medical care
    - Are homeless or unstably housed, defined as one of the following:

- Literally homeless: an individual who lacks a fixed, regular, and adequate nighttime residence
- 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.
- 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.

o Are unemployed or underemployed

SETTING UP THE PROGRAM INTERVENTION

BACKGROUND AND THEORETICAL MODEL

In the popular imagination, the City of Pasadena (population 137,122) and the Los Angeles Basin (estimated population 29 million) are what we see on television: beaches, Hollywood, and rich and famous people. However, the region has another side that is overshadowed by that popular notion. Despite Pasadena's success in reducing the number of homeless (from a high of 1,216 in 2011 to 530 in 2016, and increasing again in 2017 to 575), the problem of homelessness (measured as prevalence in number per 100,000) rivals some of the worst in the nation. Pasadena's homeless problem is worse

than Los Angeles (city and county combined), San Diego, Las Vegas, and California and the U.S. Sadly, the Los Angeles Basin is home to the largest homeless population 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).

Operation Link is based primarily on the following intervention strategies: 1) Getting to Work (Housing and Urban Development's Office of HIV/AIDS Housing and Department of Labor, 2015); and 2) Opening Doors Federal Strategic Plan to Prevent and End Homelessness (U.S. Interagency Council on Homelessness, 2015). The strategies both advocate for coordinated service provision across agencies to support the health and well-being of vulnerable populations. The proposed project also weaves together the following evidence-based models: 1) Critical Time Intervention (Herman et al., 2007); 2) Seeking Safety (Najavits, 2007); and 3) Illness Management and Recovery (Mueser et al., 2006).

Getting to Work discusses the value of employment services for PLWH, articulates what employment services are, both broadly and within the context of HIV/AIDS service provision, and explains effective practices for providing them. Getting to Work is based on the rationale that employment can be critical to improving the economic and personal well-being of PLWH. It can impact health and can increase a person's ability to live a satisfying, productive and meaningful life. We also know that employment can increase financial self-sufficiency and reduce reliance on publicly-funded benefits and other services. Additionally, Getting to Work points out that "employment can play an important role in reducing health disparities," and that "health disparities adversely affect groups who have historically experienced discrimination or exclusion based on characteristics such as race/ethnicity, religion, socioeconomic status, gender, gender identity, age, mental health, disability, sexual orientation or geographic location" (Getting to Work Module 1). PLWH in SPA 3, especially those who experience bias and cultural insensitivity, benefit from a coordinated focus that includes flexible employment options regardless of ethnic background, gender identity, or medical status.

Getting to Work is innovative in its theoretical shift toward supporting employment efforts to increase the health of PLWH. In the past, the more common focus has been on addressing the illness and symptoms in a health care setting, and services were provided in silos, which has been a major barrier to employment for PLWH. The approach to consider employment as part of a holistic plan to support the whole person in their health goals means that more than one agency must work together for an optimal outcome.

Opening Doors provides a strategy for aligning mainstream housing, health, education, and other human services to prevent and end homelessness. Like Getting to Work, the framework of the strategy supports incorporating employment and housing into HIV/AIDS service provision. A primary objective of the Opening Doors intervention is to increase economic security for people most at risk of homelessness, citing that employment is clearly a critical component of ending homelessness, and that HIV/AIDS service providers and housing providers can have a powerful role in coordinating access to employment services with a coordinated framework for service provision. The strategy is explained within the Getting to Work curriculum, with the rationale that preventing and ending homelessness is made possible through the coordinated efforts of strong public and private organizations. The program identifies objectives that will support the goal to improve system-wide coordination and integration of employment programs with homeless assistance programs and systems for vulnerable populations (including PLWH).

PPHD and its partners establish the linkage among providers, and guide each client through various networks and systems with help in scheduling appointments, advocacy with providers, and follow-up. As the Navigators facilitate clients' adherence to appointment schedules and coordination with other agencies, they also consider barriers that may exist, including lack of transportation, child care, or a place to store belongings. The Operation Link team is well informed of supportive services to help mitigate these barriers, and can provide bus vouchers/tokens, arrange for childcare, and problem-solve around other issues that might prevent clients from making appointments.

Operation Link's proactive method to link health, employment, and housing navigation services aligns with 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 high-risk homeless individuals. 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 abuse 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. What researchers found is 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). PPHD utilize "built-in" recruitment points at partner locations to help overcome this barrier, including a local homeless shelter and a partner HIV medical outpatient clinic.

Operation Link also provides services to targeted individuals following models of care that have been shown to be effective with individuals with multiple barriers. 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). 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 addressing the following elements: homelessness, unemployment/inability to be self-sufficient, and hopelessness or fear associated with terminal disease. 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 profile information). Following the Seeking Safety model enhances the client's sense of safety and provides the emotional and psychological room needed to focus on coping with today's issues and a move toward sustainable, independent living.

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

The 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 three reasons: first, each of the models are empirically supported as a standalone 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 target population, 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. Lastly, Operation Link partners with non-traditional agencies, which are not necessarily HIV specific, in order to allow clients to have the most opportunities for housing and employment.

One of Operation Link's unique approaches is the utilization of non-HIV specific resources to assist clients living with HIV. This SPNS project has allowed staff to take innovative and creative approaches to help clients find housing and employment, as well as to teach clients how to navigate systems outside of the traditional Ryan White resources. This is especially important in Los Angeles County, where many PLWH may use a blend of both Ryan White and non-Ryan White funded services.

One example of non-traditional housing for PLWH is when Operation Link's Peer Care Navigator, Precious Jackson, successfully housed one of her clients through working with the Department of Social Services, which had a pilot housing program. This client moved into his apartment on July 1, 2019.

ASSET ASSESSMENT

The City of Pasadena Public Health Department was uniquely positioned to implement Operation Link, due to its services being informed by successes and lessons learned in a previous five-year intervention strategy focused on a similar population base – bringing together traditional HIV providers with non-HIV providers to complete the coordination of holistic care. Phase I of Operation Link taught PPHD that addressing biases is more important than ever, and that extra care must be taken to match the most appropriate housing option with the Client. Additionally, providing "navigators" for each Client helped them feel safe and supported in achieving their goal.

This new iteration of the Operation Link project coordinates services by co-locating two service Navigators at the provider locations – an Employment Navigator from the Foothill Workforce Development Board, and a Housing Navigator from Union Station Homeless Services. They provide one-on-one advocacy for each client for services that can be fraught with tension and barriers for PLWH. In addition to these two system Navigators, PPHD brought in Peer Care Navigators for this project, similar to the previous SPNS project that launched the Operation Link program.

Together, the Navigators are responsible for shepherding clients through various systems, including medical, housing, employment, mental health, social services/benefits, etc. The Navigators have an essential role in following up with Clients to ensure they remain engaged in the project and continue to work toward their goals. They alert one another if a client does not make an appointment, problem-solve, and contact the client to compassionately discuss their disengagement in the program. The Navigators' empathy, compassion, and support further assist the client to remain engaged in the project, and thus adhere to treatment and pursue their goals. Whether the client needs someone to accompany them to an appointment or just needs someone to talk to, the Navigators are there.

In addition to the internal project partners, Pasadena, the San Gabriel Valley, and Los Angeles County at large have several service providers to treat HIV/AIDS, mental illness, and substance abuse, 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 experiencing homeless. 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, or driving them in company vehicles when possible. Operation Link also emphasizes the need to meet clients "where they are," which often requires the Navigators to make visits to shelters, parks, or other easy meeting areas, such as a coffee shop.

STAFF RECRUITMENT AND HIRING

The core Operation Link intervention team is comprised of a Project Director, a Project Coordinator, a Peer Care Navigator, a Peer Care Navigator Trainee, an Employment Navigator, and a Housing Navigator. Although PPHD initially hoped to hire a Nurse Case Manager, recruitment was not successful. However, PPHD's Public Health Nurses were available to assist with any urgent questions or issues.

PPHD works with the City of Pasadena Human Resources 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. During the first phase 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 abuse 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. The Peer Care Navigator hired from this initial recruitment was brought back to work on this new, expanded Operation Link project.

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

Operation Link partnered with the Foothill Workforce Development Board (FWDB) to staff the Employment Navigator position. FWDB serves employers and job seekers in the San Gabriel Valley by making investments in workplace skills development and job-specific training to help workers gain skills or obtain education and credentials that employers value. In turn, FWDB builds relationships with businesses to understand their hiring needs and match qualified workers. FWDB maintains close relationships with schools and colleges to communicate the skills that are needed in the labor market.

Similarly, Operation Link partnered with Union Station Homeless Services (USHS) to staff the Housing Navigator position. USHS is a nonprofit organization and is the San Gabriel Valley's largest social service agency assisting homeless adults and families. Their core services include outreach, bridge housing, and permanent housing. They also provide in-kind services to the Operation Link clients, including meals and showers.

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

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

- **Project Coordinator**
    - 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

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

- **Peer Care Navigator/Peer Care Navigator Trainee**
  - Conducts client care coordination, follow up and data entry
  - Conducts outreach and HIV testing (when applicable) to target population

PEER CARE NAVIGATOR TRAINEE

The Peer Care Navigator (PCN) Trainee is a new position, created specifically for this SPNS project. The PCN Trainee is a former Operation Link client who experienced homelessness and unemployment. When he first started with the Operation Link program as a client, he was in foreclosure, without employment or income, and out of care due to financial restrictions. He was in debt with not only financial institutions, but also with friends as he struggled to make ends meet. Unfortunately, he had little luck with job resources and was told to collect recyclables instead of looking for full-time work. Through Operation Link, he was able to regain stability, first through gaining employment at a local pharmacy.

His experience made him passionate about helping others, particularly in the HIV field, and began pursuing advocacy for HIV services in LA County. Meanwhile, Operation Link needed another PCN and saw an opportunity to pilot a training program to help build his resume.

As the Peer Care Navigator Trainee, he works closely with Operation Link's Navigators and is building his own caseload under supervision. He is being trained in peer outreach, case management, system navigation, and ADAP enrollment. The ultimate goal is to prepare him for full-time employment in the HIV field and for him to utilize his experience to reach and connect with other potential Operation link clients. In his own words, he writes, "Working along with the outreach team of PPHD, I have learned how hard that work is, and the patience, empathy and dedication needed to perform such a tough job. Programs like Operation Link and PORT (Pasadena Outreach Response Team) change the life of those most vulnerable helping them become again productive, responsible citizens. There is a financial investment in these projects by the City of Pasadena but the investment per each person that is saved yields returns that are limitless."

- Informs community organizations and partners about Operation Link services, and provides guidance on how to refer new clients to Operation Link
- Ensures that all appropriate forms and releases are signed
- Assists clients as necessary with receiving benefits, i.e. General Relief, health insurance through Affordable Care Act, etc.
- Conducts needs assessments and creates customized care plans, with input from Project Director, Employment Navigator, and Housing Navigator
- 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
- Builds trusting and supportive relationships with clients
- Assists in scheduling appointments
- Accompanies clients to appointments if necessary
- Assists clients with paperwork, obtaining government-issued ID, and navigating through benefits system
- Links clients into care and other supportive services
- Monitors progress and follows up on the clients' customized care plans
- Re-evaluates and updates care plans as needed

- **Housing Navigator**

  - Under limited supervision, enroll clients into program
  - Conduct needs assessment and create care plans specific to housing
  - As a community liaison representative at Union Station Homeless Services, provide liaison coordination with local and other governmental and community and service-providing agencies, including partner organizations for employment and RWHAP HIV health care services, establish linkages, and follow-up
  - Assist in organizing and establishing neighborhood networks and systems designed to improve quality of life
  - Navigate clients through partner organizations as needed
  - Provide training and/or ongoing information and facts regarding PLWH to ensure cultural sensitivity for partners and at SPA 3 HIV Providers Network meetings
  - Monitor program progress and alert Project Director to successes and weaknesses

- **Employment Navigator**

- Under limited supervision, enroll clients into program
- Conduct needs assessment and create care plans specific to employment
- As a community liaison representative at Foothill Workforce Development Board, provide liaison coordination with local and other governmental and community and service-providing agencies, including partner organizations for employment and RWHAP HIV health care services, establish linkages, and follow-up
- Interpret and explain rules, regulations, policies, and procedures related to employment and career services to clients
- Provide information on available career services at FWDB and other employment providers
- Counsel clients on eligibility and right to work
- Coordinate directly with employment services providers to link clients to employment services including: individualized job placement and job search assistance, job readiness training, identifying and coordinating on-the-job training.

TRAINING AND SUPERVISION

Operation Link provides individual supervision from the Project Director, who has a Masters in Social Work (MSW), on a weekly basis. The purpose of individual supervision in Operation Link is to provide a method of support for the Peer Care Navigator and Peer Care Navigator Trainee. The other Navigators (Housing and Employment) receive supervision from their respective agencies. 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 abuse, 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 Project Director provides one-on-one guidance and support to Operation Link's PCN staff and other Navigators as needed, 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 Project Director 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

In addition to this supervision, Operation Link staff are required to complete a minimum of 16 hours of HIV/AIDS, mental health, or substance abuse 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 (shown in Attachment A) 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).

PARTICIPANT RECRUITMENT

RECRUITMENT AND SCREENING PROCEDURES

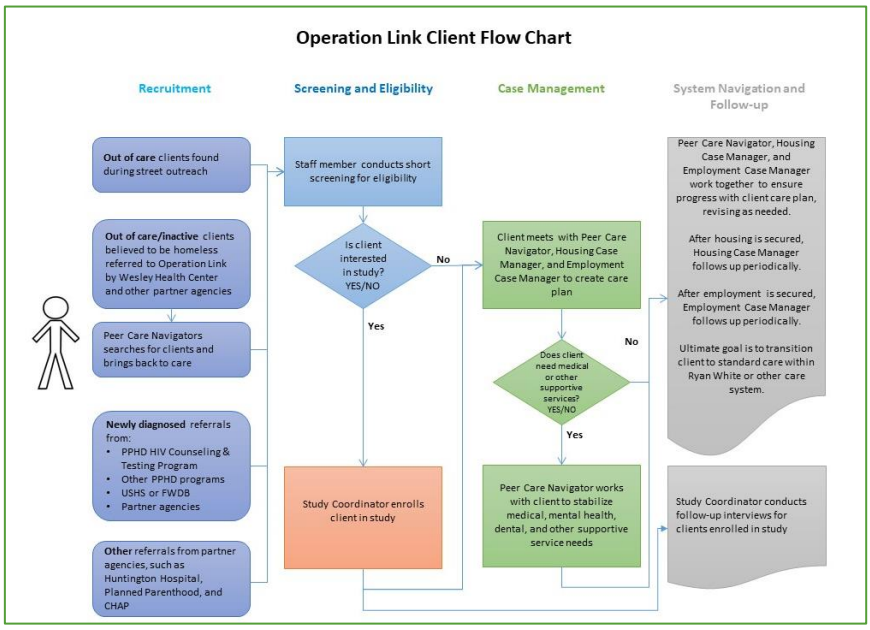

Figure 1: Operation Link Client Flow Chart

To begin recruitment at the start of the project, all Navigators 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. The 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.

The Navigators recruited the first targeted individuals by working with Wesley Health Center Pasadena, the largest local HIV outpatient medical provider, to identify former clients who were believed to be homeless or at risk for homelessness and out of care for 6 months or more. The Peer Care Navigator then attempted to reconnect these clients by outreaching to them and attempting to locate them at their last known locations.

Operation Link's partner agencies, Foothill Workforce Development Board and Union Station Homeless Services, also went through their client lists to identify potential clients. In addition, as word spread about the program, referrals from emergency rooms, other medical providers, and homeless shelters started to come in. Though formal written agreements were not formed, Operation Link would

generally take any client referrals that met the eligibility criteria. The Navigators or PPHD's office staff conduct a short screening for program eligibility, as described in the Eligibility and Enrollment section below.

ELIGIBILITY AND ENROLLMENT

For the purposes of this SPNS project, Operation Link specifically targets people living with HIV (PLWH) experiencing homelessness and unemployment in Pasadena and the San Gabriel Valley. The Navigators or one of PPHD's office staff conducts a brief screening to ensure that the program criteria are met before setting up the first meeting, usually starting with the Peer Care Navigator. The PCN usually serves as the first contact for Operation Link, conducting an assessment and starting to work with the client on a custom care plan. The PCN then brings in the other Navigators to start working with the client on their housing and employment needs.

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 Navigators. 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 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 Wesley Health Center Pasadena, which is 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 Wesley Health Center staff in assisting the client to access

all available services, such as medical, dental, mental health, substance abuse treatment, food pantry, transportation, and benefits specialty.

When it is not possible for a client to enroll into services at Wesley Health Center, the Peer Care Navigator 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 care plan to reduce barriers to access.

CLIENT INVOLVEMENT

Clients are encouraged to actively participate in the process of creating their care plans with goals that resonate with them. The Navigators 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 (Attachment B) was developed in PPHD's previous SPNS project as a means to solidify this idea that both the Navigators 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 in order to set roles and boundaries from the beginning, as well as establish graduation from the program to be a positive and important accomplishment and as a goal or something to look forward to.

HOMELESS CLIENT ADVISORY BOARD

PPHD has several projects within its Social and Mental Health Division that target the homeless population. In order to get feedback and input from current and former clients on various topics, such as program implementation, customer service, future projects, marketing materials, and outreach strategies, the Homeless Client Advisory Board was formed. Currently, one current and one former client from Operation Link sits on the HCAB. The HCAB meets monthly and is currently discussing methods of recruitment and outreach for PPHD's various programs addressing homelessness, as well as how to better respond to needs of those experiencing homelessness during non-traditional business hours and to help educate the community around homelessness and how to help. The HCAB also plans to hold a panel or forum with speakers who have experienced homelessness to share their stories.

Furthermore, PPHD now has a Homeless Client Advisory Board, tasked with providing feedback on Operation Link's services and brainstorming ideas on how to reduce stigma around homelessness in Pasadena and the surrounding areas.

SERVICE DELIVERY MODEL

NAVIGATOR FLOW AND BRIEF INTERVENTIONS

For most clients, the Peer Care Navigator (PCN) is the first contact in the Operation Link Program. Together, the PCN and client discuss the client goals and create a plan to achieve them. Because most services require identification and proof of residency, the PCN often assists with filling out paperwork for birth certificates and ID cards. The PCN will also help link the client to medical care, benefits, dental, and other supportive services as needed in order to stabilize their health to prepare for housing and employment.

Operation Link strives to find appropriate, stable housing for clients. Most clients prefer to work on their housing goals prior to looking for employment. As such, the Housing Navigator will frequently partner with the PCN to simultaneously work on housing, while the PCN is assisting with supportive services. Because Operation Link partnered with Union Station Homeless Services to staff the Housing Navigator position, USHS is able to provide in-kind services through their internal programs, such as meals, showers, and temporary emergency shelter. The Housing Navigator works with the client to establish then find the right match for housing. While some clients would thrive in a single apartment, others may require permanent supportive housing. The Housing Navigator works within the local Coordinated Entry System to conduct the required client assessment (Vulnerability Index - Service Prioritization Decision Assistance Tool, or VI-SPDAT) to determine prioritization within the system. The Housing Navigator also networks with other agencies in order to find placement opportunities and advocate for the client's needs, including move-in grants.

The timing when clients are ready to look for employment varies. While some clients are eager to look for work, others are hesitant due to concerns around losing long-term benefits, not having adequate training or education, or fear around stigma in the workplace and possibly disclosing to employers. The PCN and Employment Navigator work together with these clients to encourage them to try a small, part-time job or even volunteering to gain experience. The Employment Navigator, staffed by Foothill Workforce Development Board, is also able to link the client to various vocational training opportunities and/or classes around resume building, job applications, and interviewing techniques. The PCN also provides information to the client around how much or often can be worked before long-term public

benefits are put at risk, as well as around disclosure and laws around privacy and the Family Medical Leave Act (FMLA).

The Operation Link team also provides other 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
- 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 or collateral'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 between the Navigators once a weekly and individually as needed with the Project Director.

GRADUATION – TRANSITIONING TO STANDARD CARE

Once a client is at self-managed acuity, the Navigators work with the Project Director to determine if this client is a candidate for graduation from the Operation Link Program. 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, appropriate to the client's needs. This could vary according to needs, including living with family, permanent supportive housing, or individual apartment.
- Stable employment situation, appropriate to the client's needs. This could range from part-time or per diem work to supplement benefits or full-time employment with private insurance.
- 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
- Care plan goals completed, with no further concerns from the client

If the Navigators and Project Director 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

NEW APPROACH TO EMPLOYMENT

When Operation Link first started, the Navigators focused on helping clients find permanent employment opportunities only. However, after receiving feedback from clients on their fear or reluctance due to possibly losing benefits or having to disclose to employers, the Navigators began to rethink their strategy. In addition to the usual resources available through Foothill Workforce Development Board and other employment agencies, the Operation Link team began assisting clients in finding employment in other ways. For example, one client was undocumented and therefore not eligible for most types of job placement opportunities. However, in discussing how the client spends his time, Operation Link was able to help him find a part-time employment opportunity teaching dance classes at a local school.

Operation Link staff have started to discuss ways of slowly getting back into the employment world by asking clients if they would like to train in a certain field or perhaps volunteer to gain experience. Because many long-term survivors of HIV are often hesitant to enter the workforce after many years of being on disability, volunteering has been a great intermediary step. For instance, one client has started to volunteer as a peer support advocate at the clinic he now attends for medical care and case management. This experience has opened him up to possibly gaining employment in the future after he has gotten additional training.

Link program again. Upon graduation, clients receive a Certificate of Completion (sample as Attachment C) with a customized message from their Peer Care Navigator.

One particular barrier in the ability to graduate clients from the program has been the lack of affordable housing in Pasadena. As such, the clients may be ultimately placed outside of the immediate Pasadena area. The Peer Care Navigators then work with the client to find a medical home near their established housing.

Another challenge has been finding both housing and employment opportunities for undocumented clients. The Operation Link team is currently researching and continuing to help clients find these rare opportunities to allow them to reach criteria for successful graduation from the program.

DOCUMENTATION

Because Operation Link is a partnership between three different agencies, documentation occurs per each individual agency's protocols. PPHD utilizes Welligent as its electronic health record system and all progress notes, care plans, consents, and other releases are kept in the system. Any paper copies of medical charts, forms, referrals, etc. are kept in a file, then locked in a cabinet in a locked office.

Union Station Homeless Services requires entry into the Homeless Management Information System (HMIS) to document services provided to clients. The Foothill Workforce Development Board primarily utilizes a paper-based file for each individual, with information uploaded to various electronic systems as needed for employment related program applications.

ATTACHMENTS

- Attachment A: Logic Model
- Attachment B: Client Contract
- Attachment C: Sample Certificate of Completion

Attachment 6
LOGIC MODEL FOR OPERATION LINK II

GOAL:
Improve HIV Health Outcomes for Low-Income, Uninsured, PLWH in Racial/Ethnic Minority Communities in SPA 3

ASSUMPTIONS:
1. HIV Medical Care Providers Lack Understanding of SDofH, which Negatively Impacts HIV Health Outcomes
2. Housing and Employment Providers Lack Understanding of HIV/AIDS and the Needs of PLWA, which Negatively Impacts HIV Health Outcomes

LEVEL	INPUTS	ACTIVITIES	OUTPUTS	Intermediate	Long-Term
CLIENT Target Population: *Homeless PLWH in SPA 3 *Racial and Ethnic Minorities, Aged 18+ *Healthy Enough to Work	-Established Local HOWPA Provider (Union Station) -Established Local RWHAP Provider (Wesley Health Centers at PPHD) -Multiple Referrals Sources: 1) Wesley Health Centers; 2) Union Station; 3) PPHD; 4) Pasadena Partnership to End Homelessness; 5) SPA 3 HIV Providers Network	-Recruit and Enroll Clients -Conduct Screening and Needs Assessment -Develop Customized Client Plan -Implement Case Management and Advocacy -Conduct HIV Care Navigation -Conduct Employment Navigation -Conduct Housing Navigation -Provide Advocacy and Link to Other Supportive Services (e.g., life skills training, substance abuse treatment) -Collect Outcome Data	-Number of Outreach Contacts -Number of Project Enrollees -Number of Care Management and Advocacy Contacts -Number of HIV Care Navigation Contacts -Number of Employment Navigation Contacts -Number of Housing Navigation Contacts -Number and Type of Supports Provided to Clients -Number of Gift Card Incentives Issued to each Client	-Increased No. of Clients who had at Least One HIV Medical Care Visit in Each 6-Month Interval -Increased No. of Clients Prescribed ART in Each 12-Month Interval -Increased Adherence to Treatment for HIV/AIDS and Other (e.g., Substance Abuse) -Increased No. of Clients Receiving Housing and Employment Services -Improvements on HAB, HOWPA APR, CAPER, and DOL ETA Performance Measures	-Improved Medical Outcomes, including Viral Suppression -Clients have Housing Stability -Clients are Employed
PROVIDERS Target Population: *Providers of HIV Medical Care in SPA 3 *Providers of Employment and Housing Services in SPA 3	-Project Staffing: *Two Case Managers *Housing Navigator *Employment Navigator *Project Director, Evaluator, and Data Manager Who Worked on Previous HRSA Grant/ETAP -MOUs between PPHD and Wesley Health Centers and Union Station -Resource for System Change: SPA 3 HIV Providers Network (20+ members who provide HIV medical care)	-Navigators Coordinate Client Services Within and Across Providers -Maintain Ongoing Contact with Client Service Providers and Conduct Problem-Solving -Navigators Provide Quarterly Training to HOWPA, CES, and Other Community Entities Using PPHD's Existing HIV/AIDS Curriculum -Navigators Provide Training on Social Determinants of Health (SDofH) for Homeless PLWA at SPA 3 HIV Providers Network Meetings	-Number of Service Provider Contacts (Appointment Scheduling, Client Consultation, Follow-up Contacts, etc.) -Number of Trainings Using PPHD's HIV/AIDS Education Curriculum to HOWPA, CES, Workforce Development Board, and other Community Providers who Provide Housing and Employment Services -Number of Trainings on SDofH for SPA 3 HIV Network Providers	-Increased Understanding/ Knowledge among HIV Medical Care Providers of how SDofH Impact HIV Health Outcomes -Increased Understanding/ Knowledge among Housing and Employment Providers about HIV/AIDS and SDoH	-Increased Ability Among SPA 3 Providers to Address Social Determinants of Health (SDofH) such as Unmet Housing and Employment Needs for Homeless PLWH in SPA 3 -Improved Access for PLWA in SPA 3 to Housing and Employment Resources

CONTEXTUAL CONDITIONS AND RIVAL EXPLANATIONS

PASADENA
PUBLIC HEALTH DEPARTMENT

Operation Link Peer Care Navigator/Client Contract

Client Name: _____ Date: _____

Date of Birth: _____

I agree and understand that the Operation Link Program is voluntary. Peer Care Navigators work as advocates to help improve client care through intensive case management/navigation, peer support, and linkage to care and supportive services. I understand that Peer Care Navigators are not licensed professional counselors or therapists, nor can they provide legal advice.

Peer Care Navigator Roles and Responsibilities

Peer Care Navigators will:

- Establish and maintain contact with you via phone, text message, email, or face-to-face visits.
- Create a customized care plan with you to help prioritize your goals as it pertains to treatment, housing, and other needs.
- Provide intensive case management/navigation and peer support to help you meet your goals.
- Work collaboratively with you, your case managers (clinical, housing, etc. as applicable), and your health care providers to ensure that you are receiving quality services in a timely manner.
- Create a transition plan with you after your care plan goals have been completed to help continue with your medical adherence, housing, and behavioral health.

Client Roles and Responsibilities

I agree to:

- Maintain communication and return calls via phone, email, or text message to my Peer Care Navigator.
- Go to any and all appointments or meetings that are set up for me. If I need to reschedule, I will let my Peer Care Navigator know as soon as possible.
- Contact the Peer Care Navigator and/or the Housing Navigator or Employment Navigator if the Operation Link Program is no longer needed or helpful.
- Work in partnership with my Peer Care Navigator, my case managers (as applicable), and health care providers to help me meet my care plan goals.

CONFIDENTIALITY:

- If I reveal information that indicates a clear threat of harm to me or others, the Peer Care Navigator will need to contact appropriate authorities or take other reasonable action to prevent harm from occurring.
- Operation Link staff are required by law to report to the appropriate authority information about suspected abuse or neglect of a child, an incompetent or disable person or elderly person.
- By signing this document, I agree to maintain strict confidentiality of personal information shared in the Peer relationship (e.g. personal information about my Peer Care Navigator)

I agree to the above contract and if I have any concerns that I may call my Peer Care Navigator at (626) 744-_____ or Angélica Palmeros, MSW at (626) 744-6158.

Client Signature: _____ Date: _____

Peer Care Navigator Signature: _____ Date: _____

Certificate of Completion

awarded to

Name of Recipient

We commend you for your hard work and dedication to secure housing, gain employment, and adhere to medical care. Congratulations on your graduation from Operation Link!

Signed _____ Date _____

Peer Care Navigator

PASADENA
PUBLIC HEALTH DEPARTMENT