Operation Link

Using peer care navigators to connect individuals who are experiencing homelessness and living with HIV with a medical home in the San Gabriel Valley

Angelica Palmeros, MSW and Precious Jackson
City of Pasadena Public Health Department
June 13, 2018
Disclaimer

This project was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number H97HA24960, SPNS Homeless Initiative, awarded at $1,497,156 over 5 years with no non-governmental sources used to finance the project. This information or content and conclusions are those of the authors and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.
Project Model Overview

- An intense case management/system navigation program for individuals who are:
  - experiencing homelessness
  - living with HIV
  - diagnosed with mental health and/or substance use disorders

- Peer Care Navigators (PCNs) work with clients to find established medical homes throughout Los Angeles County that is accessible from the clients’ primary place of residence and able to meet the following needs:
  - HIV primary care
  - behavioral health
  - housing
  - care coordination services
Goals of the Project

● Provide peer support and advocacy for multiply-diagnosed PLWHA who are experiencing homelessness and diagnosed with mental health and/or substance use disorders

● 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
Target Population

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

- Of the 90,000 individuals experiencing homelessness in the Los Angeles basin:
  - 1,165 live in Pasadena
  - 2,700 people experiencing homelessness are living with HIV
  - 22,500 suffer from severe or persistent mental illness
  - 31,500 suffer from some sort of addiction
  - the basin has the second largest number of HIV cases in the country
Model Description

CLINICS
- Ryan White Clinics
- County Hospitals
- Private Providers
- FQHC’s

LOCAL
- Bus tokens
- Metro Rail Passes
- Taxi Vouchers
- Mobile Meetings

RN CASE MANAGER
Peer Care Navigator (PCN)
- In-Patient Centers
- Reintegration Program
- Treatment Services

ENHANCED PEER CARE NAVIGATION (PCN)
- Section 8
- HOPWA Program
- Transitional Housing
- Local Housing Dept.
- Shelters

HOUSING
- Social Workers
- Local NGO’s
- Crisis Counseling

CLINICAL SUPERVISOR

Mental Health

SUBSTANCE ABUSE
**Operation Link Client Flow Chart**

**Recruitment**
- **Out of care** clients found during street outreach
- **Out of care/inactive** clients believed to be homeless referred to Operation Link by PPHD clinic
- Peer Care Navigators search for clients and bring back to care
- Newly diagnosed referrals from:
  - PPHD HIV Counseling & Testing Program
  - Testing at outreach events
  - Partner agencies
- Other referrals from:
  - Walk-ins at PPHD clinic
  - Partner agencies

**SPNS Program Screening and Eligibility**
- Project Assistant conducts short screening for eligibility
- Is client eligible for study? YES/NO
  - Yes
    - Project Assistant provides client with information regarding SPNS study.
  - No
    - Client still eligible for Peer Care Navigator services.

**Consent**
- Does client consent? YES/NO
  - Yes
    - Project Assistant provides client with information regarding SPNS study.
  - No
    - Client still eligible for Peer Care Navigator services.

**Follow-Up and Data Collection**
- Peer Care Navigator completes biopsychosocial assessment (initial) and intervention encounter forms (continuous)
  - AND
  - Project Assistant conducts follow-up interviews at 3, 6, 12, 18 months
  - AND
  - Nurse Case Manager completes chart reviews at 6, 12, 18, and 24 months
- Project Assistant documents receipt of services in SPNS aggregate services form and SPNS program tracking system
Peer Care Navigators

- Three evidence-based models served as the framework of the program
  - Critical Time Intervention
  - Seeking Safety
  - Illness Management and Recovery

- Development of “Peer Care Navigator” role
  - Combines benefits of peer with case manager
  - PCN identifies and works with each service provider needed to address the client’s issues,
  - Coordinates appointments and across providers to ensure treatment is consistent with the framework of the proposed project
  - Provides intensive follow-up to ensure the client is retained in treatment
  - PCN’s “peer” aspect 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.
Recruitment

- Utilized mobile unit and foot outreach methods in targeted locations known to experience homelessness:
  - Homeless shelters
  - Parks
  - Places of worship
  - Transitional living facilities
  - Community Centers
- Provided food and hygiene kits (donated by local faith based organization) with information on the program
- Outreached to community organizations and HIV providers to assist with recruitment
Clinical Supervision of PCNs

- **LMFT**
  - Provided group and individual sessions with PCNs to help set appropriate boundaries with clients, respond supportively to the unique challenges of the work and each person’s particular life circumstances as a peer
  - Led case conferences
  - RN Case Manager
  - Provided medical insight on cases and took the lead on any medical adherence or medication management issues

- **“Client Contract”**
  - Outlines the responsibilities of both the PCN and the client
  - Sets reasonable expectations and gives ownership of clients’ individualized care plans to clients themselves
Implementation Barriers

● Decreased Use of Mobile Unit
  o Mobile unit’s affiliation with the City/government/law enforcement caused many potential clients to avoid the unit instead of drawing them in

● Transferred medical clinic to FQHC
  o Due to ACA and other factors, the City of Pasadena was no longer able to sustain its own HIV medical/behavioral/dental clinics
  o Services were transferred to a Federally Qualified Health Center with several years of HIV treatment experience and a good, trusted reputation for HIV care in LA County
Implementation Challenges

- Misunderstanding of program by HIV providers, thought the program was “poaching” clients
  - After meeting with the providers and providing overviews, they became sources of referrals

- Lack of affordable housing/inability to use local HOPWA vouchers due to unavailable units
  - Operation Link worked with housing agencies outside of the local area to find more opportunities for housing clients

- Lack of housing opportunities for undocumented clients (largely contributed to the number of ungraduated clients)

- Lack of organized basic life skills training
“Graduation”

- Operation Link referred to the transition from intensive case management to standard care as “graduation”
  - Occurred when client was at self-managed acuity and all team members (including the client) agreed that the client is ready
  - Criteria:
    - adherence to medical and behavioral health care,
    - stable housing situation,
    - ability to demonstrate basic life skills,
    - ability to follow up on referrals independently,
    - ability to navigate systems independently and/or know where to seek assistance
- Upon graduation, clients received a Certificate of Completion and a housewarming gift
Successes

- 102 clients enrolled
- 67 graduated to standard care by end of the SPNS grant
- 59% virally suppressed at 12 months
- 80% linked to medical care at 12 months
- 75% housed at 18 months
- Model has continued, utilizing a care navigator/case manager at local libraries (open to all homeless individuals)
Lessons Learned

- Increased understanding of the needs of the population experiencing homelessness in Pasadena and surrounding region
- Highlighted 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
  - Though the original case load goal for each PCN was 40, a more realistic case load goal is 20 due to the acuity of clients
- Need to meet homeless clients where they feel most comfortable
- Need to take into account all of clients needs before choosing type of housing, location, and access to medical home
Operation Link has continued and has expanded to include the following programs:

• Library Case Management – open to all individuals experiencing homelessness.
  o Provides intensive case management and linkage to care through a case manager stationed at Pasadena Central Library
• Grant for the Benefit of Homeless Individuals – SAMHSA grant which consists of teams of social workers, case managers, and paramedics to provide case management and linkage to care
• HRSA SPNS – providing navigation and linkage for housing and employment services
• Innovations – Department of Mental Health grant providing services (case management, mental health, social services, meals, showers, laundry) to homeless seniors at a community center
Recommendations

- The need to enhance life-skills partnerships to improve transition from homelessness to the demands of day-to-day life demands (i.e. bills, meal preparation, money management)
- Increase the coordination of case conferencing among partner agencies.
- Provide Peer-support through clinical supervision and trainings to support professional development and growth.
- Important linkages prior to graduation for ongoing support such as medical, mental health and substance abuse.
Operation Link Implementation Manual:

Includes documents such as logic model, client contract, assessment form, individual service plan form, and sample certificate of completion.
Contacts

Angelica Palmeros, MSW
Social and Mental Health Division Manager
apalmeros@cityofpasadena.net

Erika Davies
Project Coordinator
edavis@cityofpasadena.net

Matt Feaster, MPH
Epidemiologist
mfeaster@cityofpasadena.net

Precious Jackson
Case Manager
pjackson@cityofpasadena.net