

## Connecting with VA Health Care Resources: Information for Community Homeless Service Providers

Video Recording Link:

<https://veteransaffairs.webex.com/veteransaffairs/ldr.php?RCID=ce7405a20e201c794fe0585aeba7560e>

Password: **VpSbcn@8**

Panel Discussion

October 8, 2020



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# Overview

- Description of medical services
- Methods to determine eligibility for VA medical services
- “Best practices” on how to access VA medical services

## **Jeffery L. Quarles** **Director, Grant and Per Diem** **Homeless Programs Office**

Mr. Quarles is the Director, Grant and Per Diem (GPD) National Program Office, Tampa, Florida. He has been served as the program's Director since 2012. GPD provides grants to community organizations that provide transitional housing and supportive services to homeless Veterans and case management services to formerly homeless Veterans. Mr. Quarles has a Masters Degree in Rehabilitation Counseling and is a Licensed Independent Chemical Dependency Counselor.



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## Thomas Mattras, MD Director of Primary Care Operations

Dr. Tom Mattras, MD, is a board-certified Internist who completed both his medical school and residency training at the University of Maryland. After spending nearly 5 years in the private sector as a Primary Care provider and hospitalist, he has spent the past 21 years as a VHA employee, with 15 years as a front-line Primary Care Provider and now more than 6 more years in various leadership roles. Dr. Mattras believes strongly in the VA's mission and strives to provide personalized, pro-active, patient centered care to Veterans in a staff friendly environment that promotes accountability.



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## Clifford A. Smith, PhD Director, Field Support and Analytics, Office of Mental Health and Suicide Prevention

Dr. Smith is responsible for field implementation of mental health and suicide prevention services across the enterprise. He leads three national centers for program evaluation and data analytics. These data populate dashboards that inform the work and decisions of VHA clinicians on a daily basis. He provides data critical to executive and clinical leaders decisions about all matter regarding the operation of the VHA mental health care and suicide prevention system. He publishes and speaks nationally to demonstrate the reliability and value of VHA metrics and systems, establishing VHA as a trustworthy national leading healthcare system. He is the person to whom VACO and field leaders turn when there are operational problems in need of rapid solution.



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## **Darlene Davis, National Home-Based Primary Care (HBPC) Program Manager**

Ms. Davis has served in the VA for over 20 years, in the field of Geriatrics and Extended Care. She is a licensed Nursing Home Administrator with a Masters Degree in Health Administration from the University of Central Florida and is a Registered Dietitian, with a Bachelors Degree in Nutrition from Mansfield University of Pennsylvania. She is currently the National Home-Based Primary Care (HBPC) program manager, responsible for supporting over 400 program locations serving over 60,000 Veterans enrolled in HBPC annually.



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**Daniel Bradford, MD, National Director, Intensive Case Management Services Office of Mental Health and Suicide Prevention, Division Chief, Psychosocial Rehabilitation and Recovery Services Mental and Behavioral Health Services Durham VA Medical Center**

In his VA Central Office role, Dr. Bradford leads the VA's intensive case management programs in mental health, which are assertive community treatment (ACT) based programs serving Veterans with serious mental illnesses. In his role at the Durham VA, he provides direct clinical care and manages clinical programs serving Veterans with serious mental illness.



## Jennifer Colbert, LCSW SSVF Regional Coordinator

Responsible for the oversight of performance and compliance of grantees awarded funding under the SSVF Program.

Help to create and disseminate National Homeless Program Office directives, information, and initiatives, as well as help monitor its application in the field.

Coordinate communication between VAMC and SSVF Grantees, assisting with community planning.

Provide technical assistance to grantees and community partners on VA Programs and initiatives.

Host webinars and trainings for grantees and VA and community partners.



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## **April Barney, LCSW** **Grant Per Diem Coordinator**

Ms. Barney serves as a Grant and Per Diem Liaison for the Gulf Coast Veterans Health Care System and previously served Veterans in Oklahoma City with the HUD-VASH Program.

She currently serves VISN 16 as the Grant and Per Diem Lead.



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## **Tom Osowski, PhD LCSW**

### **Preventive Ethics Coordinator**

Dr. Thomas Osowski is a GPD Liaison/Social Worker and Preventive Ethics Coordinator for the Orlando VA Healthcare System. Dr. Osowski has 15 years of clinical experience in the VA Healthcare System, with the last several years focusing on homeless services.

In addition to working in the VA, Dr. Osowski is currently an Adjunct Clinical Professor with the School of Social Work at the University of Central Florida. He is a published author in peer reviewed journals and has received numerous awards for teaching excellence. He has presented at numerous local, state, national, and international venues focusing on his research in trauma and community response to trauma



# Thomas Mattras, MD

## Director of Primary Care Operations



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# VHA Office of Primary Care Overview

- Office of Primary Care (OPC) oversees program and policy related to the delivery of primary care in VHA, as well as implementation of VHA's patient-centered medical home model, the Patient Aligned Care Team (PACT).
- VA Primary Care honors America's Veterans by providing quality and accessible primary care to all Veterans through PACT, placing the Veteran at the center of their health care team.
- OPC promotes team-based, patient-centered care that focuses on a personalized, integrated, comprehensive and coordinated approach to health care.
- OPC actively partners with other VHA Program Offices to develop and evaluate innovative programs that integrate VHA resources into the PACT model. Stakeholders include, but are not limited to:
  - Homeless Care, Women's Health, Geriatrics, Pharmacy, National Center for Prevention, Social Work, Specialty Care, Office of Veterans Access to Care, VISNs, VA facilities, etc.
- Communication/encounter modalities: Secure Messaging, phone calls, VA Video Connect, F2F; emphasis on timely care when it is needed.



# **Clifford A. Smith, PhD**

**Director, Field Support and  
Analytics, Office of Mental Health  
and Suicide Prevention**



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**Darlene M. Davis, MHA, NHA, RD**

**National HBPC Program Manager  
Geriatrics and Extended Care -  
VACO**

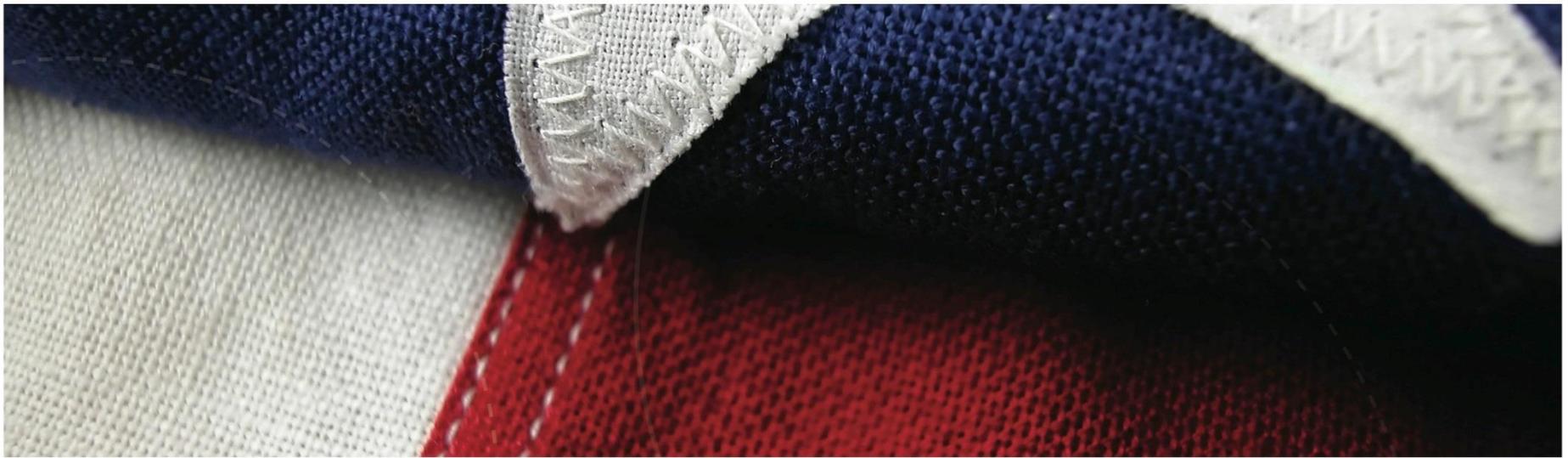


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# Home Based Primary Care

**Darlene M Davis, MHA, NHA, RD**  
**National HBPC Program Manager**  
**Geriatrics and Extended Care- VACO**

# *What is VA Home-Based Primary Care (HBPC) ?*

- HBPC is a Special Population PACT Team
- Comprehensive, longitudinal primary care
- Delivered in the home
- By an Interdisciplinary team: Medical Director, Primary Care Provider (MD, NP, or PA), Nurse, Social Worker, Rehabilitation Therapist, Dietitian, Pharmacist, Psychologist
- Targets patients with complex, chronic, disabling disease
- When routine clinic-based care is not effective

*For those “too sick to go to clinic”*

# HBPC is NOT like Medicare (MC) Home Care

- Different target population
- Different processes
- Different outcomes
- HBPC provides **longitudinal comprehensive, interdisciplinary care** to veterans with **complex chronic disease**

# The HBPC Interprofessional Team

- Program Director
- Medical Director
- Primary Care Provider (MD, NP, or PA)
- Nurse Care Manager
- Social Worker
- Clinical Pharmacist
- Psychologist /Psychiatrist
- Registered Dietitian
- Rehabilitation Therapist (KT, OT or PT)
- Program Support Assistant
- Other team members based on population needs (Chaplain, Respiratory therapist, Recreational Therapist, etc..)



140 HBPC programs nationally in 330 VA locations, with program Average Daily Census ranging from ~50 to over 500 Veterans

# HBPC Goals of Care

- ▶ Promote maximum level of health and independence
- ▶ Reduce the need for, and provide an acceptable alternative to, hospitalization, nursing home care, emergency room and outpatient clinic visits
- ▶ Assist in the transition from a health care facility to home
- ▶ Enhance quality of life through symptom management and other palliative care measures
- ▶ Meet the challenging needs and preferences of the veteran and family / support the caregiver
- ▶ Provide comfort by managing pain and other symptoms

# HBPC Admission Criteria

## **All of the following criteria are to be met in determining whether the Veteran is appropriate for admission to the HBPC Program:**

- a. The Veteran is enrolled in the VA health care system.
- b. The Veteran lives within HBPC's service area designated by each VA medical facility to represent a safe and efficient service delivery area. (often designated by driving time)
- c. The Veteran has serious chronic, disabling conditions that would be amenable to HBPC interdisciplinary intervention.
- d. The Veteran and caregiver voluntarily accept HBPC to provide or support coordinated interdisciplinary primary care.
- e. The Veteran's care needs can be met by the HBPC program.
- f. The Veteran's home environment is adequately safe for the Veteran, caregiver and staff making home visits, and determined to be an appropriate venue for care as determined by the HBPC team.
- g. The Veteran meets at least one of the risk stratification strategies: (a) Patients identified as high risk and referred from PACT- not able or appropriate for ambulatory care health care delivery; (b) Meets, Independence at Home Qualifying criteria (hospitalization in the prior 12 months, post-acute care in the prior 12 months, 2 or more activities of daily living (ADL) impairments, and 2 or more chronic conditions impacting function) or qualifies on the High Needs High Risk List; (c) Nosos greater than 5, (d) 1 year Care Assessment Needs (CAN) score greater than 95.

# Eligibility & Referral

- **Eligibility:**

- Home Based Primary Care is part of the VHA Standard Medical Benefits Package, all enrolled Veterans are eligible IF they meet the clinical need for the service and it is available.
- A copay for Home Based Primary Care may be charged based on your VA service-connected disability status and financial information. You may have a basic copay each time a VA staff team member comes to your home for a medical visit (the same as if you went to a VA clinic).

- **Referral Process:**

- VA Primary Care PACT initiated HBPC Consult
- VA Inpatient initiated HBPC Consult (preferably with PCP approval)
- If no VA PCP assignment, a local program may consider a community or self referral of a VA enrolled & eligible Veteran if they meet clinical need and the service is available.

# VHA Home Based Primary Care

[https://www.va.gov/GERIATRICS/pages/Home\\_Based\\_Primary\\_Care.asp](https://www.va.gov/GERIATRICS/pages/Home_Based_Primary_Care.asp)

## Geriatrics and Extended Care

► Geriatrics and Extended Care

► More Health Care

### QUICK LINKS

 Hospital Locator

Zip Code

 Health Programs

 Protect Your Health

 A-Z Health Topics

  
1-800-273-8255 

  
My Health, My Care: 24/7  Access to VA

## Home Based Primary Care



What is it?



Am I eligible?



What services?



How do I decide?

## What is Home Based Primary Care?

Home Based Primary Care is health care services provided to Veterans in their home. A VA physician supervises the health care team who provides the services. Home Based Primary Care is for Veterans who have complex health care needs for whom routine clinic-based care is not effective.

The program is for Veterans who need team based in-home support for ongoing diseases and illnesses that affect their health and daily activities. Veterans usually have difficulty making and keeping clinic visits because of the severity of their illness and are often homebound, but that is not required.

This program is also for Veterans who are isolated, or their caregiver is experiencing burden. Home Based Primary Care can be used in combination with other Home and Community Based Services.

### Video about Home Based Primary Care



Watch the video to hear what Home Based Primary Care providers, the Veterans they care for, and their families have to say about this program.

# **Daniel Bradford, MD**

**National Director, Intensive Case  
Management Services, Office of Mental  
Health and Suicide Prevention**

**Division Chief, Psychosocial  
Rehabilitation and Recovery Services,  
Mental and Behavioral Health Services,  
Durham VA Medical Center**



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# Jennifer Colbert, LCSW

## SSVF Regional Coordinator



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# ELIGIBILITY FOR COMMUNITY PROVIDERS

# SSVF ELIGIBILITY

- SSVF eligibility is often much easier than determining VHA eligibility
  - Can serve most Veterans without a dishonorable discharge
  - Service time only has to be 1 day of active duty in any branch other than reserves or National Guard (unless activated by the President)
  - Can use the most beneficial service entry if more than one
  - Income restrictions apply

# SQUARES 2.0

- Veterans often present for services in the context of crisis
  - Staff need to be able to quickly verify eligibility
- SQUARES 2.0 has been the fastest and most effective way to do this.
- SSVF Grantees are expected to be using SQUARES to determine eligibility.
  - Other community providers who serve Veterans can have a certain level of SQUARES access (ie: Coordinated Entry)
  - Visit [squares.gov](https://squares.gov) for more information or to find your local SQUARES Manager
- SQUARES will provide a variety of responses and program eligibility, including VA Healthcare.

# INCONCLUSIVE RESULTS

- Sometimes SQUARES will result in a need for further research to determine eligibility
- Relationship with a Veteran Service Officer (VSO)
  - These are very helpful to help read DD 214's when the status is unknown
- Typically, request a DD214 for the Veteran to have; however, not required for services
  - VAMC staff can request access to a site called VBMS through their ISO. If the Veteran has filed a claim, the DD214 is stored here.

# WORKING WITH THE VAMC

- Relationship with POC at the VAMC is important
  - Run HINQ
    - Often, homeless service staff have been given ability to run HINQ's on Veterans, therefore bypassing the time it takes to run it through eligibility
    - VHA eligibility automatically qualifies Veteran for SSVF
- DPRIS
  - Defense Personnel Records Information Retrieval System
  - Authorized users access the system and can view two repositories online in a secure and efficient manner
  - This is the site many VA Staff are beginning to access

Ask a question...



Using data to end Veteran homelessness

## Single Veteran Search

Enter as many fields as possible. Searches without SSN and last name are very unlikely to be successful. For individuals with very common names, searches will almost always fail without SSN.

First Name

SSN

Gender

Last Name

Date of Birth

Search

The details you submitted matched to more than one Veteran. Please review these records and determine which, if any, are a match for the individual you submitted.

FIRST NAME	LAST NAME	DATE OF BIRTH	SSN	GENDER	VETERAN ELIGIBILITY STATUS	CHARACTER OF DISCHARGE
		10/27/1959	***-**-****	M	2-VHA Unknown; SSVF/GPD Eligible	
		10/27/1959	***-**-****	M	7b-No Veteran Record Found: Guard/Reserve with no Active Duty Found	

Description	What it means for SSVF/GPD	What it means for VA health care/ HUD-VASH
2-VHA Unknown: Eligible for SSVF/GPD, but eligibility for VA health care is undetermined. Veteran should apply to determine VA health care eligibility.	Eligible	Apply to determine eligibility
7-Not a Veteran: We could not find any records of qualifying military service for this individual. Usually, these individuals are not eligible Veterans, though there may be exceptions, as VA's records can be missing or incomplete, especially for older Veterans. This status can appear for several specific reasons: a. This individual is reported as still on federal active duty, and is ineligible for Veteran programs until discharge. b. This individual served in the Guard or Reserve, but has no record of federal active duty. Most definitions of Veteran (including those used by SSVF/GPD and VA health care) require an individual to have served at least one day on federal active duty. c. VA has a record of the individual you searched for, but no record of any military service. VA may know this person in another capacity, e.g. as an employee or a dependent. d. VA cannot find any matching record for this individual. Keep in mind this may occur if you did not enter enough information, or if the identifiers you submitted do not match those the VA has on file, e.g. if the individual changed his/her name, or misreported his/her SSN.	Ineligible	Ineligible

**Warning: Some Veterans' records are missing or incomplete, so the lack of a match does not guarantee that the person you searched for is not a Veteran.**

Also note that results are based on a "fuzzy search" and may not be exact matches. Results are not — the Veteran you're looking for.

[See more details about results and eligibility statuses.](#)

Navigation toolbar with icons for save, print, back, forward, page 1 / 2, zoom in, zoom out, and search.

### Information Report 06/30/2020

Combat Pay / Combat Tax Exclusion Periods	Begin Date	End Date	Location
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#### Hazardous Duty Pay

Hazardous Duty Pay Periods	Begin Date	End Date	Location
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#### Profile (BIRLS)

Name: \_\_\_\_\_ Alt: \_\_\_\_\_ File No: \*\*\*\*\*300  
 SSN: \_\_\_\_\_ DOD: \_\_\_\_\_ Military Status: \_\_\_\_\_  
 DOB: 10/27/1959 Gender: Male Education: \_\_\_\_\_  
 Veteran PCA: \_\_\_\_\_

#### Military History (BIRLS)

Service	Component	EOB	RAO	Pay Grade	Char. SRV	SE/Reason
ARMY		02/16/1978	05/20/1978	E1	HON	SAT

DD 214 Entered Through VADS: Yes Reenlisted Indicator: \_\_\_\_\_  
 Vietnam Era Service: \_\_\_\_\_ POW Days: \_\_\_\_\_  
 Gulf War Indicator: No Purple Heart Recipient: \_\_\_\_\_  
 Gulf War Service Start Date: \_\_\_\_\_ Medal of Honor Recipient: \_\_\_\_\_  
 Gulf War Service End Date: \_\_\_\_\_ DD 214 Denial Indicator: \_\_\_\_\_

# **April Barney, LCSW**

Grant and Per Diem Liaison, Gulf Coast Veterans Health Care System

# **Tom Osowski, PhD, LCSW**

Preventive Ethics Coordinator, Orlando VA Healthcare System

Grant and Per Diem Liaison, Senior Social Worker



# GPD Program Eligibility

- Homeless Veteran
- **ELIGIBLE** FOR SERVICES: (Source: 3/15/2017 Memo: Eligibility for Certain VA Homeless Programs – VA Deputy Under Secretary for Health for Operations and Management.)
  - Honorable Discharge
  - General Discharge
  - Other than Honorable Discharge
  - Bad Conduct Discharge (from a Special Court Martial)
- **NOT ELIGIBLE** FOR SERVICE:
  - Dishonorable Discharge
  - Bad Conduct Discharge (from a General Court Martial)



# GPD Program Eligibility

- Non-VA Healthcare Eligible Veterans
- Goal: to provide the same high-quality connection to community-based services:
  - Medical
  - Mental Health
  - Substance Use
  - Housing
  - Employment
  - Financial



Vignette #1

Let's meet  
Jose!

# GPD Liaison Dual Role

## **MICRO FOCUSED**

- Connection to Clinical Needs
- Helping Veteran connect
- Helping Program connect
- Facilitate communication
- Facilitate positive health connections

## **MACRO FOCUSED**

- Connection to Program Oversight
- Billing
- Eligibility verification
- Inspections
- Policy/Program changes
- Problem solving

# Making the Connections

- Know your specific VA site process:
- Medical
- Mental Health
- Substance Use Disorder Services
- Dental
- Vision
- Prosthetics



# Looking at the WHOLE PERSON

- 1. Discuss healthcare and mental healthcare with Veteran
- 2. Mental healthcare and Medical healthcare as part of screening
- 3. Normalize healthcare and mental healthcare as part of services
- 4. Establish partnerships with careproviders
- 5. Track changes in health/mental health and evaluate services



# Vignette

- Let's see how Jose is doing in the GPD program.

Connecting in new ways, and using traditional methods.

Face to Face

Phone

VVC

Secure Messaging

# Contact us:

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