Coronavirus Disease 2019 (COVID-19) Medical Monitoring Protocol for Utilization by SSVF Health Care Navigators

Background

- SSVF Health Care Navigator is a new position created in August 2020.
- SSVF National Program Directors recommend that when possible SSVF Health Care Navigator positions be filled by Licensed Clinical Social Workers (LCSW).
- A medical monitoring protocol specifically for COVID-19 has been created given the complex impact that COVID-19 pandemic has had on all aspects of life.

Purpose

- Provide guidance on how to navigate local VA medical center's COVID-19 medical services
- Inform non-medical clinicians, such as LCSW, about the basics of COVID-19 screening
- Recommend COVID-19 patient education tools

Responsibilities

- SSVF National Program Directors set expectations for their SSVF grantees and will offer them training to meet these expectations.
- SSVF grantee program managers are tasked to evaluate if their Health Care Navigators understand these expectations and are appropriately utilizing them. The SSVF grantee program managers should proactively reach out to SSVF Regional Coordinators with questions and/or further guidance.
- SSVF Health Care Navigators are tasked to learn and apply these expectations and to proactively seek consultation from their program managers when needed.
- As this protocol is designed for Veterans eligible for VA medical care, SSVF Health Care Navigators will need to utilize other procedures to assist in the medical monitoring of Veterans' family members and Veterans not eligible for VA medical services.
- Homeless-Patient Aligned Care Team (H-PACT) National Program Director will inform SSVF National Program Directors when VA medical centers create new H-PACT teams and retire existing H-PACT teams. SSVF National Program Directors will disseminate this information to SSVF grantee program managers. *Attachment H-PACT* includes current list of active H-PACT teams.
- Local VA medical center's homeless coordinator will facilitate introduction of local SSVF Health Care Navigator(s) with medical contacts at the local VA medical center. Also, local VA medical center's homeless coordinator will coordinate the sponsorship of SSVF Health Care Navigator's Work Without Compensation status.

VHA Medical Care Framework

- The hub of the physical care provided by VA medical centers is the outpatient primary care team.
- VHA utilizes the PACT model for their outpatient primary care team. PACT team uses a team-based approach with the Veteran at the center of the care team which contains the Veteran's family members, caregivers, and health care professionals, including primary care provider (PCP), nurse care manager, clinical associate, and administrative clerk. When other services are needed to meet Veteran's goals and needs, another care team may be called in.

- Depending on the VA medical center, the primary care service can be aligned under Ambulatory Care Services or Medicine Service or both. Some VA medical centers have specialized PACT teams, such as Homeless-PACT. Another specialized PACT team is Women's Health PACT.
- Routine Use #30 to the Federal Register Privacy Act Systems of Records Notice provides legal authority to VA medical center staff to disclose relevant health care and demographic information to such agencies as SSVF grantees for the purpose of coordinating care for Veterans engaged in VA Homeless Programs without a formal data sharing agreement between VA medical center and SSVF grantee or prior signed, written authorization by Veteran. *Attachment Routine Use #30* gives further details.

Accessing VA Care

- VA Benefits Eligibility: Determine either online or calling (877) 222-8387 Monday through Friday between 8:00AM and 8:00PM EST. Potential health care benefits include physical, behavioral, surgical, and dental.
- VA Resource Locator: This online resource helps Veterans easily find VA resources in their area including Suicide Prevention Coordinators, crisis centers, VA medical centers (VAMCs), community-based outpatient clinics, Veterans Benefits Administration offices, and Vet Centers. More information is available at resource locator.
    - Once at a specific VA medical center's website, can locate the directory of health care services offered by that medical center on the left side of the page.
- VA Clinical Contact Centers: Veterans who are enrolled in VA health care can obtain virtual urgent care. To access: Call (844) 698-2311. Press 3. Enter your zip code. System will auto-dial to the local VAMC. At addition prompts, select "talk with a nurse" or "operator."
- Women Veterans Program Manager: All VA medical centers have a designated Women Veterans Program Manager to help women Veterans access VA benefits and health care services.
- Women Veteran Call Center: Women Veterans can call 1-855-VA-WOMEN (1-855-829-6636) to ask questions about available VA services and resources.
- Schedule and View VA Appointments Online: Site
- Average Wait Times at Individual Facilities: Site

Recommended Approach to COVID-19 Medical Monitoring

- Establish partnerships at local VA medical center starting with homeless coordinator. This homeless coordinator can facilitate introductions directly with nurse managers of various medical teams or the Administrative Officer of a Service who can then direct the introductions. Services to contact include Emergency Medicine Service and service(s) that house the local VA medical center's outpatient primary care teams; some VA medical centers have created outpatient teams that specialize in the care of Veterans diagnosed with COVID-19.
- Purposes of these introductions with these medical teams are to (1) make them aware of the services that SSVF Health Care Navigators can and cannot provide to Veterans; (2) make SSVF Health Care Navigators aware of how they can facilitate obtaining medical care for Veterans, including establishing primary care for Veterans who do not have a designed primary care provider at the local VA medical center; (3) proactively create a process to address when Veterans screen and/or test positive for COVID-19, including when to utilize the VA Clinical Contact Centers.
- Remember primary care providers or their designees are the clinicians who provide outpatient COVID-19 medical care. Thus, it is important that all Veterans eligible for VA medical services have an established primary care provider prior to Veterans becoming ill from COVID-19.
- Patient education regarding COVID-19 infection prevention plan is as important as developing partnerships with local VA medical center's medical teams. This COVID-19 infection prevention plan should include Veteran being aware of COVID-19 symptoms, COVID-19 infection prevention and control measures, how and when to contact primary care provider and VA Clinical Contact Centers, and VA self-monitoring tools (please see below). This plan

should also include Veteran having an established primary care provider. If the Veteran does not have a one, then assist Veteran in obtaining a primary care provider. If the Veteran declines, then utilize motivational interviewing skills to determine the reason for declining and assist in addressing this reason.

Patient education: The reality is that some people who acquire COVID-19 will experience a rapid decline in their health (as in days). Patient education and self-monitoring tools might assist in detecting this decline faster as compared to solely depending on clinician intervention.

- Assess how Veteran learns the best. Assessment methods include: (1) asking Veterans if they learn better if someone verbally tells them information, if they read the information, or both; (2) knowing Veterans' highest educational level that they completed; (3) knowing if Veteran has any visual, hearing, or cognitive difficulty; (4) knowing Veterans' preferred language for patient education information (both verbal and written); (5) After the Veteran processes the patient education information, ask Veterans questions about the patient education information to determine their comprehension.
- Provide concrete and consistent patient education to Veterans. The purpose of this education is to increase and maintain Veterans' health literacy about COVID-19 prevention, control, and symptoms along with when to seek medical attention for COVID-19 treatment. CDC has created such instructions in many languages. Resource can be found here. Another example is HUD-VASH Social Isolation Care Packages: A Strong COVID-19 Practice.
- Provide VA self-monitoring tools: (1) VA Mobile app Annie: Helps monitor symptoms and advises when to contact Veteran's VA care team or CCC. Link here; (2) COVID-19 screening tool (which employees and Veteran patients can utilize): link; (3) Remote Patient Monitoring – Home Telehealth (RPM-HT): Veteran's VA prescriber enters a RPM-HT consult for COVID-19 home monitoring. Depending on HT's assessment, Veterans may be prescribed kits, which include thermometer and pulse oximeter, and case management;(4) COVID Coach app: link.
- Educate Veterans on how to make their own masks if they do not have access to masks (link).

Mechanism for Health Care Coordination

- VA offers Work Without Compensation (WOC) employment status. Although the VA does not pay the WOC employee, WOC status enables WOC employee further health care coordination opportunities, such as access and using VA electronic resources including electronic medical records. An additional step will need to occur for WOC employee to be issued a VA email address and account. Example of one VA medical center's WOC application process is found here.
- WOC employees who need to provide care coordination will need to go through local VA medical center's credentialing and privileging process.
- Once WOC employee has VA employee PIV card and a card reader, WOC employee can access VA electronic resources remotely using non-VA computers through VA Citrix Access Gateway (CAG). *Attachment CAG* describes how to use CAG.
- A Service within the local VA medical center will need to sponsor a WOC status for SSVF Health Care Navigators. The local VA medical center's homeless coordinator will coordinate the sponsorship of SSVF Health Care Navigator's Work Without Compensation status.

COVID-19 Medical Monitoring Protocol: Screen or Test Negative for COVID-19

1. Determine if Veteran has an established primary care provider.
    a. If Veteran doesn't have an established primary care provider, then assist Veteran in obtaining one. If the Veteran declines, then utilize motivational interviewing skills to determine the reason for declining and assist in addressing this reason.
2. Contact Veteran at least once a week.

3. During each contact, review Veteran's COVID-19 infection prevention plan and ask screening questions. *Attachment SSVF COVID-19 Guidance Health and Symptom Check* lists questions.

COVID-19 Medical Monitoring Protocol: Screen or Test Positive for COVID-19

1. Follow established process that SSVF Health Care Navigator and local VA medical center have created to address when Veterans screen and/or test positive for COVID-19, including when to utilize the VA Clinical Contact Centers.
2. During each contact, review Veteran's COVID-19 infection prevention plan.
3. Follow local public health department's and SSVF grantee management's recommendations regarding employee COVID-19 testing and isolation/quarantine.
4. Follow local public health department's and SSVF grantee management's recommendations regarding when SSVF Health Care Navigator can resume providing Veteran face-to-face care. In the interim, virtual care should be provided.

Attachments

H-PACT

H-PACT.xlsx

Routine Use #30

Routine Use 30_Final.pdf

CAG

CAG StoreFront Windows and Mac (

SSVF COVID-19 Guidance Health and Symptom Check

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