VA | U.S. Department of Veterans Affairs

Health Care Navigator Manager and Supervisor Office Hour February 19, 2021

Link to Audio

WEBINAR FORMAT

- Webinar will last approximately 1.5 hour
- Participants' phone connections are "muted" due to the high number of callers
- Questions can also be submitted anytime to SSVF@va.gov

QUESTIONS…


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AGENDA

- Welcome and Introductions
- Recap of Health Care Navigator History and Program Office Training/Support
- SSVF Vaccine Coordination Support Expectations
- SSVF HCN VA and local Coordination
- HCN Supervision and Internal Support
- Questions

HEALTH CARE NAVIGATORS IN CONTEXT

- HCN Role mandatory for SSVF as of fall 2020
- Additional CARES Act funds allowed for HCN hiring
- VA views Health Care Navigation as a critical new service within the SSVF portfolio
- Goal is to continue to offer HCN services in perpetuity even though CARES funding may subside in 2021/2022
- Health Care Navigation is an added SSVF services, not a separate program

HCN Program Office Support to Date

REGIONAL COORDINATOR AND DIRECT TECHNICAL ASSISTANCE

- Ongoing availability via email and direct contact for support

- Community of Practice Series
  - 6 Regional sessions over twelve weeks
  - Focus on onboarding, program integration, service design
  - Offers RC, TA and sharing of lessons learned with colleagues
  - 2nd round likely in Spring 2021 for those HCNs not included in first round

HOUSING SKILLS PRACTICE CENTER

- HSPC is a Learning Management System that has self-paced online trainings
- Three required HSPC Training for HCNs
  - Health Care Navigation 101
  - Professional Boundaries and Service Strategies
  - VA Health System 101
- Other trainings include multi-part SSVF RRH 101 series for all staff, income maximization and more coming soon
- More content specific to HCNs being planned for spring 2021
- SSVF Grantee Learning Manager should ensure HCN has access to system

WEBINARS, OFFICE HOURS AND OTHER SUPPORT

- Ongoing webinars and Office Hours to Support HCNs
  - Introductory content, focus and positon overview
  - Vaccine coordination expectations and needs
  - Connecting to VA Medical Center POCs and Coordination
  - Non-VA Health and Behavioral Health Services
  - Highlight other grantee examples, program office priorities and other topics

- Office hours and Webinars, along with other online training, will continue as needed

HCN Role and Overview

WHAT IS A HEALTH CARE NAVIGATOR?

- SSVF health care navigators will work with Veterans on a variety of issues to assist them in identifying and overcoming challenges to accessing the healthcare system or adhering to recommended health care plans

- SSVF health care navigators are (or will be) trained to assist Veterans with the following:
  - Gaining access to health care
  - Supporting health care plans by identifying barriers to care and supporting Veteran in accessing care
  - Providing education on wellness related topics

WHAT DO SSVF HCNS DO? BIG PICTURE

Assist Veterans in accessing healthcare systems

- Work with the Veteran to identify a health navigation plan that meets the Veteran's unique needs, choices and goals
- Gaining entry to VA health care (including mental health care) or community care when Veterans are not interested in or eligible for VHA
- Connecting Veterans to VA health care by working with the VAMC to facilitate enrollment
- Helping with documentation and paperwork required for enrollment
- Following up on enrollment progress to ensure that the Veteran is enrolled in VA or community health care services
- Coordinating with health partners to ensure Veteran has access and can follow through with health care needs and plans and appointments

WHAT DO SSVF HCNS DO? DAILY EXAMPLES

- Help Veterans get access to appointments when needed
- Assist Veterans in utilizing services, including preventative health care
- Help Veterans identify barriers to meet goals in health care plans
- Assist Veterans in understanding and communicating with providers to make informed decisions about health care
- Problem-solve barriers to care (i.e. transportation, childcare, communication)
- Provide education or create linkages for Veterans and other staff to learn about wellness related topics. This could include education for other SSVF staff to help build broader organization expertise.

PROGRAM EXPECTATIONS

- All Veteran households enrolled in SSVF should be assessed for HCN needs and have access to some level of Health Care Navigation, if needed, but may be limited depending on need/caseload
- Veteran family members can also receive health care navigation services
- Veterans must be enrolled in SSVF, but should not be enrolled in SSVF solely for the purpose of HCN services
- HCN is NOT a separate program; it is added service to SSVF
- SSVF's core mission of assisting Veterans in obtaining or remaining permanently housed remains

CLARIFYING ROLES

Role of Housing Navigators

- conduct housing barrier assessments
- assist with documentation
- assist with completing housing related paperwork
- identity housing preferences
- connect Veteran to landlords
- assist with lease up process
- provide help with move-in costs (deposit, rent, utilities)

Role of Health Care Navigators

- assist with healthcare enrollment
- help gain access to appointments
- help develop care priorities based on Veteran desires
- identify barriers to health care goals
- help with transportation to health care appointments using normal SSVF funds encourage communication with health care providers
- ensure coordination of care

SSVF AND CLINICAL CARE

- SSVF grantees CANNOT provide direct health care services; navigators are not health care providers and do not deliver direct patient care
- Mental health counseling is not an eligible SSVF activity and therefore not within the scope of the SSVF health care navigator's job duties
- SSVF Supervisors/Managers need to help balance role that has clinical underpinnings but is not direct clinical care

PRIMARY AREAS OF NEED/FOCUS AT ONSET

- Creating linkages to VAMCs and local health resources
- Create, with supervisor support, internal process map/policies for HCN service integration into SSVF portfolio
- Understand, with supervisor support, how HCNs will communicate, collaboration and coordinate with other SSVF staff and the Veteran
- Create, with supervisor support, process for prioritizing Veterans who need more immediate or intensive health care navigation services
- Ensure primary focus on those Veterans for whom health care access is a barrier and who desire navigation assistance in accessing health and behavioral health supports

HCN Coordination Expectations

HCN VAMC RELATIONSHIP

- SSVF Health Care Navigators will establish working relationships with VAMC staff to ensure coordination and collaboration.
- Routine Use 30 states that the VA may disclose relevant healthcare and demographic information to health and welfare agencies, housing resources, and community providers, consistent with good medical-ethical practices, for Veterans assessed by or engaged in VA homeless programs for purposes of coordinating
- VA Memo dated Oct 10, 2019 *Coordination of Homeless Services* requires all VAMCs to establish an SSVF Point of Contact (POC)
- VA Memo dated July 16, 2020 *Protocol for Homeless Veterans..* requests that VAMCs offer immediate appointments to Veterans residing in SSVF hotels

SSVF HCN AND VA SERVICES AND COORDINATION

- Each VAMC should have an assigned SSVF POC; role and activity of POC likely varies across country
- VA SSVF POCs may assist HCN in understanding how Veterans receive primary care appointments
- VA SSVF POCs may assist with the initial coordinating process and with bridging initial communications with other VA teams such as MHICM, HPACT, HBPC and Mental Health (see appendix)
- Reach out to your SSVF Regional Coordinator or review the spreadsheet included with this presentation for POC contact information

SSVF HCN AND NON-VA SERVICES

- Some Veterans will want to engage in non-VA services or may live in areas where non-VA services are more readily available/accessible
- Each HCN should become familiar with the process to enroll in Non-VA health care benefits and should compile a resource guide
  - Health Care Coverage
  - Behavioral Health Supports
- Veteran family members may be eligible for or need support in accessing non-VA health care system

REDUCING HEALTH DISPARITIES

- Implement Data Informed Practices
- Partner with local organizations that are deeply connected in communities that have disparate health outcomes
- Leverage the expertise of communities with disparate health outcomes and create shared goals for reducing disparities
- Collaborate with Veterans with lived expertise

SSVF VACCINE Coordination

SSVF AND COVID-19 VACCINES

- SSVF Program Office goal is that grantees facilitate access to COVID vaccinations for Veterans as soon as they are available
  - SSVF staff, particularly HCNs, are expected to work with their VAMC, and with the community planning process for vaccinations for people experiencing homelessness, to ensure Veterans enrolled in SSVF have access to vaccinations

VACCINE ACCESS PLAN - SSVF

- Health Care Navigators connect all SSVF participants
- Community access may be preferable to VHA (vaccine availability or transportation barriers)
- Coordination needed to ensure both doses scheduled and received
- Requires internal and external coordination and support across staff and services

PROCESS TO ACCESS VACCINE FOR VETERANS – VAMC

- Contact Homeless Program Manager at local VAMC as soon as possible.

- All Veterans enrolled in SSVF, whether they are currently homeless or housed, are considered homeless under the VHA's vaccine plan.

- Veterans will probably need to go to the VAMC for vaccination – transportation should be facilitated by grantee, VAMC or other sources

PROCESS TO ACCESS VACCINE FOR VETERANS – COMMUNITY

- Contact local CoC to determine if they are planning for vaccine distribution for people experiencing homelessness and program staff.

- If CoC is not working on a vaccine distribution plan, then contact local public health department

- Follow-up on community process to include SSVF program in vaccine distribution to homeless programs. Stay up to date on changes in vaccine plan for community.

PROCESS TO ACCESS VACCINE FOR SSVF STAFF

- If SSVF staff are not VHA Eligible Veterans then they cannot receive vaccine from local VAMC.
- Staff may be able to receive vaccine through their health provider or from the local public health department.
- The federal government designated staff and management of outreach programs, homeless shelters, and other programs sustaining human life as essential workers.
- Agency leadership can reference this memo when identifying staff that should be prioritized for vaccinations. Sample letter for public health is available

HCN Supervision, Support and Consultation

HCN SUPERVISOR AND MANAGER GOALS

- All HCN must be **acclimated** to the SSVF Program Mission, Goals, and Service Provisions
- All HCN and Supervisors/Managers should work together to **develop processes and procedures** that are equitable to all Veteran Families being served.
- Supervisors/Managers will need to ensure roles and responsibilities **between staff are clarified** while supporting communication among staff
- Supervisors/Managers will need to provide regular and **ongoing support** to HCN for role development and process improvements.

ACCLIMATION TO SSVF

- SSVF Program Guide
- LMS Trainings (general, military culture and HCN)
- Education about different roles and responsibilities within local SSVF Grantee Agency
- Present and discuss position description and expectations
- Develop meeting schedule for ongoing supervision

PROCESS MAPPING AND DEVELOPMENT

- Work with HCN to develop a streamlined procedure for equitable internal service coordination
- Work with HCN to develop an equity informed prioritization strategy for engagement in navigation services
- Work with HCN on Veteran centered assessment tools/approaches that focus on Veteran's desires and priorities
- Work with HCN to develop a balanced case load sizes, based on varying level of Veteran need and service intensity

PROCESS MAPPING AND DEVELOPMENT CONTINUED

- Review HCN actions and services to ensure they compliment housing services and avoid confusion

- Develop internal plan for HCN communication, case file management, and HMIS documentation protocols within the context of SSVF Program housing focus

INTRA-AGENCY UNDERSTANDING AND COMMUNICATION

- Provide initial and ongoing education to other SSVF Staff about the role of the HCN.
  - Support internal discussions to ensure clarity of roles across staff
  - “Role with resistance” and acknowledge active development of the HCN role

- As process and procedures are developed for accessing and ending HCN supports, ensure the information is clearly communicated to all other SSVF staff
  - Actively seek constructive feedback about processes and do not wait to long to correct course when problems arise

- SSVF Program Office recommends supervisors/managers work with the HCN and all staff to develop a data collection plan.
  - The data collected should help understand service delivery needs, and promote equity in service coordination

HCN SUPPORT

- Support HCNs in making difficult decision in how to allocate time when competing needs arise
- Support the time needed to connect to and learn how to navigate the VAMC and Veteran resources both local and national for medical, behavioral health, and benefits needs
  - This will include Veteran Service Groups, Veterans with Lived Expertise Groups, and Veterans Benefits Administration
- Support the time needed to connect to and learn how to navigate non-VA resources and build health and behavioral health related expertise and portfolio

Successful Supervision:

- Evaluating job performance, enhancing strengths, identifying and improving weaker areas, and accountability
- Review of client caseload, client plans, and client issues
  - Discuss current status of individual health goals/plans with intentional conversations about how to plan for case closing. "Beginning with the end in mind."
- Review developed processes and procedures to make improvements and reduce barriers to care
- Review Documentation to ensure meets agency standards
- Discuss the HCN's role as a team member on-site and when working with community collaborators
- Discuss how HCN work fits into the context of the agency/program

HCN CONSULTATION STRATEGIES

- Provide a safe space for a general check-in. This can facilitate a “normal” space to address:
  - HCN self-awareness, self-care and introspection and how this influences their service delivery
  - HCN use of self while providing a place to reflect on any transference or counter transference issues and how their own triggers can influence the way they deliver services
  - Areas a HCN may need support to manage stress and time, reducing chances of burn out
- It will also be important for Supervisors to address any boundary issues that may arise.

HCN CONSULTATION STRATEGIES

- Provide an opportunity to share successes and challenges, and utilize those as opportunities for growth and skill development
- Offer cross training or mentorship when skill deficits are identified
- Trainings should include discussion of culture, e.g., race/ethnicity, Veteran culture, and a review of health disparities.
  - The role of the HCN provides an important service that will begin to reduce these health disparities and barriers for our most vulnerable Veterans to get the care and services they need.

PREPARING FOR THE HARD CONVERSATIONS

1. Continually work to establish trust and authentic rapport between HCN and Supervisor

2. Create a safe and consistent time to meet and go over difficult situations and circumstances (supervision)

QUESTIONS / DISCUSSION