



U.S. Department  
of Veterans Affairs

# SSVF Health Care Navigators

August 13, 2020

Updated Guidance and FAQ available  
[www.va.gov/homeless/ssvf](https://www.va.gov/homeless/ssvf)

Link to Audio



## SSVF HEALTH CARE NAVIGATORS

- On July 16, 2020 SSVF was awarded \$400 million in supplemental CARES funding
- A portion of this funding will be used by SSVF grantees to employ designated health care navigator(s) to work with VAMCs and other healthcare systems ensuring appropriate care coordination for Veterans



## WHAT IS A SSVF HEALTH CARE NAVIGATOR?

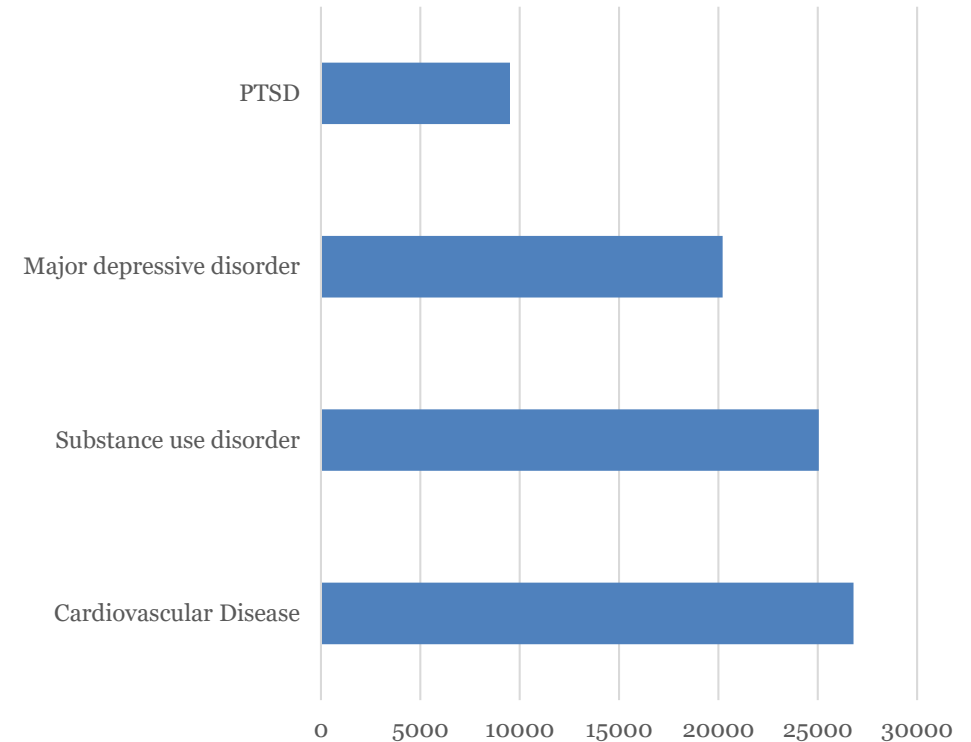
- SSVF health care navigators will work with Veterans on a variety of issues to assist them in identifying and overcoming challenges to accessing the healthcare system or adhering to recommended health care plans
- SSVF health care navigators are trained to assist Veterans with the following:
  - Gaining access to health care
  - Supporting health care plans by identifying barriers to care
  - Providing education on wellness related topics



# WHY DOES SSVF NEED HEALTHCARE NAVIGATORS?

2018 [VA Annual Report](#)  
indicated that 63% of SSVF  
Veteran participants had a  
disabling condition

Major Health Problems- SSVF Exiters





## WHY DOES SSVF NEED HEALTHCARE NAVIGATORS?

- One study showed that homeless Veterans have higher rates of chronic disease than non-veteran homeless (Goldstein, Luther, Jacoby, & Haas, 2008)
- Veterans who rely primarily on VA emergency rooms often receive fragmented care
- 20% of Veteran emergency room utilizers returned to the ER again within 30 days (Hastings et al, 2011)





## WHY DOES SSVF NEED HEALTHCARE NAVIGATORS? (2)

- Veterans reported that the VA eligibility process can be overly complicated and difficult to access (Blue-Howells, McGuire, & Nakashima, 2008)
- Veterans may have barriers to accessing care or keeping health care appointments, lack of transportation or childcare, for example
- Veterans can benefit from education about available health related resources and benefits



## WHAT DO SSVF HEALTH CARE NAVIGATORS DO?

- Health care navigator programs have been used by VA to assist Veterans with specific health care needs such as cancer or other chronic illnesses
- Health care navigators are effective at improving access to care
- Navigator programs have been successful at decreasing no show rates and increasing health screenings in healthcare systems, (Ali-Faisal et al)



# WHAT DO SSVF HEALTH CARE NAVIGATORS DO?

## Assist Veterans in accessing healthcare systems

- gaining entry to VA health care (including mental health care) or community care when Veterans are not eligible for VHA
- connecting Veterans to VA health care by working with the VAMC to facilitate enrollment
- helping to gather documentation and complete paperwork required for enrollment
- following up on enrollment progress to ensure that the Veteran is enrolled in VA or community health care services





## WHAT DO SSVF HEALTH CARE NAVIGATORS DO?

- Help Veterans get access to appointments when needed
  - supporting Veterans in identifying health care needs
  - working collaboratively with health care teams to facilitate access to care
- Assist Veterans in utilizing available services including preventative health care
  - communicating with Veterans and health care teams about appointments



## WHAT DO SSVF HEALTH CARE NAVIGATORS DO?

- Help Veterans identify barriers to adhering to recommended health care plans
- Assist Veterans in understanding and communicating with providers to make informed decisions about health care
  - supporting and encouraging Veteran to discuss questions about medication or treatment goals with providers
- Problem-solve barriers to care (i.e. transportation, childcare)



## WHAT DO SSVF HEALTH CARE NAVIGATORS DO?

- Provide education or create linkages for Veterans to learn about wellness related topics
  - providing pamphlets or other literature on smoking cessation, diabetes management, exercise
  - inviting guest speakers to education groups on health-related issues for Veterans
  - linking Veterans to support groups or other programs at the VA or in the community to support their health goals



## WHO ARE HEALTH CARE NAVIGATORS?

- Social workers with an LCSW or equivalent background are often hired as health care navigators
- Health care navigators are familiar with social services or healthcare settings
- Health care navigators communicate effectively with Veterans and health care teams
- Must be able to establish relationships with Veteran, health care teams, and community service providers



## WHO ARE HEALTH CARE NAVIGATORS?

- Reminder - SSVF grantees do not 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 health care navigators do not make treatment recommendations





## INCORPORATING HEALTH CARE NAVIGATORS INTO YOUR TEAM

- SSVF health care navigators can be hired directly as permanent or temporary employees
  - a sample SSVF health care navigator position description is available on the SSVF website
- Health care navigators can be acquired by contracting with an organization that provides these services
  - contract staff are required to participate in all SSVF health care navigator training and activities
  - SSVF grantees must provide adequate oversight of contracted staff providing services



## INCORPORATING HEALTH CARE NAVIGATORS INTO YOUR TEAM

- The health care navigator must understand their responsibilities and role in the SSVF team
- SSVF program managers should introduce the new health care navigator to their team and clearly outline the role and job duties of the position
- The health care navigators should be introduced to community providers and VA including the homeless team, VA enrollment staff and HPACT



# INCORPORATING HEALTH CARE NAVIGATORS INTO YOUR TEAM

- Role of Housing Navigators

- conduct housing barrier assessments
- assist with documentation
- assist with completing housing related paperwork
- identify 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 enrollment
- help gain access to appointments
- identify barriers to health care goals
- help with transportation to health care appointments
- encourage communication with health care providers
- ensure coordination of care



## NEXT STEPS

- The SSVF program office will provide initial training to the health care navigators in October 2020 to ensure that they understand their role and responsibilities in terms of providing services to Veterans
  - training will combine pre-recorded webinars and live (remote) training modules
  - training will provide SSVF health care navigators with a basic understanding of VA and community health care, mental health and substance use treatment resources available to Veterans



# QUESTIONS

Questions will be held until all presentations are finished





# CITATIONS

Ali-Faisal, SF, Colella TJ, Medina-Jaudes N, Benz Scott L (2017) The effectiveness of patient navigation to improve healthcare utilization outcomes: A meta-analysis of randomized controlled trials. Patient Educ. Counseling 100 (3):436-448

Blue-Howells, J., McGuire J., Nakashima J (2008). Co-location of health care services of homeless veterans: a case study of innovation program implementation. Social Work in Health Care, 47, 219-231.

Goldstein, G, Luther JF, Jacoby AM, Hass GL, Gordon AJ. A Taxonomy of medical comorbidity for veterans who are homeless. J Health Care Poor Underserved. 2008;19(3):991-1005. doi:10.1353

Hastings, S.N., Smith, V.A, Weingberger, M., Schrader, K.E., Olsen, M. K., & Odone, E.Z. (2011). Emergency department visits in Veterans Affairs medical facilities. The American journal of managed care, 17(6 Spec No.), e215-23

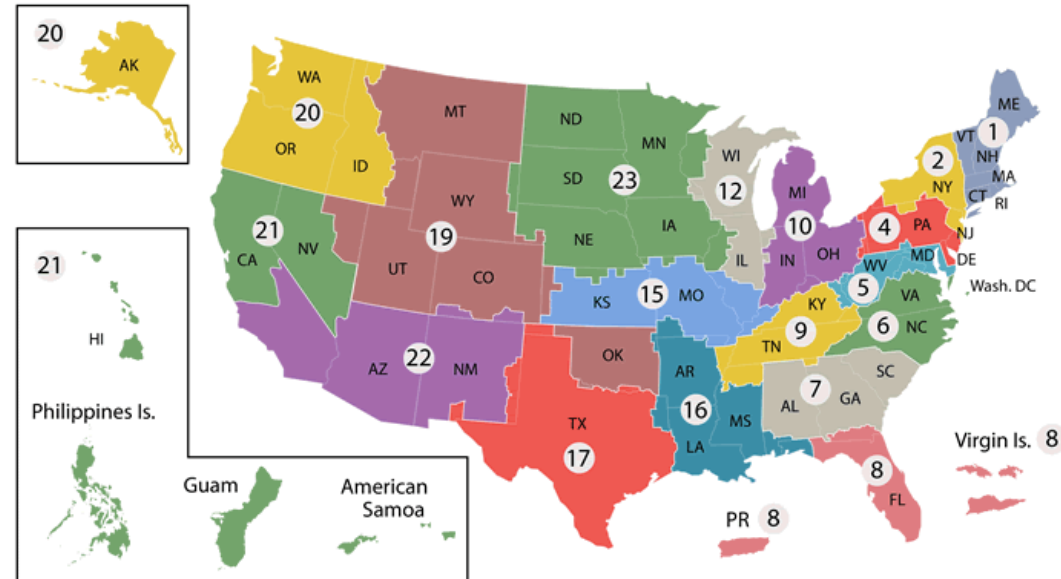
## SSVF & VA Coordination

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Regional Coordinator, SSVF Program Office



# VISN 1 Coordination

- Shara Katsos, VISN 1 Deputy Homeless Coordinator
- John Chiechi, Grant Per Diem Liaison with VA Connecticut Healthcare System



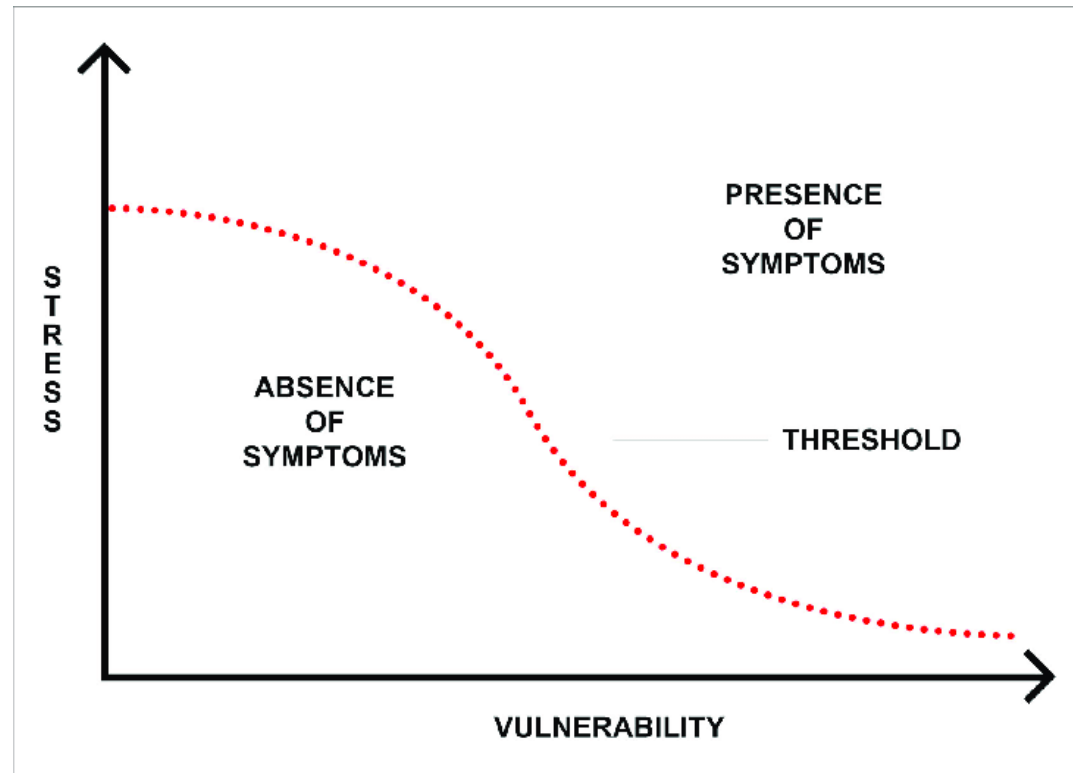
# Hotel/Motel Placements in New England

- 12 SSVF Grantees
- From March 17, 2020 – July 30, 2020, SSVF Grantees placed **434** Homeless Veteran Households in hotel/motels with Emergency Housing Assistance (EHA) in VISN 1
  - High-risk for COVID-19
  - Unsheltered
  - Asymptomatic in need of quarantine



## Risk Factors

- Increased stress during global pandemic
- Increased isolation in hotel/motel
- Impact of demonstrations against racism
- Reduced access to affordable ways to purchase and prepare food
- More limited supportive services and ability to search for housing





How does Case Management  
increase Protective Factors for  
Veterans placed in hotel/motels?



## VAMC & SSVF Coordination Formalized Plan



The goal is to collaborate with SSVF to provide VAMC services for healthcare eligible Veterans placed in hotels.



# Process

- 1) Established VAMC SSVF Point of Contact (POC) to ensure VA services (i.e. mental health, substance use disorder, medical, housing...) are in place for SSVF participants in hotels
- 2) SSVF Grantees will hire Health Care Navigators to work with POC
- 3) Ongoing case conferencing for those in EHA



# What helped make this work?



Choose **VA**

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# Contact Information



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**VA**



# U.S. Department of Veterans Affairs

VA Greater Los Angeles Healthcare System

Natalie Lusk, LCSW - Coordinated Entry Specialist

# Background

- As SSVF grantees began enrolling Veterans in EHA, VA and community partners identified the need to track placements and link to VA resources.
- SSVF grantees submitted HMIS numbers for Veterans enrolled in EHA to the COC Veteran Coordinator and VA CES. We reviewed data in VA and community systems, and then referred to VASH for potential screenings.

- Recognized the need for SSVF and VA points of contact to connect in order to help facilitate housing plans with the Veteran.
- Included SSVF and VA points of contact on revised tracker.
- Recognized the need to also link Veterans in EHA to HPACT, providing medical support to Veterans and SSVF grantees in the community.

# EHA – VA Tracker

Clarity ID	Name	SSN #	Age	Race/Ethnicity	Acuity Score	CERS program	VA Notes and POC	HMIS Notes	HPACT Assignment: yes/no	HPACT Team #	Veterans Phone #	SSVF POC	Motel
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