U.S. Department of Veterans Affairs

SSVF Health Care Navigators

November 6, 2020

Updated Guidance and FAQ available
www.va.gov/homeless/ssvf

Link to Audio

SSVF HEALTH CARE NAVIGATORS - AGENDA

- Brief Review of Health Care Navigator Role
- Importance of Health Care Navigators
- Overview of Outreach to VA Medical Center Partners
- Tools, Training and Resources
- HMIS Documentation
- Next Steps

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?

- 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
- Homeless Veterans are 4 times more likely to use emergency rooms than non-homeless Veterans (Tsai, Doran & Rosenheck, 2013)

Assist Veterans in accessing healthcare systems

- 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 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
  - establishing relationships and 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
  - understanding resources available to make referrals

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

SSVF HEALTH CARE NAVIGATORS

- 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 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

SSVF 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

SSVF HEALTH CARE NAVIGATORS – OUTREACH TO VA

- SSVF Health Care Navigators will establish working relationships with VAMC staff to ensure coordination and collaboration
- 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 HEALTH CARE NAVIGATORS – VA POC

- 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 HEALTH CARE NAVIGATORS

- SSVF Program Office in partnership with technical assistance providers has developed sample tools that grantees may use
  - Screening Tool
  - Health Care Navigator Assessment Tool
  - Navigation Plan
- The tools were developed as samples to assist grantees, but these are not required
- The sample tools can be modified to meet individual client or agency needs

Screening Tool

- Can be administered to all SSVF participants to determine if referral to HCN is appropriate
- Collects information on the following
  - access to benefits and insurance
  - basic health status
  - unmet health needs
  - Veteran desire for additional health support
- Some information is collected on the screening tool only and should be provided to the HCN

Assessments

- Collects significantly more information on Veteran's health status, access to medical care, and health needs
- Highlights service gaps, unmet needs, and necessary referrals
- Informs development of a comprehensive service plan
- Two versions of the assessment tool are available
  - Abridged assessment collects high level health information
  - Detailed assessment collects detailed information on health symptoms and substance use

Navigation Plan

- Informed by the Screening Tool, Assessment, and engagement with the Veteran
- Includes health goals and priority actions identified by the Veteran
- May include actions to be completed by the Veteran, HCN or other care team member
- Recommended that plan be reviewed and updated every 30 days

How to Use these Tools

- Honor Veteran's choice and use client centered approach
- Veteran may opt out of participating or answering questions
- Goals and priorities for engaging in health care services are determined by the Veteran
- Motivational interviewing may increase engagement with health care services
- Use to guide a conversation rather than a checklist

SSVF HEALTH CARE NAVIGATORS

- Grantees will develop protocols for prioritizing Veterans for Health Care Navigator intervention
  - Veterans who are not already enrolled in health care
  - Veterans identified as having a complex illness and difficulty accessing care
  - Veterans identified as having mental health or substance use disorders
  - Vulnerable Veterans living in hotels
- Services are voluntary and Veterans may deny health care navigator assistance

Documenting your work in HMIS

Use V2 "Services Provided"

- Referrals to VA for enrollment or appointments
  - Response 3 "Assistance obtaining VA Benefits"
    - Dependent Response 4 "health care services"
- Referrals to community health care
  - Response 4 "Assistance obtaining/coordinating other public benefits
    - Dependent Response 1 "health care services"

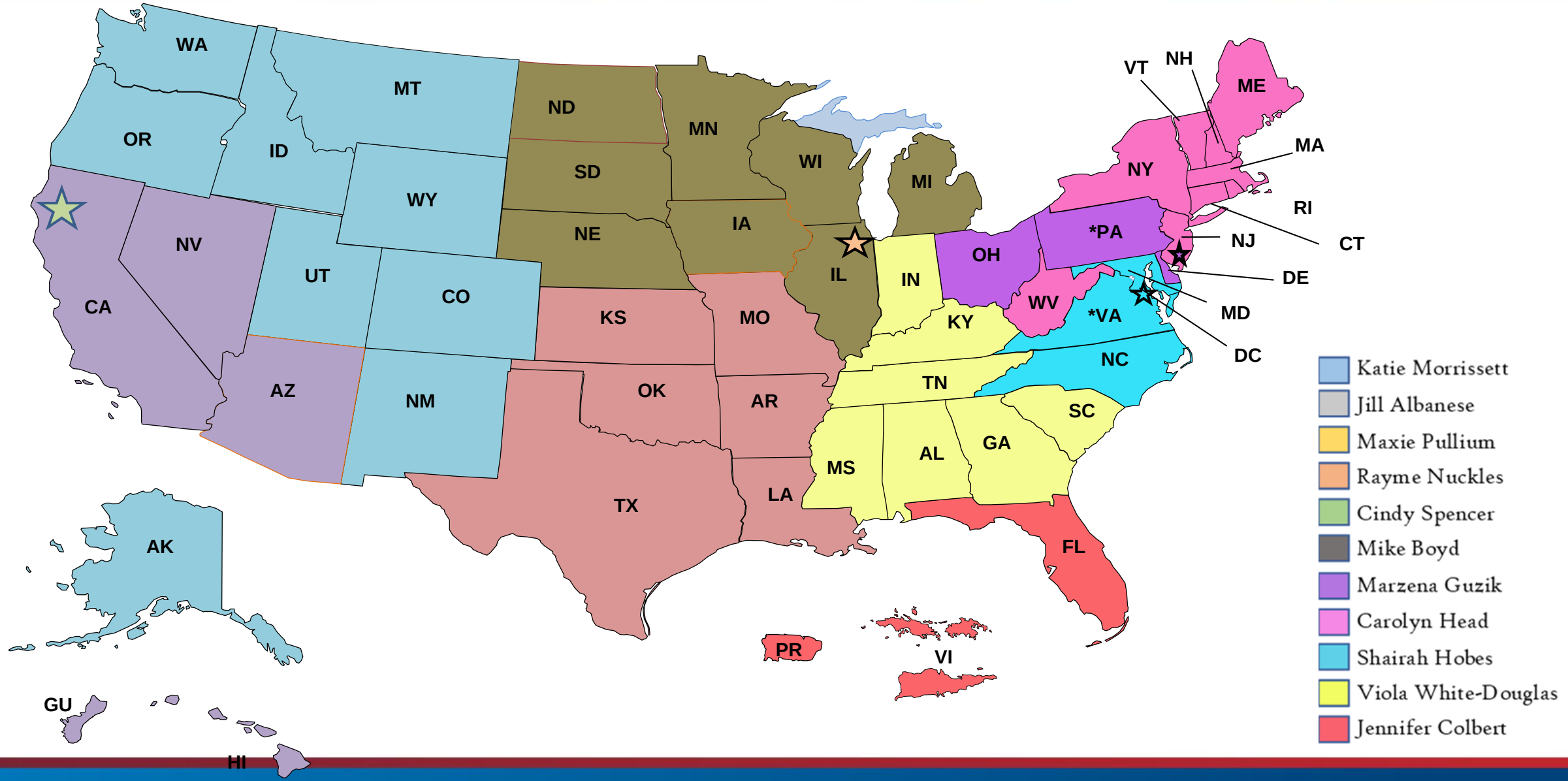
SSVF HEALTH CARE NAVIGATORS RESOURCES

- Resources for Health Care Navigators
- SSVF Learning Management System (LMS)
- SSVF Website
  - https://www.va.gov/HOMELESS/ssvf/?page=/ssvf_university/new_staff_development
- SSVF Program Guide
  - https://www.va.gov/HOMELESS/ssvf/docs/SSVF_Program_Guide_December_2019.pdf
- SSVF HCN Office Hours Nov 6 – Dec 11
- HCN Communities of Practice Jan 11- Feb 12

SSVF HEALTH CARE NAVIGATORS NEXT STEPS

- Review SSVF Program Guide and Webinars on the website
- Complete LMS Modules
  - Registration mail will be sent to health care navigators
- Register for the Permanent Housing Conference
  - Handout attached with instructions for WebEx and TMS (separate from LMS) registration
- Reach out to VA SSVF POCs
  - Excel spreadsheet attached or reach out to your SSVF Regional Coordinator

FY2021 Regional Coordinator Assignments



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CITATIONS AND ADDITIONAL RESOURCES

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.

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

Tsai, J., Doran, K.M., & Rosenheck, R.A. (2013). When health insurance is not a factor: national comparison of homeless and nonhomeless US veterans who use Veterans Affairs Emergency Departments. *American Journal of Public Health, 103*(S2), S225-S231

Appendix

MHICM Handbook https://www.bing.com/search?q=va+mhicm+handbook&FORM=QSRE3

HBPC webpage https://www.va.gov/GERIATRICS/pages/Home_Based_Primary_Care.asp

HPACT webpage https://www.va.gov/homeless/h_pact.asp