Approaches to Navigation Services for Individuals with Serious Mental Illness


Prepared for:
Centers for Medicare & Medicaid

Submitted by:
The Lewin Group, Inc.
Institute for Healthcare Improvement

July 16, 2012
The goal of the Medicare-Medicaid Coordination Office (MMCO) in the Centers for Medicare & Medicaid Services (CMS) is to ensure beneficiaries enrolled in Medicare and Medicaid have access to seamless, high quality health care that includes the full range of covered services in both programs. To support these efforts, MMCO contracted with The Lewin Group, along with the Institute for Healthcare Improvement, to investigate provider-led practices that show promise in increasing provider capacity to deliver integrated care to Medicare-Medicaid enrollees. Based on its research, the Lewin team developed four guides that present resources, examples, and tools for providers interested in enhancing their ability to deliver integrated and coordinated care, including this one on Approaches to Navigation Services for Individuals with Severe Mental Illness.

MMCO directed the Lewin team to focus its investigation of promising practices on providers that serve individuals with physical disabilities, dementia or Alzheimer’s disease, or serious mental illness. The team selected several provider-led practices through an iterative process based on an environmental scan and guidance from numerous experts. It also conducted site visits to selected practices to understand the core components that contributed to their success.

Based on the site visits and input from a Technical Evaluation Panel, the Lewin team identified four inter-dependent, high-level concepts that support the delivery of integrated, coordinated care:

- Integrating physical health services into behavioral health organizations
- Supporting self-management for adults with serious mental illness
- Workforce development to support care management
- Navigation services for individuals with severe mental illness

Approaches to Navigation Services for Individuals with Severe Mental Illness is based largely on information from the Montgomery County HealthConnections program. The examples drawn from this program were supplemented with an environmental scan and key informant interviews with experts in this area.
# Table of Contents

## Introduction
- What is Navigation? ................................................................. 1
- Why Navigation is Important? ............................................... 2
- What is in This Guide? ........................................................... 3

## Components of Navigation
- Engaging Enrollees in Care and Building Therapeutic Relationship ........................................... 5
- Personalized Health Coaching and Wellness Planning ................................................................. 5
- Health Assessment and Clinical Interventions ................................................................................. 5
- Care Coordination and Linkages to Community Services ............................................................ 6
- Advocacy ....................................................................................... 6

## Your Organization’s Context and Considerations ...................................................................... 7

## Provider Tools to Support Self-management ............................................................................. 9
- Tools Used by Navigators .............................................................................................................. 9
- Tools to Train Navigators ............................................................................................................ 10
- Tools for Organizations Seeking to Implement Navigation Services .......................................... 10

## Acknowledgements ................................................................................................................... 12

## Appendix A: Brief Psychiatric Rating Scale (Version 4.0) ......................................................... 13
## Appendix B: Medication Reconciliation Form ........................................................................... 14
## Appendix C: Navigator Patient Tracking Form ........................................................................... 15
## Appendix D: Behavioral Health Navigator Job Description from The Penn Foundation, a Participating Site of HCHC .................................................................................................................. 16

## Annotated Bibliography ............................................................................................................. 17
- Provider Organizations Referenced in This Guide ................................................................. 18
Introduction

What is Navigation?

Navigation is an approach behavioral health providers can adopt to deliver a greater degree of integrated care to adults with serious mental illness (SMI) and chronic or complex medical conditions. Navigation refers to the function of linking patients (and family members) with essential health and community services. Navigation is a “barrier-focused intervention” that aims to assist patients in identifying and overcoming barriers to care. It is typically a time-limited service, usually related to an episode of care, for example follow-up on an abnormal colorectal cancer screening examination.

In the past several decades, patient navigation has been used to increase the receipt of effective care and services for individuals with a developmental disability, cancer, HIV, diabetes, and asthma. Although navigation services have mainly been used among underserved individuals, they have also been used among the general population. As navigation services and programs have proliferated, so have the definitions, program descriptions, roles, and job titles associated with these services. Today, patient navigation reflects quite heterogeneous program designs and is delivered by lay and professional workers including nurses, social workers, certified case managers, community health or outreach workers, and trained mental health peers.

One way in which navigation services differ from traditional care coordination services is that navigators often outreach and interact with patients face-to-face and navigators monitor receipt of services. The combination of services provided by navigators is fundamentally driven by an individual’s needs. Navigators play an active role in troubleshooting problems as they arise, as well as engage individuals in self-care and wellness activities (see Table 1). At the core of navigation is the focus on building a strong relationship with the individual and between the individual, her community, and her entire care team, which can include a primary care physician and specialty care providers such as psychiatrists, pharmacy and community-based service providers, as well as patient-identified supports. Mental health peer navigators may be ideal for individuals with SMI as peers are able to establish credibility and build relationships quickly. Another core function of navigation among SMI individuals is the promotion of self-advocacy, recovery, and independence.

---

“Patient navigation” was termed in 1983 by Dr. Harold Freeman as part of a New York City program designed to assist low-income women obtaining breast cancer screening and follow-up care.

---

1 Agency for Healthcare Research and Quality, Outcomes of Community Health Worker Interventions. AHRQ Publication No. 09-E014, June 2009.
3 Centers for Disease Control, Addressing Chronic Disease Through Community Health Workers: A policy and systems level approach.
Table 1: Key Functions and Services that may be Provided by Navigators

<table>
<thead>
<tr>
<th>Health Education and Coaching</th>
<th>Advocacy</th>
<th>Linkages to Health System and Community Services</th>
<th>Health Assessment and Triage</th>
<th>Outreach-patient and Care Team</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal setting with consumers</td>
<td>Provide social support and informal counseling</td>
<td>Coordination of care with various service providers</td>
<td>Health indicator monitoring (e.g., blood pressure, weight)</td>
<td>Engages consumers to participate in navigation</td>
</tr>
<tr>
<td>Personalized wellness planning</td>
<td>Attend visits and meetings with consumers</td>
<td>Appointment scheduling</td>
<td>Mental status assessments: PHQ-9, Consumer Health Inventory, Brief Psychiatric Rating Scale Version 4.0</td>
<td>Communicates with case manager at health plans</td>
</tr>
<tr>
<td>Interpreting instructions from PCP and specialists</td>
<td>Culturally appropriate support</td>
<td>Assistance with housing</td>
<td>Risk Assessments</td>
<td>Facilitates communication with large treatment team providers</td>
</tr>
<tr>
<td>Provide education to promote health literacy.</td>
<td>Increase self-advocacy</td>
<td>Referral support</td>
<td>Establishes strong partnerships with PCP, specialists, therapists, and family members</td>
<td></td>
</tr>
<tr>
<td>Increase skills for self-management and wellness</td>
<td></td>
<td>Employment support</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Why Navigation is Important?

Navigation coordinates care, providers, and services across siloed mental, behavioral, and physical health care delivery systems, leading to greater holistic and person-centered care; navigation also assists individuals in overcoming other barriers to care and to increase their engagement and active participation in care. Poverty, discrimination, uneven access to medical care (and high quality medical care), cognitive impairment, and other environmental factors (e.g., distance to health care, language differences) create barriers to timely and appropriate care for individuals with SMI. Behavioral health agencies and providers adopting navigation will expand their capacity to provide care that is more integrated and reduce gaps in care for individuals with SMI.

Navigation is associated with increased use of ambulatory primary and specialty care and reduced use of inpatient and crisis services.\(^4\),\(^5\),\(^6\),\(^7\),\(^8\) From a health plan perspective, the up-front

---


\(^7\) Davidson L et al. Peer support among persons with severe mental illnesses: a review of evidence and experience *World Psychiatry* 2012;11:123-128

\(^8\) Navigation delivered by professional health care workers, trained lay health workers, or trained peer supports have all demonstrated a reduction of high-costs services.
Approaches to Navigation Services for Individuals with Serious Mental Illness

Early results from the Montgomery County HealthConnections navigation program for SMI consumers in Pennsylvania demonstrated reduced emergency room visits, hospital admissions, and use of crisis services.

Costs of a navigation program may be offset by reductions in the use of high cost services. A navigation program developed by Molina Health plan of New Mexico in 2005 saved $7,676 across 15 members with multiple chronic conditions during a six-month period. The program paired community health workers with social workers to deliver navigation services.

For behavioral health providers, delivering navigation services can engage staff to work at the “top of their licenses.” In the Montgomery County HealthConnections program, navigators report being highly satisfied with their roles and the ability to care holistically for their clients. Behavioral health providers will also find that supporting navigation services within their organization may aid in establishing a team-based approach to care. Navigators must interact and collaborate with other provider agency staff to ensure comprehensive care for clients.

Consumers receiving navigation services report increased feelings of recovery, independence, and the ability to manage their illness. They also note improved care experiences and increased overall satisfaction with care. In addition, family medicine physicians at SUNY’s Primary Care Institute found that SMI consumers receiving navigation services had greater connections with primary care. In the Montgomery County HealthConnections program, participating individuals had improved mental health and physical health when measured using the validated Short Form (SF-36) Health Survey.

For health systems, navigation can reduce missed appointments, increase efficiency of specialty care use, and reduce duplication of diagnostic services and medicines. For health systems, another benefit of navigation may be increased information sharing across providers to support coordination. This is particularly true for navigation delivered by nurses and mental health clinicians, clinically trained staff who are empowered to communicate with a range of health care providers.

What is in This Guide?

This guide offers resources that may assist providers seeking to develop navigation programs. In the sections that follow, readers will become familiar with key components of navigation. Included are examples

9 National Community Voices Initiative, Northern Manhattan Community Voices. Financing community health workers: why and how: Policy Brief. 2007. Morehouse School of Medicine and Community University Center for Community Health Partnerships

The examples in this guide are primarily from the Montgomery County HealthConnections navigation program. Piloted in 2009 and currently ongoing, this program used navigation to integrate physical and behavioral care and services for SMI consumers with complex medical needs.
of how behavioral health leaders and provider agencies in the Montgomery County, PA HealthConnections program implemented these components to integrate care using navigation. Factors and features associated with successful navigation as identified by experts in this field are also described. Finally, this guide includes tools and other resources to help providers get started.
**Components of Navigation**

In this section, we describe the services and functions provided by navigator teams in the Montgomery County HealthConnections navigation program. In this person-centered model of care, consumers drive the menu of services that are provided by their navigator team.

**Engaging Enrollees in Care and Building Therapeutic Relationship**

Navigator teams engage in active outreach to enroll individuals into the HealthConnections program since mailings about the new navigation service alone were found to be insufficient. Navigators explain the program in-person to individuals – an approach that was effective in engaging individuals. In-person outreach also helps navigators and consumers begin to establish and build therapeutic relationships. In some cases, peer supports provide outreach to individuals to explain the program.

Navigators are also available to meet wherever individuals feel most comfortable, such as their home or a local coffee shop. Making the consumer comfortable with treatment and at ease is part of the person-centered approach. Moreover, navigators are a center point within a larger care team, advocating for the consumer’s needs.

**Personalized Health Coaching and Wellness Planning**

Montgomery County provider agencies, officials, and advisory board members designing the navigation program have found that registered nurses (RN) and masters’ level mental health (MH) clinicians are the most effective staff to personalize coaching and wellness plans to address an individual’s complex needs in a holistic manner. These highly trained navigators work as a team and can draw upon the consumer’s larger treatment team, including behavioral health clinicians and peer supports within the provider agencies, as needed, to provide reinforcement and support for the personalized plan. Each navigator team brings their discipline-specific clinical expertise, as well as training in motivation interviewing to support self-management and wellness planning with consumers.

Navigators deliver self-management support to consumers via coaching and wellness planning. Patient-centered support is facilitated by an ‘Integrated Wellness Plan’ tool. Navigators use this tool to work with consumers to set goals in all domains of their life, identify treatment team members (including peer supports, therapists, or family) to help meet the goals, set a realistic time frame, and alert individuals when they have achieved or adapted their goals.

**Health Assessment and Clinical Interventions**

Navigators also conduct health status monitoring and risk assessments (e.g., mental health and drug and alcohol assessments) in the HealthConnections program. Monitoring a consumer’s progress can inform the care team about whether or not an intervention is working, leading to further treatment personalization. Risk assessments are critical to guiding treatment and...
preventative care priorities and guides client referrals to other resources. LeeAnn Moyer, Deputy Administrator in the Department of Behavioral Health and Disabilities in Montgomery County, says that the clinical expertise and training of the navigators enables these assessments and clinical interventions, such as medication reconciliation and medication administration.

**Care Coordination and Linkages to Community Services**

Care coordination across multiple specialty and primary care providers and settings including residential treatment facilities and emergency departments as well as communication with health plan case managers is a key function of the highly trained navigators in the HealthConnections program. An integrated member profile (See Tools for organizations seeking to implement navigation services section) supports navigators to deliver person-centered care planning and care coordination. The integrated member profile combines mental health and physical health utilization and pharmacy data and is drawn from both Keystone Mercy and Magellan Behavioral Health plan data on a quarterly basis.

Navigators also provide linkages to community services appropriate to each client. Over time, navigators gain experience with community-based providers and services enabling them to serve a wider range of individuals.

**Advocacy**

HealthConnections’ navigators also serve as strong advocates for consumers. Simultaneously, the navigator teams strive to increase the individual’s self-advocacy and promote independence. Navigators advocate on behalf of client’s housing, schedule timely appointments, and provide employment support. They may also suggest that an individual use a peer support service or attend a wellness program.
Your Organization’s Context and Considerations

An organization that wishes to develop a navigation program will need to evaluate how best to do so in the context of its own leadership, vision and culture; business model; organizational structure, skills, and processes; and consumer population. Organizations will recognize the large diversity among existing navigation programs and that one type of program or model will not fit all needs. Programs and services should be designed with local needs, resources, and patients in mind. However, our interviews with experts and leaders working to expand navigation services identified several areas that are broadly applicable and may increase the successful of a navigation program.

Identify Consumers for Participation in Navigation. Initially, establishing criteria for selecting who will be most appropriate for navigation is important to ensure staff time and organizational resources are used where needed most. Not all individuals with SMI will need or benefit from navigation. Amistad, a non-profit, consumer-run organization launched the Peer Coaching Initiative at Maine Medical Center in November 2011 to provide alternative treatments targeted to individuals with SMI with frequent emergency room (ER) use for psychiatric crisis. Peer navigators were placed in ERs to engage clients and then provided navigation over time. The program was successful in reducing the average number of ER visits from 17 to 9 in the first three months.14 In the HealthConnections program, potential consumers were first identified by Montgomery County health plans using risk stratification models to predict who was likely to use significant health care services.15

Consider Registered Nurses with Experience in Primary Care or Physical Health Care. Your organization can determine the appropriate health worker to deliver navigation services to adults with SMI. This may be related to your program goals and consumers you want to participate. Registered nurses may be particularly effective navigators if goals include integrating care across multiple providers and settings and performing health assessments that encompass physical health. In the Montgomery County HealthConnections navigation program, registered nurses formed half of a navigator team for consumers with SMI.

Nursing expertise was aimed at increasing access to the appropriate use of ambulatory care services. With one individual, for example, a nurse performed a lung assessment, noticed wheezing, and observed a patient incorrectly using an inhaler. The nurse was able to teach the patient correct use of the inhaler and prevented a visit to a primary care clinic.

Staff working as navigators need training to deliver integrated care for consumers. In the HealthConnections program, leaders found that navigators needed training to develop or improve motivational interviewing skills, and knowledge of co-occurring disorders and interventions to support smoking cessation.

Leaders may need to consider how navigation services fit into existing agency services. Behavioral health providers may find that integrating navigation services or a program within existing agency offerings is important. Staff not engaged in navigation services may need direction on how to work with navigators. Behavioral health provider organizations that implemented the HealthConnections navigator program found they had to orient their existing staff to view navigators as a complementary service that is, in part, successful because it connects consumers to existing treatment staff at the organization.

Providers may need to adjust workflow and health center operations so that Navigators and existing mental health and behavioral health staff can communicate about shared consumers in a structured manner. In several provider agencies, Navigators regularly sat in on treatment team meetings to communicate with mental health clinicians about the consumers’ health status and goals.
Provider Tools to Support Self-management

The tools and other resources below are organized into several categories. The first category includes tools navigators can use with consumers to track their interactions and engagement, conduct health assessments or personalize care planning and wellness. The second category includes resources for organizations seeking to train navigators. The third category contains guidance documents and resources your organization can use to implement a navigation program, including sample job descriptions and consent forms. The items marked with an asterisk (*) represent tools used in the Montgomery County HealthConnections program.

Tools Used by Navigators

*Medication reconciliation form*

This form was developed by Montgomery County Health Connections and can be used by navigators to keep prescribing physicians and care team members aware of a client’s complete medication list.

See appendix item B.

*Weekly Navigator Status Tracker Report*

This tool was developed by Montgomery County Health Connections and can be used by providers to track the clients they engage each week, treatment refusals, referrals and status changes.

See appendix item C.

*Second Generation Antipsychotic Tip Sheet*

A tool designed by Montgomery County Health Connections and can be used by other providers to assist navigators in monitoring for metabolic side effects of second-generation antipsychotics.


*PHQ-9*

This nine item depression scale of the Patient Health Questionnaire can be used by providers to diagnose depression and select and monitor treatment.

http://www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9/questionnaire_sample/

*Brief Psychiatric Rating Scale Version 4.0*

This assessment is used by Montgomery County Health Connections and can be used by other providers to measure psychiatric symptoms.

See appendix item A.
**Consumer Health Inventory (CHI)**

This assessment is used by Montgomery County Health Connections and can be used by other providers to assess a patient’s progress in behavioral symptoms, strength, provider relationship, work-school participation, emotional health and physical health over time.


**Tools to Train Navigators**

**Certificate Program in Primary Care Behavioral Health**

This training program was developed by the University of Massachusetts Medical School and can be used by health providers to train navigators on integrating physical and behavioral health.

[http://www.umassmed.edu/Content.aspx?id=144778&linkidentifier=id&itemid=144778](http://www.umassmed.edu/Content.aspx?id=144778&linkidentifier=id&itemid=144778)

**Patient Navigator Certificate Program**

This training program was developed by Sonoma State University and can be used by health providers to train navigators on supporting patients with chronic diseases.

[http://www.sonoma.edu/exed/patient-navigator](http://www.sonoma.edu/exed/patient-navigator)

**Colorado Patient Navigator Training Program**

This training program was developed by University of Colorado Denver and can be used by health providers to train navigators on building fundamental patient navigator skills and knowledge.


**Patient Navigator/ Community Health Worker Conference**

This conference was sponsored by the Massachusetts Department of Public Health and the United States Department of Health & Human Services Office on Women's Health Region I and can be used by health providers to train navigators on current topics and strategies in navigation.


**Tools for Organizations Seeking to Implement Navigation Services**

**Consent to Release Protected Health Information**

This form was developed by Magellan Health Services and can be used by health plans to obtain consent to share health information with both the physical and behavioral health providers.

**Integrated Member Health Profile**

The Integrated Member profile was developed by Magellan Health Services and can be used by navigators and navigator teams to personalize care planning and wellness. The sample profile contains domains of health information including service utilization across physical and behavioral health providers and settings, including pharmacy data. Data in this profile is drawn from health plan claims and requires health plans to develop.

http://www.magellanofpa.com/media/157111/member%20profile%20example.pdf

**Guide to Integrated PH/BH Assessment**

This guide was developed by Montgomery County HealthConnections and can be used by other providers to outline all of the essential elements required in conducting physical and behavioral health evaluations.

http://www.magellanofpa.com/media/156700/core%20elements%20bh_ph%20evaluations.pdf

**SAMHSA Wellness Trainings**

This training can be used by mental health agencies to educate staff on consumer wellness activities and current research on programs that are working to reduce early mortality among persons with mental health problems.

http://promoteacceptance.samhsa.gov/10by10/training.aspx

**Behavioral Health Navigator Job Description**

The Penn Foundation, a participating provider in the Montgomery County HealthConnections program, uses the following behavioral navigator job description.

https://www.pennfoundation.org/jobs/jobs/behavioral-health-navigator.html

or see appendix item D

**Webinar - Changing Roles: How Health Navigators Support Whole Health**

This webinar presented by The National Council for Community Behavioral Healthcare can be useful to behavioral health organizations interested in implementing navigation services.

http://www.thenationalcouncil.org/galleries/resources-services%20files/March%202022%20webinar%20final%20PPP.pdf
Acknowledgements

The Lewin Group is a premier national health and human services consulting firm with more than 40 years of experience delivering objective analyses and strategic counsel to public agencies, non-profit organizations, and private companies across the US. The Lewin Group works extensively with CMS and has significant experience leveraging information from literature reviews, interviews, and focus groups.

The Institute for Healthcare Improvement (IHI) is an independent not-for-profit organization that works with health care providers and leaders throughout the world to achieve safe and effective health care. IHI focuses on motivating and building the will for change, identifying and testing new models of care in partnership with both patients and health care professionals, and ensuring the broadest possible adoption of best practices and effective innovations. Based in Cambridge, Massachusetts, IHI mobilizes teams, organizations, and increasingly nations, through its staff of more than 100 people and partnerships with hundreds of faculty around the world.

Contributors and Reviewers

- Deborah Bukovec, LCSW, Magellan Behavioral Health of Pennsylvania, Inc.
- Allison Coker, Public Health Analyst, Substance Abuse and Mental Health Services Administration
- Larry Davidson PhD, Yale Program for Recovery and Community Health
- Peter Driscoll LCSW, Executive Director, Amistad Foundation
- Kimberly Griswold MD, Family Medicine Department, State University of New York
- Lori Marshall, RN HealthConnections Navigator
- LeeAnn Moyer, Deputy Administrator of Behavioral Health, Montgomery County Department of Behavioral Health and Developmental Disabilities
Appendix A: Brief Psychiatric Rating Scale (Version 4.0)

Brief Psychiatric Rating Scale (Version 4.0)

<table>
<thead>
<tr>
<th>Name/ID #</th>
<th>Date</th>
<th>Rater</th>
<th>Hospital/Location</th>
<th>Period of assessment</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Assessed</td>
<td>Not Present</td>
<td>Very Mild</td>
<td>Mild</td>
<td>Moderate</td>
<td>Moderately Severe</td>
<td>Severe</td>
<td>Extremely Severe</td>
</tr>
</tbody>
</table>

Rate items 1-14 on the basis of patient's self-report during interview. Mark "NA" for symptoms not assessed. Note items 7, 12, and 13 are also rated on observed behavior during the interview. PROVIDE EXAMPLES.

1. Somatic Concern
2. Anxiety
3. Depression
4. Suicidality
5. Guilt
6. Hostility
7. Elevated Mood
8. Grandiosity
9. Suspiciousness
10. Hallucinations
11. Unusual Thought Content
12. Bizarre Behavior
13. Self-neglect
14. Disorientation
15. Conceptual Disorganization
16. Blunted Affect
17. Emotional Withdrawal
18. Motor Retardation
19. Tension
20. Uncooperativeness
21. Excitement
22. Distractibility
23. Motor Hypersactivity
24.annerisms and Posturing

Sources of information (check all applicable):

- Patient
- Parent/Relative
- Mental Health Professionals
- Chart

Confidence in assessment:

1 = Not at all, 5 = Very confident

Explain here if validity of assessment is questionable:

- Symptoms possibly drug-induced
- Undiagnosed due to lack of report
- Undiagnosed due to negative symptom
- Patient uncooperative
- Difficulty accessing due to formal thought disorder
- Other
Appendix B: Medication Reconciliation Form

Central Montgomery Mental Health/Mental Retardation Center
Navigator Program
MEDICATION RECONCILIATION FORM

Patient’s Name: ___________________________  DOB: ____________

Directions:
This form is meant to be utilized by all members of the patient’s treatment team. The purpose of this form is to ensure all prescribing physicians are aware of all medications. Please review this list and forward any changes to Central Montgomery MH/MR Center’s Navigator. If you have any concerns, please contact the prescribing physician directly. Central’s Navigator can provide the most up to date contact information as needed. Please forward any future medication changes to Central’s Navigator. This form will be redistributed when medications change or quarterly, whichever comes first. Please sign below (to indicate review) and fax back to Central.

ALLERGY/INTOLERANCE

<table>
<thead>
<tr>
<th>MEDICATION</th>
<th>REACTION</th>
<th>MEDICATION</th>
<th>REACTION</th>
<th>MEDICATION</th>
<th>REACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td>3.</td>
<td></td>
<td>5.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td>4.</td>
<td></td>
<td>6.</td>
<td></td>
</tr>
</tbody>
</table>

MEDICATION   DOSE   FREQUENCY   INDICATION   ORDERING PHYSICIAN

Source: □ Patient   □ Family   □ PCP   □ Specialist(s)   □ Central’s Medical Record   □ Other __________________________

Form completed by: ___________________________ Date: ____________

Signature indicates review: ___________________________ Print name: ___________________________ Date: ____________
# Appendix C: Navigator Patient Tracking Form

<table>
<thead>
<tr>
<th>PHASE II</th>
<th>Provider:</th>
<th>b</th>
<th>c</th>
<th>d = (b-c)</th>
<th>e</th>
<th>f</th>
<th>g</th>
<th>h</th>
<th>i = (d+f+g)</th>
<th>Members Contact Pending (end of week)</th>
<th>Members Contact Pending (end of week)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<p>| Member Status Change (c above) |</p>
<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>MA / CIS #</th>
<th>Moved out of County</th>
<th>Lost Eligibility</th>
<th>Transferred</th>
<th>Deceased</th>
<th>Incarceration</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Member Refusals (g)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Last Name</td>
<td>First Name</td>
<td>MA / CIS #</td>
<td>Reason</td>
<td>Re-engage Y/N</td>
<td>Refer to Plan Y/N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------</td>
<td>------------</td>
<td>------------</td>
<td>--------</td>
<td>-------------</td>
<td>-----------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Member Unable to Contact (h)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Last Name</td>
<td>First Name</td>
<td>MA / CIS #</td>
<td>Reason</td>
<td>Re-engage Y/N</td>
<td>Refer to Plan Y/N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------</td>
<td>------------</td>
<td>------------</td>
<td>--------</td>
<td>-------------</td>
<td>-----------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Member Referred to Recovery Coach</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Last Name</td>
<td>First Name</td>
<td>MA / CIS #</td>
<td>Reason</td>
<td>Date Referred</td>
<td>Date Assigned</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------</td>
<td>------------</td>
<td>------------</td>
<td>--------</td>
<td>---------------</td>
<td>---------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix D: Behavioral Health Navigator Job Description from The Penn Foundation, a Participating Site of HCHC

Behavioral Health Navigator

To learn more about the Health Choices Health Connections (HCHC) click here.

Position Overview
The Behavioral Health Navigator utilizes clinical expertise in behavioral health assessment, planning, and intervention to work in partnership with the HCHC participants, a Nurse Navigator, and other healthcare professionals in the provision of holistic and integrated healthcare counseling and support. The Behavioral Health Navigator works as part of the HCHC team, a collaborative care model based on the person-centered healthcare home concept. This model seeks to integrate behavioral health and physical healthcare for adults with serious mental illness.

Essential Job Responsibilities/Requirements

- Outreach and engage prospective HCHC participants on-site and/or in the community.
- Ensure program participants have received current comprehensive physical and behavioral health evaluations, complete clinical and psychosocial evaluation of behavioral health needs as required.
- Assess changes in healthcare utilization and identify intervention/support gaps.
- Provide wellness education and counseling as well as identify/coordinate care with other community resources/sponsors.
- Develop and update participant-driven integrated wellness recovery plans as needed.
- Outreach other healthcare professionals as applicable to obtain relevant information, communicate changes in health status and medication regimes, advocate for healthcare needs, and assure follow-up to aftercare recommendations if participant is hospitalized.
- Complete and submit outcome measurement tools required for each individual as needed and utilize in treatment.
- Develop and assist with implementing a community support plan/crisis plan with other professionals and natural supports as needed.
- Maintain detailed progress notes for each session and submit progress notes, along with other necessary paperwork, on a weekly basis.
- Attend individual supervision meetings, team meetings, trainings, and learning collaboratives related to the HCHC program.
- Maintain required productivity expectation.

Hours

- Part-time (20 hours/week) with potential for full-time employment.

Education/Experience/Training

- A Master's Degree in Social Work, Psychology, or a related field and at least one year experience working with individuals diagnosed with a serious mental illness. Experience working with individuals with medical conditions preferred.
Annotated Bibliography


This is a comprehensive systematic review of the evidence on characteristics of community health workers (CHWs) and CHW interventions, outcomes of such interventions, costs and cost effectiveness of CHW interventions, and characteristics of CHW training.


The National Community Health Advisor Study identifies steps to strengthen outreach services delivered by Community Health Advisors throughout the United States. The Study, funded by the Annie E. Casey Foundation, began in late 1995 and focused on issues that must be addressed to build the capacity of CHA programs and be more easily recognized and reimbursed.

Centers for Disease Control, *Addressing Chronic Disease Through Community Health Workers: A policy and systems level approach*.

This document provides guidance for integrating community health workers (CHWs) into community-based settings to prevent chronic disease. The document provides general information on CHWs and describes evidence demonstrating the value and impact of CHWs in preventing and managing a variety of chronic diseases. In addition, descriptions are offered of chronic disease programs that are engaging CHWs, examples of state legislative action are provided, and recommendations are made for comprehensive polices to build capacity for an integrated and sustainable CHW workforce.


This paper provides a review of the research conducted on peer support among individuals with severe mental illness and outlines effective strategies for implementing peer support services.


This brief describes the two-year pilot programs in Southeast and Southwest Pennsylvania and presents preliminary findings based on an analysis of key informant interviews and performance measures. It provides early lessons for states and Medicaid health plans interested in implementing similar programs. Final evaluation results for the project, including outcome and utilization data, will be released in mid-2012.


This brief describes the methodologies that have been used to create and finance various Community Health Worker (CHW) programs by a range of organizations.

This article provides a systematic review of thirty-three articles published from November 2007 through July 2010 on the impact of patient navigation in cancer care.


This study follows 175 participants who were recruited from a psychiatric emergency room as part of a randomized trial examining access to primary care after a psychiatric crisis. The intervention group was assigned primary care navigators while the control group received usual care. Results of the study revealed that patients with mental health peers were statistically more likely to follow through with primary care, and patients who had both a navigator and a peer connected to primary care at even higher rates.


This report from the Montgomery County HealthConnections program in Montgomery County, Pennsylvania provides an overview of the history, organization and goals of the program as well as preliminary outcomes.


This article describes the Healthy Amistad, Peer Coaching Initiative in Portland, Maine. The program is funded by the Maine the Maine Department of Health and Human Services and encourages those who frequent the emergency department with psychiatric related issues to meet with trained peers in a community setting to lessen their dependence on emergency care.

**Provider Organizations Referenced in This Guide**

**Amistad Inc.**

Amistad is a non-profit, 501(c)(3) organization based in Portland, Maine focusing on adults with persistent and severe mental illness and has become a leader in developing services that are organized and delivered by peers. Amistad operates three individual programs - the original Peer Support and Recovery Center in Portland, a Peer Support program in the Emergency Room of Maine Medical Center in Portland, and a Peer Support Program housed in the Riverview Psychiatric Center in Augusta.

Address: 66 State St # 2 Portland, ME 04101
Phone: (207) 773-1956.
Website: [http://www.amistadinc.com/](http://www.amistadinc.com/)
Montgomery County HealthConnections
Magellan Health Services

In 2008, the Center for Health Care Strategies (CHCS) launched a multi-state, national effort to improve the quality and reduce expenditures for Medicaid beneficiaries with complex medical and behavioral health needs. Pennsylvania was among the states selected to participate in this effort. Pennsylvania implemented two pilots, SMI Innovation Initiatives, one in the southeastern (SE) and one in the southwestern part of the state. The SE Partnership, Montgomery County HealthConnections, included the following partners: Bucks, Delaware and Montgomery Counties; PA Department of Public Welfare; CHCS; Magellan Behavioral Health and Keystone Mercy Health Plan. Each county was at liberty to implement the plan in different ways. The Montgomery County HealthConnections was developed collaboratively with several core specialty behavioral health provider agencies serving Montgomery County MA residents - Central MHMR; Creative Health Services; Abington Creekwood Center; Penn Foundation and Horizon House. Implementation commenced in June 2009.

Phone: 877-769-9782
Website: www.MagellanofPA.com

Penn Foundation

Penn Foundation is a leading 501(c)(3) non-profit provider of community behavioral health services in southeastern Pennsylvania. Penn Foundation offers a wide-range of innovative programs, including Assertive Community Treatment. Penn Foundation is designed to meet various types and levels of mental, emotional, behavioral, and spiritual healthcare needs.

Address: 807 Lawn Avenue, Sellersville, PA 18960
Phone: (215) 257-6551
Website: https://www.pennfoundation.org/

Creative Health Services

Founded in 1957, Creative Health Services, Inc. is a non-profit community mental health center which provides behavioral healthcare to individuals in need of recovery and personal wellness. Over the past 50 years, Creative Health Services has grown into a multi-service, multi-site organization serving over 5,000 adults, children and families each year throughout the Tri-County region. In addition, Creative Health Services maintains active collaborations with ten area school districts, the judiciary system, several United Ways, the Tri-County Community Network, and other human service agencies.

Address: 929 Willow Street, Pottstown, PA
Phone: (610) 326-7734
Website: http://www.creativehs.org/
Central Montgomery MH/RC

Central Montgomery Mental Health/Mental Retardation Center, or Central, is the oldest private, not-for-profit, multi-service community mental health center in Montgomery County, PA. Central provides services to more than 4,000 individuals and families through specialized programs, covering a full spectrum of behavioral health services.

Address: 1100 Powell Street, Norristown, PA 19401
Phone: (610) 277-4600, X119
Website: https://www.centralmhmr.org/

Horizon House

Horizon House is a non-profit organization that provides community-based services to over 4,500 individuals throughout the Pennsylvania region. Horizon House’s interventions include treatment and rehabilitation programs, service/resource coordination, housing, educational programs, and employment training and support.

Address: 3275 Stokley Street, Philadelphia, PA 19129-1128
Phone: (215) 386-3838
Website: www.hhinc.org

Abington Memorial Hospital

Abington Memorial Hospital (AMH) is a 665-bed, regional referral center and teaching hospital, which has been providing comprehensive services for people in Montgomery, Bucks and Philadelphia counties for more than 90 years.

Address: 1200 Old York Road, Abington, PA 19001
Phone: (215)481-2000
Website: http://www.amh.org/