**The Lewin Group**
**Assessing Organizational Ability to Provide Navigation Services**
**August 23, 2017**
**2:00 p.m. EDT**

**Alana Nur**: Good afternoon, everyone, and thank you for joining us today for our webinar on assessing organizational ability to provide navigation services.

This is the first webinar in a series of two webinars on navigation services. The second webinar on providing navigation services for clients with serious mental illness and chronic physical health conditions will be held this coming Monday, August 28th at 2:00 p.m. ET.

Today's webinar is going to be interactive with 50 minutes of presenter-led discussion followed by ten minutes of presenter and participant discussion. There will be an opportunity for questions and answers at the end of the webinar, so please submit your questions to us using the chat function. A copy of the slides and a recording of the presentation will be available at https://resourcesforintegratedcare.com/.

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To earn continuing education credit for this webinar, complete the post-test through the Centers for Medicare and Medicaid Services' Learning Management System and score 80% or higher by midnight on September 11, 2017. More information is available at https://resourcesforintegratedcare.com/Behavioral_Health/2017_Navigation_Services_Webinar_Series/Assessing.

The Medicare-Medicaid Coordination Office in the Centers for Medicare and Medicaid Services ensures that beneficiaries enrolled in Medicare and Medicaid have access to seamless, high-quality healthcare that includes the full range of covered services in both programs. To support providers in their efforts to deliver more integrated coordinated care to Medicare-Medicaid enrollees, MMCO is developing technical assistance and actionable tools based on successful innovations and care models such as this webinar.

This webinar is developed by the Lewin Group and hosted by the Medicare-Medicaid Coordination Office.

I would like to take a moment to introduce our three speakers for our webinar today. My name is Alana Nur, and I am a Federal Health and Human Services Consultant at the Lewin Group. I will be helping facilitate our webinar today.

Our first speaker is Dr. Alice Geis. She is the Director of Integrated Healthcare at Trilogy Behavioral Healthcare, a community mental health center in Chicago. She is an assistant

professor at Rush University where she teaches in the Master's and Doctoral program. She is board certified as a psychiatric mental health nurse practitioner with doctoral preparation in systems leadership nursing. She has held a number of clinical administrative, academic, and consulting roles, including director of a hospital-based psychiatric home care program, member of the United Nations team investigating war crimes in the former Yugoslavia, and program development consultant.

Kimberly Smathers, our next speaker, has been employed by the Lewin Group since May 2013 as a Federal Health and Human Services Managing Consultant from 2008 to 2013. Previously, she worked as Vice President of Business Development at Heartland Health Center, a Chicago area federally qualified health center. Ms. Smathers leads efforts to support behavioral health organizations and providers in delivering behavioral health and other health services under the technical assistance to support providers in providing care to Medicare and Medicaid enrollees' contract with the Medicare-Medicaid Coordination Office at the Centers for Medicare and Medicaid Services.

Our next speaker, Mindy Klowden, is the Director of Technical Assistance for the SAMHSA/HRSA Center for Integrated Health Solutions and provides individualized consultation and training to community mental health centers, primary care clinics, and other healthcare systems and providers working to integrate primary care, mental health, and substance abuse treatments.

Ms. Klowden also works on healthcare payment and delivery system reform. Prior to joining the National Council, Ms. Klowden served as the Director of the Office of Healthcare Transformation at the Jefferson Center for Mental Health in Colorado. In this role, she was an advisor to executive and senior management on healthcare policy and trends, developed key health reform initiatives, and worked to cultivate and sustain interagency partnerships that support the integration of behavioral health with primary care.

To provide a brief overview of our presentation today, we will start out with a few polls, which we will get to in a moment. Alice Geis will provide an overview of navigation services, and Kimberly Smathers will review RIC's navigation services organizational assessment tool or NAV OAT. Dr. Geis will then also discuss how her organization has used the NAV OAT to assess capacity for navigation, and Mindy Klowden will discuss best practices for implementing navigation services at your organization. We will then move into questions and answers.

Next, I will review the learning objectives that we have for today. Upon completion of this webinar, you will be able to understand the importance of navigation services in providing integrated care to clients managing mental illness and/or substance use conditions, recognize their organization's ability to provide navigation services using the NAV OAT, and identify concrete next steps for expanding organization's capacity to integrate navigation services. Now, I will pass off the presentation to Alice Geis. Alice, please go ahead.

**Alice Geis:** Hi, I am Alice Geis. Thanks for being part of the webinar. I look forward to your questions and discussions at the end. First, so we get on the same page, let's have a quick discussion of what we mean by navigation in the healthcare setting with more details to follow.

Briefly, navigation is the process of helping clients obtain high quality coordinated care through linkage, advocacy, education, and attention to wellness. Navigators overcome barriers to care through one-to-one working relationships with clients and developing relationships across the care team.

While some of you may not have individuals with job titles of navigator in your organization, it's likely some staff are providing what we're calling navigation services. Before we get into too much detail about the “who” and the “what” of navigation, I want to quickly consider the “so-what” question, which is why are navigation services important? To answer, we need to consider the population that we serve. Members of some populations have vulnerabilities that make it more likely that they will need help with navigation. This includes the population many of us serve, those with serious mental illness and substance use disorders combined with multiple medical comorbidities.

The cause of this vulnerability is multi-factorial. It includes common symptoms, for example, in areas such as cognition, endurance, and asset regulation, which can accompany many mental illnesses. There are different takes on what qualifies for serious mental illness, so we have included a definition from SAMHSA here.

We also know that having such complex health problems can lead to bad outcomes. Some of that is tied to the barriers faced by this population. Common problems include regular health screenings being missed more often, lack of access to specialty care, or inadequate reimbursement. In addition to missing particular services, poorly coordinated care can also contribute to less than ideal outcomes. This can stem from problems in areas of medication reconciliation, information sharing at times of transition from one setting to another, or inadvertent overlap of services, such as when individuals are seeing multiple providers of the same type or receiving conflicting provider input.

To deepen our understanding of navigation I will call out some of the aspects of the role and the activities of a navigator. The actions of a navigator are important, but central to the role is the relationship with the client. Many of our clients have had challenging experiences with the healthcare system. For example, involuntary hospitalizations might have started in a way that was traumatizing to a client, or a lack of provider understanding of mental illness might have led to years of suffering without adequate treatment.

In any case, relationships should be built across the care team, but all of that coordinating capacity might lead to failure without a central focus on the working relationship with the client. This becomes important when we talk of a navigator providing linkages. A warm handoff involving a trusted person increases the likelihood of follow through with the referral. Overcoming barriers to care can involve navigator actions, but also must include, when possible, teaching and training the client in self-advocacy, in education regarding health and illness, and the function of health systems. Increasing the client's self-reliance in these functions is key.

I have a brief example. Once when I was conducting a group training in self-advocacy and discussed the topic of reporting side effects in requesting a medication change from a provider rather than just stopping the medication on your own, one client said, "You mean we can say

that?" They did not even realize that they could have that power in the working relationship. Facilitating the necessary level of communication and collaboration to provide truly integrated healthcare is harder than it sounds, as many of you know.

Who provides these services? We'll get a little more detail about that in a minute, but the answer really depends on the complexity and type of need, the type of system, whether you are working with a service or a reimbursement focus, and budgetary constraints. Next slide.

Another question that helps us understand what clients need from navigation services is what is it about systems that can make navigation more difficult? You all work in systems. They may be larger or smaller built on partnership arrangements or fairly self-contained, but there are elements of these systems which can make healthcare navigation difficult for many, and most difficult for vulnerable populations such as older adults or people with serious mental illness. Parts of those systems can become encased in silos that do not communicate well with other areas. You may need to communicate with other systems on behalf of your clients, but run into problems with compartmentalization with the needed programs, equipment, medication, or services being difficult to procure due to the impact of different operational workflows or different reimbursement mechanisms.

The need for healthcare navigation emerges from these inherent difficulties. Services can be fragmented. Behavioral health services are still compartmentalized from general health services. Licensed healthcare providers are still educated in silos, while more programs are embedding material and interdisciplinary team care that clinical program students learn and still lag behind in giving the real world experience working in tightly coordinated integrated teams. Transportation or mobility problems may negatively affect clients' ability to access specialty care.

If you provide behavioral health services, you are likely to have some or all of these key members helping provide services. I think we are missing pharmacy on this one and the all-important family or significant others, but you get the picture. The client is at the center. Who helps the client make the plan come together instead of being a collection of parts that pull in different directions? Well, in your organization, as I said earlier, you might not call the person a navigator, but a case manager might help do this. However, once the client is participating in services external to the organization, the complexity increases and so does the need for good coordination of care and help navigating.

I want to say a little bit more about who does each piece of healthcare navigation. Yes, nurse practitioners and physicians do healthcare navigation, but typically not the outreach for direct teaching and training elements. If you are like most organizations, you want to right size who is doing what--have everyone working to the top of their licenses or experience. This is why you need navigators. Otherwise, you will have people who are working at something that someone else should be doing. For example, you might have a primary care provider who should be diagnosing and prescribing treatments or medications for medical or psychiatric illness waiting on hold to get prior authorization for a medication they previously ordered.

In many organizations, RNs contribute significantly to complex care coordination. They may provide a detailed assessment of need that includes information that helps to individualize navigation services. This can include assessment of health literacy, motivation to change behavior, pertinent information from the psych med surge and population health realms. Nurses often have expertise in communicating with hospital and other health systems and can advocate for clients and teach self-advocacy.

Another quick example, one new outreach nurse just last week told me of a situation where she was visiting a client in the hospital, and the hospital RN stated that he was going to be discharged imminently despite the fact that a recent blood sugar was 550, which is very high. The hospital staff was going over discharge instructions, asking if the client performed home blood glucose monitoring. Due to his psychiatric symptoms, the client was not reporting accurately. The outreach RN was able to provide correct information and an intervention, which was to insist that the attending be paged at that point. While this intervention only bought another day in the hospital, the client did leave in more stable condition.

Another group that does navigation are licensed social workers or counselors. They provide invaluable assistance in activities as diverse as tracking availability of various community resources, integrating information about trauma history, and helping with selection and referral to psychotherapy services.

Case managers called recovery counselors, in the setting I work in, often provide significant amounts of navigation services. They help clients track appointments and medication refills. They support smoking cessation efforts and other wellness services. They might also provide support to peer staff who often do many of the same activities.

To sum up some of the most important parts of healthcare navigation, it is important to use outreach. This gives the ability to overcome transportation, mobility, and cognitive barriers. Leave clients where they are geographically and psychologically. Provide a client-centered or recovery model focus. Practice cultural awareness. Ensure client access to best practices, to evidence-based care when possible. Excellent communication follow-up and closing the loops on communication in between organizations is very important and modeling persistence and teaching self-advocacy to clients. Now, I am going to pass it back to Alana.

**Alana Nur:** Thank you so much, Alice. Next, we will move into a review of the navigation services organizational assessment tools from Kimberly Smathers. Kimberly, go ahead.

**Kimberly Smathers:** Great. Thanks, Alana. To give some background, Resources for Integrated Care developed the Navigation Organizational Assessment Tool, or as we'll call it today, the Navigation OAT, with the input of subject matter experts in navigation including Alice Geis. The tool is derived from the experience of behavioral health clinicians, primary care clinicians, and individuals with expertise in implementing navigation services with individuals with serious mental illness and substance use conditions.

The tool is built upon the recognition that individuals with serious mental illness have high rates of medical comorbidities and significantly shorter lifespans, largely due to high rates of chronic

health problems including obesity, diabetes, hypertension, and other cardio respiratory illnesses. There is a need for coordinated services for individuals with serious mental illness that recognize the interconnectedness of mental and physical health, adverse childhood events and adult physical illness.

This assessment tool is designed to assist behavioral health organizations in assessing the various aspects of their organization's ability to provide navigation services to clients managing serious mental illness and substance use conditions. Specifically, the Navigation OAT allows organizations to assess the presence and the quality of elements that are necessary for navigation services and to create a path toward providing or strengthening such services within their organizations by connecting identified gaps to tangible next steps in the form of a customized action plan.

The tool is broken into two main sections. The first section is focused on organizational capacity to support navigation services and addresses topics such as documenting for a specific population, barriers to care and client characteristics, organizational infrastructure needs including funding, culture, staff roles and training, partnerships, and key program processes including care team workflows and data documentation.

The second section delves into pillars of navigation support services with a focus on what navigation looks like on the ground. It contains sections on building client relationships including cultural competence and communication practices, health literacy, health coaching and wellness planning, including support for client-centered goals and self-management, care coordination, and linkages to community services.

The Navigation OAT is available online through a downloadable PDF, which you can print and complete, as well as an interactive Excel tally scoresheet, which creates a customized action plan based on your responses. Depending on your preferred method of administrating the Navigation OAT within your organization, you may find the use of either version more convenient for facilitating team discussion of responses and for having a reference to refer back to as you enact plans to strengthen navigation services. The tool should ideally be completed by at least two staff members within your organization, identify several people with different perspectives such as clinical and support staff, administration, or peer support specialists and others. It is important to include multiple points of view.

Individuals should be instructed to choose one response for each question, and you may want to emphasize the importance of answering reading questions honestly, even if the reading is low. All answers are for internal use, and staff should feel empowered to give their candid appraisals. As you go through the tool, you may find that the organization is engaging in activities to provide navigation services, but that you refer to these under a different name or refer to the staff completing these activities by different names. It is understood that individuals with titles such as case manager, care coordinator, or peer support specialist may in some organizations be doing the work of what is called a navigator in this tool. When questions asked about a navigator, consider the relevant staff person in your organization who will perform that function.

Finally, large organizations that have multiple sites will receive the most useful responses if they ensure that all individuals completing the tool use the same scope when they answer each question. For example, you may instruct individuals to answer questions with your entire organization in mind and to select the response that is appropriate across the majority of sites. Alternatively, you may wish to concentrate on a subset of a few targeted sites in order to dive more deeply into their needs. Your choice of scope is subject to what your organization hopes to get out of its use of the Navigation OAT.

On the screen, you will see a screenshot of the first few questions in the Excel-based version of our tool. There is a column for responses and a column listing the corresponding section of the action plan.

Based on your responses to the questions, the results tab of the Excel sheet is populated with a customized action plan that you can save, print, or copy into other planning documents for your organization. Action plan steps are automatically included if you select responses that fall in the middle or the bottom of the response skills. For example, for the questions shown in the prior slide, action plan steps would be populated when the somewhat or the no response was chosen.

You can find the Navigation OAT at the link on the screen. Additional resources related to navigation services are available at the second link including our navigator tip sheets addressing the intersection of serious mental illness and common physical health issues such as diabetes and smoking. These will be explored further in a follow-up webinar scheduled for Monday August 28. Now, I will turn it back over to Alana.

**Alana Nur:** Thank you, Kimberly. Next, we will turn to Alice Geis again to discuss her organization's experience using the NAV OAT to assess capacity for navigation. Alice, please go ahead.

**Alice Geis:** Okay, thank you. Now, I want to touch on how we administered the tool in the agency and how you might use it. I would recommend convening a small group, as Kimberly discussed, diverse work function. You can limit to a section of the tool because time is always an issue, so we completed part one, the organizational capacity to support navigation services section, and plan to complete the second part, pillars of navigation support services, at another setting.

You want to agree on the timeframe to consider. For example, ask participants to think about the past six months. I would also encourage you to think about your framework. For example, rapid cycle quality improvement is one such framework, also known as plan/do/study/act or plan/do/check/act that many organizations are using to help them do quality improvement in a fast-paced environment. RCQI is a quality improvement method that identifies, implements, and measures changes made to improve a process or a system based on the model for improvement developed by Thomas Noland and colleagues at associates in process improvement. Next slide.

Who participated? There were three individuals all with different goals in the organization. The first was an RN experienced in navigation in all different agency settings including an outreach team, which serves higher acuity clients, clinic setting, and also in the residential programs. The

second was a program director who had experience leading teams of recovery counselors, the name used for case managers, who was in charge of the residential programs, drop-in center and managing peer staff. Then myself, the integrated health director, who has jurisdiction over wellness and health behavior change groups, provide consultation and leadership to the RN and occupational therapy groups, and develop coordination of care and wellness service provision models for the organization.

I will talk, briefly, about what this small group gleaned from completing the first half of the tool. We knew that we were going to face some extra challenge with navigation due to having two electronic health records. Some of you may be faced this challenge as well. We were reminded of this in our response of "usually" in the question about storing, tracking, and sharing pertinent information. We do a pretty good job of this, but I was reminded that we could tweak some systems. For example, by streamlining our releases of information and looking at the frequency and audiences for shared reports.

We do a lot of planning with external organizations for some transitions. For example, Williams and Colbert class members, people we are helping to move out of nursing homes related to these consent decrees composed on the state of Illinois. However, similar planning with acute care inpatient facilities sometimes cannot happen, and we experience challenges getting timely access to acute care records. We were prompted to take another look at that, and we've had some discussions with local hospitals about doing that, but we want to move it forward.

When reviewing our score in the comprehensive curriculum for navigator's item, we realized that we could provide more detail to staff in orientations and training about which navigation elements will be the responsibility of the various team members. Lastly, while we do use an integrated health assessment for those clients who receive services from an RN, not all of our clients do. The tool prompted the discussion about how we might either make those nursing resources more available to a larger segment of the population or use nursing to develop those plans and then pass them off to others.

Finally, the agency is still parsing the results of the assessment, but we do have some thoughts about how results can be used, and I will share that with you. We have been looking at the new employee orientation sequence for other reasons. We have been looking at this, and we've considered how some material about navigation might find its way into those meetings. Existing staff got updates in team meetings and in training materials uploaded onto our training software, so there is a path to getting information to them through those channels.

Understanding how much navigation an organization does and which levels of employees do it can assist with communication with managed care organizations and optimization of reimbursement for needed navigation services. Last, using the OAT can facilitate looking at staff roles in relation to navigation and adjusting roles to best meet client needs and agency staffing patterns. Now, I will pass it back to Alana.

**Alana Nur:** Thank you, Alice. Now that we have gone over your organization's experiences, I would like to pass it off to Mindy Klowden, who will be discussing some best practices for implementing navigation services and linking patients. Mindy, please go ahead.

**Mindy Klowden:** Thank you, Alana. I'm going to be drawing on my experience of working in community mental health and also working with practices across the country that have been working to implement behavioral health and primary care, many of which are instituting navigation programs or looking at how they can best maximize the existing staff that they have to provide navigation functions.

Dr. Geis talked about that when it comes to thinking about who your navigation staff are that, in many cases, many organizations have folks that have a role that includes navigation functions. It is kind of more the exception than the rule for there to be an actual navigation department or someone who's entire role is to be a navigation staff, although those do exist within some organizations. What is important for your organization, if you are looking to start a navigation program, is to think about the existing resources that you have and how you can best reallocate staff. If you have funding to develop a navigation function, make sure that you have a good understanding of what your goals are for that program and that you're aligning the way that those roles are formed to the intent of the program.

If you think about all of the different pieces within an organization and who is touching the life of a client, you may have a nurse care manager, a healthcare coordinator, a more traditional case manager in behavior health. Many community mental health centers have peer specialists or peer health coaches, and then there are the therapists. All of these different roles may have some piece or part of delivering navigation services.

What is important to understand as an organization is that when you are introducing a new function, it is important to be explicit about who is going to have what kind of responsibility in terms of implementing navigation services. There are some real pros and cons to having existing staff take on this role versus dedicating new staff to it. Obviously, there is the financial aspects, but there is also the workflow issues that come about. If you are looking at reallocating staff, you have to have a good understanding of what will they stop doing in order to take on navigation functions.

When you're introducing the navigation role, what you're really doing is starting to move beyond just coordinating care across healthcare delivery systems or internally across behavioral health and primary care providers and starting to introduce the idea of supporting patients and clients in accessing the services and supports that they need in the community to address social determinants of health. It's a whole new kind of mindset for many healthcare delivery systems to many organizations to be thinking not just about how do we get folks into healthcare, but how do we improve people's health by linking them to affordable housing and to food resources and other community supports.

Whomever you determine will take on the navigation functions within your organization, it is important that those folks become an integral part of your integrated care team. I can give you a real concrete example of why this is important. If you're working with a patient on addressing diabetes, for example, and you're having trouble understanding the barriers that the patient is having to changing their diet, the navigator may have a piece of information that no one else on the team has. They may, for example, know that that patient is receiving all of their food from a

food pantry or that they're actually living in a homeless shelter and going to food kitchens in order to be fed. There are barriers that they are facing in managing their lives and those are important for the medical team and the behavioral health team to have an understanding of, so that you can work together on whole person care.

Considering the staff that has the navigation functions as an integral part of the integrated care team, also means that they are actively involved in integrated care team communication. What we have learned in terms of best practices around integrated care team communication is that it really needs to be intentional. There needs to be some time dedicated to simply talking across the multi disciplines, talking together about the needs of patients that are dealing with complex health and social issues.

The ways that we have done this are through daily huddles, which may be first thing in the morning or maybe done over the lunch hour. We also conducted weekly care team meetings, which seem to be most acceptable if a care coordinator or other staff member who is in charge of helping to identify in advance which patients you need to be discussing within the care team meeting leads them. You are also using risk stratification methodologies in order to focus so that you maximize that hour or whatever amount of time you are spending on the care team. We also have shared care plans and access to a common EHR, which ensures that folks that are responsible for navigation have access to the EHR and that there a place within the EHR to actually record information that the navigator is collecting about the patient and sharing that across the integrated care team. Some EHRs need to be supplemented with care management software or databases that are developed specifically for the purpose of working to address whole health in a more coherent way, and then having urgent communication mechanisms in place.

All of this requires a new way of thinking about delivering healthcare services and behavioral health services. That requires an investment in staff training, professional development, and developing core competencies. I'd like to talk about this in terms of developing of culture of integration within your organization. Again, because we're really talking about addressing not only healthcare needs, but health and the social determinants of health, it's important that staff have a good understanding of why--why are navigation functions being introduced and how is this going to benefit the patient and improve the organization and improve the organization's outcomes.

Along with educating folks about why navigation is being put in place, there also needs key processes and procedures to be developed. For example, you may be looking at how do we change or adjust our human resource policies so that job descriptions have a clear way of conveying that this is an expectation. You may also want staff members to not only be aware of who is providing navigation functions, but also understand how they are going to be evaluated in terms of their success in providing these functions. Training staff in team-based care, as we just talked about, and becoming a part of a team, recognizing everyone's role within the team, training staff in cultural competency, and educating staff on social determinants of health are ways of accomplishing those goals.

Then, when it comes to assessment and development of whole person goals, there may be organizational healthcare assessments in place. You may have behavioral health treatment plans,

but when you're introducing the navigation functions, what you are beginning to do is to look at how do we assess where this person is in their recovery process and what are their needs within the community in order to help them to get healthy. You also want to manage what is going on with their lives. You may need to introduce some new questions that you have not previously asked and those questions as part of the assessment process need to be within the electronic health record or otherwise accessible by the whole care team.

That relates to this next slide here about developing the necessary data infrastructure. It's important that you have in place a system for identifying patient needs as they relate to the navigation functions, as they relate to social determinants of health, and that that assessment is accessible by members of the care team.

It's also important that if you are helping patients to access community services and developing relationships in the community with agencies that you will be referring your patients to, that you have in place the necessary releases of information. This is particularly true if you are an organization that is covered under 42 CFR Part 2, which governs the sharing of information related to substance use disorder treatments.

Then if you are making these referrals, you will want to have a data infrastructure in place that helps you to track the success of those referrals. Did someone actually make it to the food pantry or were they able to access that specialist, and what kind of follow-up is necessary to help support them in accessing those resources?

Then what metrics will you use? Some of this may be dictated by your funding. For example, if you have a grant that is supporting the implementation of a navigation team or a navigation role, you may have metrics that the funder is expecting for you to be reporting on. However, even if you do not have that in place, your organization should strategically decide what will we measure and how will we know that the investment we've made in putting a navigation function in place has actually been successful.

Then lastly, as Dr. Geis alluded to, having a continuous quality improvement process in place is important to be able to measure the impacts that you're having and make the necessary tweaks along the way.

Then it's important that if you are connecting folks to resources in the community, that you have some staff that are dedicated to maintaining up-to-date information on what those resources and the necessary referral processes. This can be maintained electronically and/or it can be used as handouts that you share with both patients and staff. I say with both patients and staff because you are not only helping to support the patients in identifying resources in the community and access those resources, but you are also helping to support staff. For example, in the therapy session with a patient, you learn that the patient is homeless and, as an example, need to be able to say beyond hey, we have some folks that provide a navigation function that you can connect with, they could actually right there and then say, you know what, I have this handout for you. You can take this with you and it will help connect you with some affordable housing resources.

Some organizations take a helpline approach during either the hours that the clinic is open or maybe even an after hours' call line. That, of course, requires the investment of staff that are trained to answer the phone and help connect people as needed. Some helpline approaches that we have seen in community mental health centers are actually more for staff. If, in that example that I was using a moment ago, a therapist is in a session and the patient says, "you know what? I just lost my housing," the therapist could call the helpline right there and then and find out how to direct the patient.

Then lastly, it is important that there are resources dedicated to developing and maintaining community collaboration, so that you're able to provide the patient with accurate information about referral processes. The organizations you're referring to should have a good understanding of the needs of patients with serious mental illness or substance abuse disorders and how you can work together to improve the overall health of your community.

Of course, money does not grow on trees, as much as we would all like it to, so the question is always well, how we pay for navigation services. As I said in the beginning, if you do not have funding upfront in terms of some kind of a grant that can help you get a program started, the first place to start is assessing your existing staff capacity and to capitalize and build on existing resources. This may require some workflow redesign and some process mapping that you use to really get a good understanding of who is currently doing what, what do we want to add in, and how do we best allocate those staff resources.

Then in terms of coordinating billing, it's valuable to do some kind of analysis or time study to look at what exactly are we doing within the navigation function or within the navigation department and what, if any of what we're doing, is billable. Just to use an example, I know that I have worked with a community mental health center that was providing telephonic support that they considered navigation services, and it was case management. They were trying to get their staff off the phone as quickly as possible, so answer the patient's questions, connect them to resources, and get off the phone. However, there was always more that they could be talking about. What they realized is that if they had the appropriate staff in terms of licensure providing these services, if they were on the phone eight minutes or more with the patient, that that was actually billable as a case management service. It is important to have a good understanding of what can be billed and, if you are providing services that cannot be billed, do look at other ways to support that through alternative payment/value-based payment contracts or pursue grant funding.

Of course, all of this can be very challenging and overwhelming for an organization to start up. I am going to talk about some common pitfalls. One of the ways that a navigation's program or function can easily fail is if there's a lack of leadership or a lack of investment on the part of the leaders in making sure that this is successful. You really do need to have support from the top down. You also need to focus on culture change. Rather than just implementing new processes and new ways of doing things, you need to be looking at how do we develop the staff understanding, how do we message about the importance of what we're doing, and how this fits in with an overall vision of the organization to really address whole health.

I talked before about adequate investment and staff training and having really clearly defined roles so that everyone within the care team understands who is doing what when it comes to supporting the patient and providing that navigation function. If you have dedicated navigation team members, making sure that the staff as a whole has a good understanding of who this new person is, this new team member, what role they play, and how that can support the rest of the team. Having clearly written policies and procedures, adequately investing in documentation and use of data, and investing in community relationships is all important.

Then poor communication can really be a downfall, both internally and externally. Internally, again, the care team needs to understand the functions and roles, and externally the partners that you are referring to need to have a good understanding of the needs of the patients you are serving, what your organization does, and how you're looking to collaborate with them.

I did just want to mention that the Center for Integrated Health Solutions, which is funded by SAMHSA and HRSA and is administered by the National Council for Behavioral Health, is available to provide individualized consultations to behavioral health and primary care providers that are working to integrate care and to implement navigation services. Now, I am going to turn it back over to Alana.

**Alana Nur:** Thank you, Mindy. Now we have time for a few questions. If you could enter any questions that you have into the chat function right now. We will start with a question for Alice. What are some ways that navigators can teach self-advocacy to their clients?

**Alice Geis:** Okay. I can tell you how we have done this. We conduct individual and group cycle education. For example, one way we've done this is we have masters level psychiatric or public health nursing students intermittently at the agency, and they do health talks in the drop-in center, which frequently this content may involve role play or other information. I have done a psychotherapy group, which addresses clients' difficulties by asking what they need and advocating for themselves. However, the case managers and the registered nurses who often model the behavior that they are trained to help the client learn do the bulk of this. They may be calling about referral authorization or just even trying to reach a physician or a nurse practitioner and do that with the client so that maybe next time the client can do it with the staff there or ultimately do it independently. I hope that answers your question.

**Alana Nur:** Yes. Thank you, Alice. That was a clarification. Another question for you, do care coordinators fit into the group of caseworkers and care managers?

**Alice Geis:** I am not exactly sure how to answer that. I guess it depends on what those job titles mean in your organization. I think they have proliferated, so care coordinators, care managers, case workers, case managers. I think the important differentiating feature to me is really what the primary mission of the individual is. I think provider organization-based individuals may have a slightly different framework from reimbursement or MCO's, for example. Both kinds of organizations may have people with this title. They are doing many of the same things in terms of linkage to services and prioritizing needs in terms of real world or whole person priority such as housing needs in order for someone to have a stable base of operations in which to access the

rest of their needed services. I think it is not so much the name of the person, but the kind of system they are working in and what their primary focus is.

**Alana Nur:** Thank you. Okay, so we have time for one more question. As a reminder, if you have any more questions that we were not able to get to, please feel free to email us at RIC@lewin.com and we will follow up with everybody after the webinar. The last question, this is for Alice or Mindy, briefly if there is a diabetic client who is noncompliant with meds because of psych affective disorder that this particular client isn't able to address, how would you suggest we help this man help himself?

**Alice Geis:** Mindy, you want to go for this one or shall I?

**Mindy Klowden:** I will offer a few comments. The first thing that I think of is you want to have a reframe of rather than thinking of noncompliance, think of what are the barriers that this patient is having to compliance. It is a matter of making sure that you are using motivational interview skills and that you are having the right person have the conversation with the client about what is going on with them. It may be that utilizing a person in a peer role to kind of draw out what is going on and how can we help support you. Let us set some small goals, some reachable goals. I think of the navigation function, just as I talked about in my presentation, in terms of thinking about what does this person have access to in terms of healthy food. Do they have refrigeration, if they need that for insulin, making sure that you are looking kind of at the big picture of what is going on with the patient.

**Alana Nur:** Thank you, Mindy. I would also like to add that we will be covering many related topics to the type of situation in our upcoming webinar on Monday as well. We would love to have you join us there again. That brings us to the end of the webinar. If you could please complete our brief evaluation of the webinar so that we can deliver high quality presentations in the future, that would be wonderful. If you have any questions for us, please email us at RIC@lewin.com. For more information about obtaining digital education products, there is more information at https://resourcesforintegratedcare.com/. Thank you so much for joining us, and everyone have a wonderful day.