NAVIGATION SERVICES IN BEHAVIORAL HEALTH

ORGANIZATIONAL ASSESSMENT TOOL

RESOURCES FOR INTEGRATED CARE

Resources for Plans and Providers for Medicare-Medicaid Integration

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Introduction

This assessment tool is designed to assist behavioral health organizations in providing navigation services to clients managing serious mental illnesses. Ensuring that clients receive appropriate and coordinated care is the responsibility of front-line staff, providers, and administrators. This tool allows organizations to assess their capacity for delivering navigation services and to connect identified gaps to tangible next steps in the form of a customized action plan.

Individuals with serious mental illness (SMI) have high rates of medical comorbidities and significantly shorter lifespans than those without SMI.[1] A 2012 study from The National Institutes of Mental Health noted a reduction of 11 to 32 years. Little of this disparity is explained by mortality factors specific to mental health issues, such as suicide. Most of it is related to high rates of chronic health problems, including obesity, diabetes, hypertension, and other cardiorespiratory illnesses.[2] There is a need for coordinated services for individuals with SMI that recognizes the interconnectedness of mental and physical health[3,4] and of adverse childhood events and adult physical illness.[5] Individuals with SMI are, however, less likely to receive well-coordinated care due to insufficient linkages between mental health care and other services.[6] Various models of integrated services, where care is provided by an interdisciplinary[7] team in a well-coordinated fashion with the aid of one or more navigators, are rapidly being developed across the country. These approaches offer the promise of improving the health and overall wellbeing of individuals with SMI and assisting behavioral health organizations in their efforts to meet the financial and clinical demands of new payment and care delivery models.

Navigation

Navigation services may be referred to with terms such as case management, care coordination, etc. In this tool, navigation refers to the overall function of linking clients (and their natural supports) with essential health and community services. This work may be called by a different term in your organization.

Client

Providers may use a variety of terms when referring to individuals receiving health care services including "patient" and "consumer." For the purposes of this document, these individuals are defined as "clients."

Natural Supports

Clients may have a variety of individuals that support their recovery including family members, friends, other loved ones, neighbors, and employers. For the purpose of this document, these individuals are referred to as "natural supports."

Defining Navigation

Navigation is an approach that 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 clients (and their natural supports) with essential health and community services. It is a "barrier-focused intervention" that aims to assist clients in identifying and overcoming barriers to care. As navigation services and programs have proliferated, so have the definitions, program descriptions, roles, and job titles associated with these services.[8,9] Today, patient navigation reflects 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. It is very likely that your organization is currently engaging in activities to provide navigation services, though you may refer to these under a different name.

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 monitor receipt of services. The combination of services provided by a navigator 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. At the core of navigation is the focus on building a strong relationship with the individual and between the

individual, the community, and the 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 client-identified natural 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 individuals with SMI is the promotion of self-advocacy, recovery, and independence.

Using this Tool

The intended audience for this tool is organizations with existing behavioral health navigation programs and those that are interested in implementing navigation services for people with SMI. Organizations may use this tool to assess the presence and quality of elements necessary for navigation services and to create a path towards providing or strengthening such services in their organizations. Suggested action plans are linked to the organization's responses to the assessment questions.

Note that this tool measures an organization's capabilities around the specific functions that we refer to as navigation. It is understood that individuals with titles such as case manager or care coordinator may, in some organizations, be doing the work of what is called a healthcare navigator in this tool. When questions ask about a "navigator," consider the relevant staff person in your organization who performs or will perform that function.

The tool should be completed by at least two staff members within your organization. Identify several people with different perspectives such as clinical and support staff, administration, peer support specialists, etc. It is important to include multiple points of view. You may also want to emphasize the importance of answering rating questions honestly, even if the rating is low. All answers are for internal use, and staff should be empowered to give their candid appraisal.

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. Or perhaps 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 your organization's preferences; however you define it, it is important to communicate this decision clearly to all involved.

Instructions and Scoring

Those completing the tool are asked to rate a number of items. These ratings will assist organizations in creating their own customized action plan for implementing or strengthening their navigation services program. Respondents also have the option of completing an excel version of the tool at www.resourcesforintegratedcare.com where you can print or save a customized action plan that is generated based on your responses to the assessment questions.

Rate each item as it applies to your organization on the provided scale. For each item, there is a hyperlink to the relevant section of the Action Plan section. You may choose to view the Action Plan for each item or to view the Action Plan only for those items with a mid-range or lower self-assessment rating (e.g. yes/no items with "no" or "sometimes" answers). The Action Plan Items that you find most useful for your organizational planning may be copied and pasted into your own personalized action plan for navigation service development.

Organizational Assessment Tool

I. Organizational Capacity to Support Navigation Services

A. Population Considerations

Item	Response	Action Steps
1) Is your organization able to document, in a way that can be easily shared with all care team members, the number of clients with key characteristics/conditions (e.g. substance use, comorbidities, trauma, disabilities, etc.)?	☐ Yes ☐ Somewhat ☐ No	I.A.1
2) Is there an acuity measure in place (taking into account mental health, physical health, and substance abuse information) to identify higher risk clients (e.g. those most at risk of needing acute care and/or a more restrictive environment of care)? *An acuity measure categorizes or quantifies the severity of an illness and the level of associated risk.*	☐ Yes ☐ Somewhat ☐ No	I.A.2
3) Are social and financial barriers to care (e.g. housing, benefits, social support) consistently assessed for the population?	☐ Yes ☐ Somewhat ☐ No	I.A.3
4) Are cultural and linguistic barriers to care consistently assessed and addressed for the population (e.g. using in-person or telephonic interpretation, ensuring that provider and staff practices are culturally competent, developing patient materials in the most common non-English languages)?	☐ Yes ☐ Sometimes ☐ No	I.A.4

B. Organizational Infrastructure

1. Integration of Services

Item	Response	Action Steps
a) Is integrated primary care and behavioral healthcare provided onsite?	☐ Yes ☐ Somewhat ☐ No	I.B.1.a
b) Is pertinent information necessary for client care stored, tracked, and shared among the client's care team within the organization?	☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never	I.B.1.b
c) Is there an electronic health record (EHR) in use?	☐ Yes ☐ No	I.B.1.c
d) If the organization is part of a co-located model (e.g. an FQHC offers primary care services onsite in your behavioral health center), are	☐ Yes ☐ No	I.B.1.d

Item	Response	Action Steps
agencies using a single EHR?	☐ N/A	
e) Does the organization have the necessary technology and workflows/processes in place that enable use of an HIE (Health Information Exchange)?	☐ Yes ☐ Somewhat ☐ No	I.B.1.e
f) If primary care and behavioral healthcare services are co-located, is a combined Release of Information (ROI) in use?	☐ Yes ☐ No ☐ N/A	I.B.1.f
g) Does the organization consistently have timely access (e.g. within 48 hours) to information about hospitalizations and emergency room visits?	☐ Yes ☐ Sometimes ☐ No	I.B.1.g
h) Does the organization have the ability to participate in discharge planning with inpatient facilities?	☐ Yes ☐ Somewhat ☐ No	I.B.1.h
i) Does the organization have a consistent and reliable process to link clients to community resources either onsite or via referral (e.g. employment assistance, help with entitlement programs, transportation, housing, social activities)?	☐ Yes ☐ Somewhat ☐ No	I.B.1.i

2. Funding and Resource Considerations

Item	Response	Action Steps
a) Has the agency determined which, if any, navigation services are reimbursable by Medicaid, Medicare, or through a third party payer?	☐ Yes ☐ Somewhat ☐ No	I.B.2.a
b) Has the organization identified grant funding available to support existing navigation services and/or navigation services that you wish to begin offering?	☐ Yes ☐ Somewhat ☐ No	I.B.2.b
c) Have you determined if existing staff can be "re-tooled" to perform navigator functions (either additional functions or new functions you wish to begin offering)?	☐ Yes ☐ Somewhat ☐ No	I.B.2.c

3. Organizational Culture

Item	Response	Action Steps
a) How many staff members are experienced in working in integrated settings with clients that have both SMI and serious medical comorbidities?	☐ All staff ☐ Most staff ☐ Some staff ☐ A few staff ☐ No staff	I.B.3.a
b) What is the level of success that staff exhibit when required to collaborate and work as a team? (e.g. are staff comfortable giving and receiving constructive criticism, voicing concerns or asking questions of leadership, or acknowledging when they do not know an answer and need to ask a colleague?)	☐ High ☐ Moderate ☐ Low	I.B.3.b
c) If physical health services are provided onsite (by partners or your own staff), do leaders and clinicians from both organizations agree on the need for and scope of navigation services?	☐ Yes ☐ Somewhat ☐ No ☐ N/A	I.B.3.c

Item	Response	Action Steps
d) Does the organization have tobacco usage policies in place at facilities for staff members and clients?	☐ Yes ☐ Somewhat ☐ No	I.B.3.d
e) Is Trauma-Informed Care (TIC) embedded in the organizational culture (e.g. is there a TIC committee, is TIC language included in job postings and policies, and are staff members trained in TIC?) *Trauma Informed Care is an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma.*	☐ Yes ☐ Somewhat ☐ No	I.B.3.e
f) Are the efforts of staff members providing navigation services valued by leadership, providers, and other staff members (e.g. communicating with navigators, inclusion of navigators in the agency's management structure, inclusion of navigation services in strategic planning)?	☐ Yes ☐ Somewhat ☐ No	I.B.3.f
g) In a recent situation requiring your organization to change culture, processes, and/or workflows, rate the level of success your organization experienced in effectively responding to this change.	☐ High ☐ Moderate ☐ Low	I.B.3.g
h) Rate the level of "client-centeredness" in organizational culture (e.g. active involvement of clients in their care, responsiveness of staff to client preferences, internal decision-making driven by client needs)?	☐ High ☐ Moderate ☐ Low	I.B.3.h
i) To what extent does the organizational culture support navigators in performing social support functions (e.g. expressing empathy and caring emotions, listening to client problems, and providing advice and suggestions) while ensuring appropriate boundaries between staff and clients?	☐ High ☐ Moderate ☐ Low	I.B.3.i

4. Workforce

Item	Response	Action Steps
a) Has your organization outlined the core functions of navigation that would best meet the needs of your clients and determined which of these functions are already being addressed by current staff?	☐ Yes ☐ Somewhat ☐ No	I.B.4.a
b) Has your organization matched navigator functions to existing (and future) staff roles?	☐ Yes ☐ Somewhat ☐ No	I.B.4.b
c) Has the organization created a comprehensive curriculum to be used for initial and ongoing navigator training?	☐ Yes ☐ Somewhat ☐ No	I.B.4.c

C. Partnerships

Item	Response	Action Steps
1) Are there memoranda of understanding (MOUs) and/or linkage agreements with partner organizations that provide integrated care services? (e.g., primary care, HIV testing, substance abuse counseling, wellness coaching)	☐ Yes ☐ Somewhat ☐ No	I.C.1

Item	Response	Action Steps
2) Have you determined if existing partnerships can be expanded or potential community partners developed to share the costs of providing navigation services?	☐ Yes ☐ Somewhat ☐ No	I.C.2

D. Program Processes

1. Care Team Workflow

Item	Response	Action Steps
a) Is there a plan to ensure that navigators have easy access to the rest of the care team (e.g. establishing regular care team meetings)?	☐ Yes ☐ Somewhat ☐ No	I.D.1.a
b) Is there an established process for referrals to navigators?	☐ Yes ☐ Somewhat ☐ No	I.D.1.b
c) If navigators include (or will include) peers or unlicensed staff, is there a plan for supervision by a nurse or another health professional?	☐ Yes ☐ Somewhat ☐ No ☐ N/A	I.D.1.c

2. Data Documentation

Item	Response	Action Steps
a) Is an individualized integrated client health assessment - connecting medical, psychiatric, disability, trauma, social, and other elements - consistently in use for all clients during the intake process? *An individualized assessment is typically completed during an initial client encounter or incrementally over the first few client encounters.*	☐ Yes ☐ Somewhat ☐ No	I.D.2.a
b) Is key clinical and operational information readily available to navigators in a format that supports the creation and regular update of a navigation plan for each client as well as the tracking of client progress at the individual and population level? *Such data may include information related to upcoming and past appointments, prior utilization of services, diagnoses, and other information.*	☐ Yes ☐ Somewhat ☐ No	I.D.2.b
c) Is collaborative documentation used to enhance client participation in recognizing progress towards goals? *Collaborative documentation is the collaboration between clinicians and clients in the documentation of assessments, planning of services, and progress notes. This practice allows clients to provide input into services and their progress and assists in clarifying understanding of key issues.*	☐ Yes ☐ Somewhat ☐ No	I.D.2.c
d) Is information on client's receipt of recommended health screenings and preventive services readily available to navigators?	☐ Yes ☐ Somewhat ☐ No	I.D.2.d

3. Evaluating Services

Item	Response	Action Steps
a) Does the agency have an evaluation plan that includes the assessment of key program outcomes for the navigation program at regular intervals?	☐ Yes ☐ Somewhat ☐ No	I.D.3.a
b) Has the agency determined what additional outcomes may need to be measured related to navigation services?	☐ Yes ☐ Somewhat ☐ No	I.D.3.b
c) Is feedback from clients elicited on a regular basis (e.g. client self-assessment tools, client satisfaction surveys, client input on services needed)?	☐ Yes ☐ Somewhat ☐ No	I.D.3.c

II. Pillars of Navigation Support Services

A. Building Client Relationships

1. Communication

Item	Response	Action Steps
a) To what extent do navigators consistently treat each client interaction as an opportunity to build a therapeutic relationship and further establish trust?	☐ High ☐ Moderate ☐ Low	II.A.1.a
b) To what extent do schedules and communication channels allow for necessary inter-staff communications (e.g. between navigators and clinicians) that support effective navigation services?	☐ High ☐ Moderate ☐ Low	II.A.1.b
c) To what extent do navigators and staff ensure that spaces for client interactions are inviting and safe and that they reflect the cultures of the client population served?	☐ High ☐ Moderate ☐ Low	II.A.1.c

2. Cultural and Linguistic Competency

Item	Response	Action Steps
a) To what extent are the cultural and linguistic characteristics of the client population are represented in the organization's workforce?	☐ High ☐ Moderate ☐ Low	II.A.2.a
b) Are health information materials and other documents available for clients in their primary language?	☐ Yes ☐ Sometimes ☐ No	II.A.2.b
c) Have you reviewed Standards for Culturally and Linguistically Appropriate Services (National CLAS Standards) and assessed the extent to which organizational structures/processes reflect these standards?	☐ Yes ☐ Somewhat ☐ No	II.A.2.c

B. Health Literacy

Item	Response	Action Steps
1) Is an initial assessment of health literacy level conducted for each client?	☐ Yes ☐ Sometimes ☐ No	II.B.1
2) Does your organization consistently provide regular group or individual sessions for clients to increase health literacy? For example, topics may include reading nutrition labels, medication side effects, self-care for illness, advance directives, etc.	☐ Yes ☐ Sometimes ☐ No	II.B.2

C. Health Coaching and Wellness Planning

1. Goal Setting

Item	Response	Action Steps
a) To what degree are clients actively engaged in the process of setting health and other goals?	☐ High ☐ Moderate ☐ Low	II.C.1.a
b) To what degree are client goals shared with the team and updated in a timely and efficient way?	☐ High ☐ Moderate ☐ Low	II.C.1.b
c) To what degree are nursing or other clinical staff available to consult with navigators when developing health goals with clients (if navigators do not have the necessary training/licensing to ensure sufficient knowledge of physical health issues)?	☐ High ☐ Moderate ☐ Low	II.C.1.c
d) If navigators are directly providing health coaching, is there a process in place that ensures a feedback loop between client/navigator/provider to assess progress and modify goals?	☐ Yes ☐ Somewhat ☐ No ☐ N/A	II.C.1.d

2. Self-management Support

Item	Response	Action Steps
a) To what extent do agency policies, procedures and infrastructure support navigators and other staff in their efforts to promote client self-management skills?	☐ High ☐ Moderate ☐ Low	II.C.2.a
b) To what extent do navigators model behaviors with clients that support self-advocacy (e.g. suggesting questions to ask a specialty healthcare provider in a follow-up appointment)?	☐ High ☐ Moderate ☐ Low	II.C.2.b
c) To what extent do navigators treat clients in a way that respects their independence and takes into account client understanding of health issues?	☐ High ☐ Moderate ☐ Low	II.C.2.c
d) Are important members of clients' natural support system identified and appropriately involved in their self-management activities? *Natural supports include relationships that occur in everyday life that may support client recovery and health. This could include – but is not limited to – immediate family,*	☐ Yes ☐ Sometimes ☐ No	II.C.2.d

Item	Response	Action Steps
extended family, friends, neighbors, co-workers, employers, mentors, sponsors, coaches, landlords, etc.		

D. Care Coordination

Item	Response	Action Steps
1) To what degree do navigators have the necessary infrastructure to easily access and share client information across providers (e.g. clear policies, access to electronic tools, data-sharing arrangements with partners, etc.)?	☐ High ☐ Moderate ☐ Low	II.D.1
2) To what degree are clear information sharing and confidentiality policies established, in compliance with 42CFR and HIPAA?	☐ High ☐ Moderate ☐ Low	II.D.2
3) Are navigators trained to be able to appropriately recognize the need for referrals?	☐ Yes ☐ Somewhat ☐ No	II.D.3
4) To what degree are processes consistently followed for navigators to make referrals to appropriate internal and external resources? *Consider a diverse range of referral situations, such as emergent care, specialty care follow-up, psychiatric interventions, wellness and health education, and preventive services.*	☐ High ☐ Moderate ☐ Low	II.D.4
5) To what degree are processes consistently followed for tracking and following up on referrals (including soliciting and addressing reasons for non-completion)?	☐ High ☐ Moderate ☐ Low	II.D.5

E. Linkages to Community Services

Item	Response	Action Steps
1) Is a regularly updated list of linkages to quality social support resources in the community available for clients?	☐ Yes ☐ Somewhat ☐ No	II.E.1
2) To what extent is client feedback on linkages to social support resources sought and used to refine lists and patterns of referrals?	☐ High ☐ Moderate ☐ Low	II.E.2
3) To what extent is there strategic engagement by leadership in the maintenance of positive working relationships with community resource organizations (e.g. proactively identifying agencies to regularly connect with based on client needs, maintaining relationships with key leaders at identified organizations)?	☐ High ☐ Moderate ☐ Low	II.E.3

Recommended Action Steps

Below are "Action Steps" related to the scored items in the Navigation Organizational Assessment Tool. Some of the action steps are presented in a sequential way, relating to increasing program complexity and/or higher resource availability. The action steps for other items are presented as a

series of options, which could be equally effective in achieving the desired organizational change, depending on preferences and organizational structure.

I. Organizational Capacity to Support Navigation Services

A. Population Considerations

I.A.1	• Review systems for the ability to collect information on the following client characteristics/conditions: substance abuse disorders, medical co-morbidities (e.g. diabetes or hypertension) in addition to a serious mental illness, early and/or adult trauma histories, learning disabilities, intellectual and/or developmental disabilities, and linkages to primary care providers, specialty care providers, and other behavioral health providers. • Implement and use standardized intake questions that collect information on any population characteristics not currently assessed. The following resource contains a wide range of screenings tools, including ones for stress, depression, quality of life, mood and anxiety disorders, suicide-related thoughts, drug and alcohol use, and trauma: http://www.ibhpartners.org/wp-content/uploads/2015/12/ScreeningTool-Mandy.pdf Return back to the tool
I.A.2	• If not using an existing acuity measure, examine current methods by which the organization determines the necessary level of care for each client and evaluate if your organization would benefit from a more formal method of categorizing and quantifying risk. • When considering how to measure and define acuity, you may find it helpful to do a survey or focus group with staff to identify clients whose needs often exceed the resources of usual care patterns. What do these clients have in common? What other information would it be helpful to know about them? This will help you in identifying key data elements that relate to acuity. Be sure to consider elements related to mental health, physical health, and substance abuse. • You may find that data sources such as frequency and recency of ER usage and hospitalization are helpful in identifying higher acuity clients. Return back to the tool
I.A.3	• Implement information collection at intake related to barriers to care that have the potential to make it more difficult for clients to access and fully benefit from care. Clearly document barriers both for tracking at the individual level and in order to use this information to determine trends for the overall client population. Recurring barriers that the organization cannot address may suggest the need for program expansion or new partners. Return back to the tool
I.A.4	• If not in place, implement information collection at intake regarding languages spoken.

	• Using this information, assess the sufficiency of resources for interpretation services (by phone or in person), staff diversity and training to ensure cultural and linguistic competency, and the availability of patient materials in preferred languages. Return back to the tool

B. Organizational Infrastructure

1. Integration of Services

I.B.1.a	• If primary care is not co-located with behavioral healthcare, determine where most clients are currently receiving their care. As Federally Qualified Health Centers (FQHCs) and FQHC "look-alikes" are common sources for primary care for this population, assess existing FQHC partnerships and the feasibility of developing partnerships if they do not already exist. This site (www.findahealthcenter.hrsa.gov) provides assistance in locating FQHCs. • If you are interested in increasing the integration of behavioral health care and primary care, whether provided onsite or not, see related resources available at https://www.resourcesforintegratedcare.com/concepts/integrating-care and at https://www.samhsa.gov/integrated-health-solutions/build-practices/care-approaches/models-frameworks Return back to the tool
I.B.1.b	• Whether using a paper chart or an electronic medical record, examine the ease with which all members of a care team are able to access the information in a client record. • Ensure that staff members are entering information in a timely manner so that all members of care team have up-to-date information on a client. • Examine current workflows related to information exchange among different members of a care team; consider implementing morning huddles or regular care team meetings. Return back to the tool
I.B.1.c	• Conduct a cost/benefit analysis to determine the feasibility of implementing an electronic health record system. Return back to the tool
I.B.1.d	• If your agency is part of a co-located model and there are two EHRs in use, explore the implementation of a bidirectional interface between the two systems so that information can be shared accurately and efficiently. • To implement a bidirectional interface, first identify the information that is necessary to share between the systems, and then outline the resources and workflow modifications that are necessary to share this information. This process will assist you in working with your software vendor to set up the interface.

	Return back to the tool
I.B.1.e	• Research whether your state has a Health Information Exchange (HIE) and if so, determine what the process is to join the exchange. Evaluate the requirements for HIE participation alongside your current technology infrastructure and workflows. The federal government provides helpful basic information on HIEs at http://www.healthit.gov/HIE. • Consider joining any existing taskforces related to your state's HIE. Return back to the tool
I.B.1.f	• If primary care is collocated with behavioral health services, consider implementing a combined release of information (ROI) during the intake process to ensure that the exchange of client information occurs as efficiently as possible. Return back to the tool
I.B.1.g	• Initiate and strengthen relationships with the hospitals your clients are most likely to visit, based on geography and collection of this data from clients. Work with hospital staff to create and improve communication channels so that you receive notification of clients' hospitalizations and ER visits, such as an electronic alert within your EHR or a phone call. These kinds of interactions are sometimes made easier if you are both part of the same managed care plan, accountable care organization, or other entity where a shared data portal can be accessed. Return back to the tool
I.B.1.h	• Initiate and strengthen relationships with the hospitals your clients are most likely to visit, based on geography and collection of this data from clients. Work with hospital staff to create and improve communication channels so that you can participate in discharge planning when your clients are hospitalized. • The ability to participate in this process requires that an agreement with the hospital be in place so that you receive notification when a client is hospitalized and/or that a client or their natural support is able to easily contact your agency to assist them as they plan for discharge. Return back to the tool
I.B.1.i	• Develop a community resource list that outlines services and programs that may be available to clients. In many areas, you may call 2-1-1 for free information related to food, housing, employment, healthcare, counseling, and other resources. Learn more at http://www.211.org. • Potential resources include, but are not limited to, the following: employment assistance, education training programs, wellness programming (e.g. smoking/tobacco cessation, healthy eating, and physical activity), group treatments, individual counseling, entitlement programs (SSI, SSDI, Medicaid, etc.), transportation assistance, housing assistance, and community and/or social connections (e.g. YMCA, dance classes, bingo, etc.). • Evaluate the strength of the referral channel for each type of resource and identify any

	areas for improvement, such as the identification of a single point of contact at the other agency, ability to track referrals made, gaps in available resources, etc. Return back to the tool

2. Funding and Resource Considerations

I.B.2.a	• Determine which current and potential navigation services are reimbursable by Medicare, by Medicaid in your organization's state, or by a third party payer. If you have access to a state association for behavioral health providers, this is a helpful place to clarify what is reimbursed. The SAMHSA-HRSA Center for Integrated Health Solutions also offers resources related to billing in an integrated environment which can be found at: https://tinyurl.com/y75pwqp7 Return back to the tool
I.B.2.b	• Research potential local, regional, state and federal grant opportunities related to navigation, and join list serves and e-newsletters that may include announcements for grant opportunities such as http://www.grants.gov. • Talk with current funders about your plans to implement navigation services. One approach might be to discuss a limited pilot of the navigation services you identify as most impactful for your clients. During this limited pilot you may be able to demonstrate effectiveness and leverage additional funding for expanded services and/or to identify ways to have the services reimbursed by third party payers. Return back to the tool
I.B.2.c	• Examine your current organizational structure with an eye towards the navigation services you wish to offer. Consider current staff functions and skills, salary costs, and program outcomes to determine what navigation functions current staff members may be able to assume. • Make sure to consider the ability to receive reimbursement; in your state, staff with certain licensure or credentials may be eligible to receive reimbursement for certain services where others cannot. For assistance in this area, see https://www.samhsa.gov/integrated-health-solutions/build-practices/operations-administration/billing-finances. • Consider how your current funding arrangements influence your ability re-tool staff and their functions. For example, you may find that some kinds of staff that are funded by a particular grant cannot have their duties altered without an explicit discussion with the funding agency. • When identifying the resources necessary to "re-tool current staff," be sure to think through additional training needs.

	Return back to the tool

3. Organizational Culture

I.B.3.a	• Assess the skills of your current workforce. If unknown, consider implementing a simple survey to determine staff familiarity with working in an integrated care setting. These results may inform your hiring and training decisions as you expand or begin providing navigation services. Return back to the tool
I.B.3.b	• Examine current communications, meetings, and workflows that exist between teams. Determine if changes to these structures should be made in order to generate authentic sharing and teamwork. • Consider offering training on interdisciplinary team work. Encourage staff to work collaboratively, and ensure that your incentive structures also encourage teamwork. • Offer less structured opportunities for teams to work together and get to know each other through ad-hoc committees or social events. Return back to the tool
I.B.3.c	• Make time to discuss navigation services with executive and clinical leadership on both the physical health and behavioral health side. Assess buy-in for creating or expanding navigation services, and determine if both groups are working from the same shared definition of what navigation services are and what they are expected to accomplish. Return back to the tool
I.B.3.d	• If not in place, consider a transition to a "smoke-free" campus. Though this policy sometimes encounters initial resistance from staff and clients, it encourages healthy habits and reinforces the messaging around the importance of tobacco cessation that staff provide. Offer tobacco cessation support groups for both staff and clients. • Train all clinicians in a standardized approach to tobacco cessation, such as "Ask, Advise, Refer." For more information see www.breathend.com. Return back to the tool
I.B.3.e	• Engage with resources such as http://www.traumainformedcareproject.org/ and http://beta.samhsa.gov/nctic to learn more about Trauma-Informed Care opportunities. • Implement a Trauma-Informed Care Committee with representation from a variety of departments and consumers, and offer trainings for clinicians on how to work with clients who have experienced trauma. • Examine whether the physical space is a warm and welcoming environment. From the perspective of the client, does the space feel safe? Is there an absence of triggering material? Is it private? Is there a predictable and consistent structure when visiting the

	space? Return back to the tool
I.B.3.f	• Conduct facilitated discussions with staff about the value of providing navigation services. Determine what, if any, misinformation exists related to the role of navigators. Provide trainings to staff members to better understand navigation services and functions. Focus on the benefits for clients and staff. Identify aspects of the current staff's responsibilities that may be shifted and/or supported by appropriately trained navigators. • Review the agency's management structure, strategic planning process, and information flows to assess opportunities to increase the inclusion of navigation services. Return back to the tool
I.B.3.g	• Examine current workflows, processes and policies related to organizational decision making. Consider offering training for leadership on change management. Determine what processes and workflows may need to be adapted to accommodate additional flexibility within the organization. • Resources related to change management are available from many sources, including consultants and online information. One such source is http://www.change-management.com/tutorials.htm. Return back to the tool
I.B.3.h	• Regularly conduct client satisfaction surveys and share results internally with clients and staff and, as appropriate, externally with partners and community members. • Develop a consumer advisory board that meets regularly and advises on all levels of the organization. Consider including a consumer representative from the advisory board in ongoing management meetings, and include consumers on the organization's board of directors. You can also consider inclusion of "secondary" clients such as relatives or natural supports of clients with SMI. • Evaluate policies and practices for the extent to which they are driven by client needs and preferences and how successfully they promote active involvement of clients in their care. Return back to the tool
I.B.3.i	• Foster agreement among organizational leadership on the value of providing social support and informal counseling through navigation services. Reinforce strategies for providing social support, such as empathetic listening and helping to solve problems, during staff training. • Set clear policies and expectations regarding professional boundaries between navigators and clients. Discuss potential scenarios and appropriate responses: What if a client asks to borrow money? What if a client requests a ride home? What if the client offers a gift? Return back to the tool

4. Workforce

I.B.4.a	• Identify the navigation functions that are the highest priority for the organization. Identify the functions that are currently being performed by staff members in their current roles. Return back to the tool
I.B.4.b	• Based on identified needs, available staff, and the trade-offs among various staff types (below), map navigation functions to staff roles and consider the impact on future hiring needs. It may also be helpful to consider which desired navigation functions may already available through external agencies (e.g. care coordinators in managed care organizations). Better understanding what is available to your clients outside your organization may help you prioritize the use of your own staff for navigation functions. • *Registered Nurses (RNs) often have more experience communicating with professionals within the healthcare system. Along with their familiarity with physical health, mental health, and public health problems, they may be positioned to take a more proactive approach to resolving client issues related to the healthcare system. Many also have a holistic health orientation as well, with some education in nutrition and other wellness topics. However, nurse salaries are higher than other potential navigator types, and some nurses have focused only on a single sector or have little experience beyond their pre-licensure education. • Licensed Social Workers or other Master's level clinicians often have more experience in serving as a liaison to community resources. Many also have an in-depth understanding of mental health and substance abuse diagnoses and prior training hours focused on the clinical treatment of behavioral health problems. However, these clinicians often have less experience in the physical health sector, and some may be unfamiliar with assisting clients with aspects of their care that are not directly related to behavioral health • Case Managers (Bachelor's degree, unlicensed) are generally an existing resource within behavioral health provider organizations and often have prior experience in working across sectors. They may also be better positioned to provide increased contact with clients that can allow for faster development of trusting relationships that can support clients in making healthy choices. However, they typically have less physical health experience than nurses and less training in mental health treatment than master's level clinicians. • Peer Support staff are well-positioned to act as active role models for clients as they have often coped with similar problems. They typically have an advantage in successfully reaching out to difficult-to-engage clients. However, some peer support staff may have a lower literacy level, though training programs can help with this. Inclusion of peer support staff also requires sufficient supervision, which may add costs, to ensure that professional boundaries are maintained with clients. * Advanced Practice Nurses (APNs) have been used in some systems to provide complex care coordination. These provider-level practitioners are often most needed to directly provide

	primary care or psychiatry services. Therefore, generalist RNs who, at the bachelor's level and above, have preparation in psychiatric, medical-surgical, and public health nursing, among other areas, are the category of worker considered here. Return back to the tool

I.B.4.c	• The following checklist may assist you in ensuring that your curriculum for navigator staff training is comprehensive and thorough:
	  ○ Value of navigation services, navigator role, expectations
	  ○ Key processes and policies (e.g. referral processes, care coordination practices)
	  ○ Nature of client-navigator relationship and appropriate professional boundaries
	  ○ Engagement of client natural supports, including peer supports
	  ○ Available resources, such as technology, other staff members, resource lists, or handouts
	  ○ Basic clinical training in common chronic illnesses such as diabetes and hypertension and how these conditions interact with a serious mental illness diagnosis. Basic training on smoking cessation approaches.
	  ○ Training on the philosophy of client-centered care and the promotion of client self-management techniques
	  ○ Training on population health principles and the use of data to inform care
	  ○ Competency training in the following: teamwork, cultural and linguistic competence (including National CLAS standards), motivational interviewing, empathetic listening, modeling self-advocacy behavior and role-playing scenarios with clients, communication skills, trauma-informed care, and de-escalation techniques for working with clients experiencing strong emotions.
	  ○ Policies related to risk management and safety. If navigator staff will be working out in the community, ensure that training addresses safety guidelines. Sometimes local law enforcement officers are willing to visit training sessions and give localized input on best practices to ensure safety in the community.
	
	• After training topics are finalized, identify which can be conducted by existing staff and which you might reach out to partners for assistance. You might also explore available training and certification programs that could be of value to your navigators (such as the Patient Navigator Training Collaborative, http://patientnavigatortraining.org, Wellness Recovery Action Plans, http://www.mentalhealthrecovery.com/wrap, UMASS Center for Integrated Primary Care, http://www.umassmed.edu/cipc, and SAMHSA's Whole Health Action Management training program and peer support model, https://www.samhsa.gov/integrated-health-solutions/resource-library/wham.
	
	• You may also find it valuable to connect your staff to a wider learning community (such as a statewide association or a learning collaborative) to share ideas and resources. Local academic institutions may serve as natural partners by providing continuing education opportunities, timely access to new ideas and information, and potential research study partnerships that may help inform future program development.
	
	Return back to the tool

C. Partnerships

I.C.1	• Examine current agency partnerships to determine gaps in care and opportunities in areas such as primary care, HIV testing, substance abuse counseling, and wellness coaching. Determine if clients would benefit from deepening informal partnerships through the development of memoranda of understanding (MOUs) or linkage agreements. • Prepare standardized materials to share with potential partners that describe your organization's services and the navigation services you provide, or would like to provide. Return back to the tool
I.C.2	• Discuss navigation services in meetings with current partners to determine if there are additional opportunities related to navigation that would expand the scope of available services for clients, increase the efficacy of navigation services, and/or reduce associated costs. • Invite representatives from potential new partners to a discussion about navigation services, outlining the benefits for staff and clients and cost savings. Reach out to board members and staff to determine if there are existing contacts at these organizations. Return back to the tool

D. Program Processes

1. Care Team Workflow

I.D.1.a	• Adjust operational schedules and meeting patterns to include navigators at regular team meetings or case conferences. • Depending on the type of navigator(s), provide coaching to both navigator staff and other team members on the navigator's role and how to participate together in meetings. Return back to the tool
I.D.1.b	• You will need to clarify whether all clients are automatically assigned to a navigator of some sort, or if only a subset should be. Determine who in the organization is responsible for referring clients to a navigator and what the system for follow-up will be. Develop guidelines for exactly how internal referrals are to be made and what the responsibility of the navigator is for reaching out to clients. Return back to the tool
I.D.1.c	• If the organization currently employs RNs, consider establishing consultation time for peer and unlicensed navigators with an RN to establish and update health goals and strategies for supporting behavioral change.

	• If the organization does not currently employ RNs, consider establishing a partnership agreement (e.g. contact faculty practice group at local college of nursing, hire part-time) with an organization to provide RN consultation to peer and unlicensed navigators. Return back to the tool

2. Data Documentation

I.D.2.a	• If you are developing an integrated assessment process for the first time or revising a current form/process, consider including clients in this process through a committee or focus group. • If you are currently using an EHR, evaluate the system's functionality to pull information into the assessment form from other parts of the health record, like primary care visit notes or navigator notes. To the extent that you can avoid duplicate data entry, you will reduce time spent in assessment and make better use of client information. • Determine who should complete each component of the assessment. Can you have navigators complete part of the form with clients to reduce provider burden? Is there a component clients can complete themselves while waiting? Consider the flow of information across staff members and where each information component will be stored after it is collected. • In the section of the integrated assessment that addresses health history, consider including questions pertaining to psychiatric, medical, substance abuse, intellectual or developmental disability, or learning disability history. Also consider inclusion of questions related to medications, health habits, client's understanding of their own health status, trauma history, current health literacy, and time to first cigarette of the day (for smokers). • You may also consider incorporating the measurement of vital signs, weight and BMI during the health assessment process. If you have access to the necessary onsite resources, you may also find it valuable to include point-of-care testing for lipids, glucose or HbA1c, and carbon monoxide in exhaled air (for smokers). • Take into account client's cultural beliefs when conducting a health assessment. Return back to the tool
I.D.2.b	• Data that navigators need in order to perform critical functions include but are not limited to the following: assessment results from intake, upcoming appointments and prior missed appointments, smoking status, trauma information, clinical diagnoses, diabetic management status (including HbA1c), client self-assessment of health status, histories of surgeries and hospitalizations, prior emergency room usage, and medication and pharmacy information. • Review internal documentation for availability of such data. Gather a small work group to determine which elements your organization deems most critical for navigators to access.

	Evaluate gaps in data that may require accessing information from external providers (for example, notes from specialists), and determine the best workflow for obtaining the information. • Implement workflows to obtain key data regularly on clients who will be receiving navigation services. • Ensure that navigators are able to access this information either directly through the client's health record or through summative reports and/or dashboards that include both organizational metrics (e.g. % of clients meeting HbA1c goals) as well as actionable client-level data for navigator use. Return back to the tool
I.D.2.c	• Collaborative documentation is when clients and clinicians work together to document assessments, progress notes, and plans for care. It is most easily implemented when an electronic health record is in use, though it can be used with paper records as well. • This practice can increase capacity for additional appointments and increase communication between clients and clinicians; it is a departure from the traditional view of the purpose of documentation and requires clinicians to alter their writing style and focus during documentation. • The National Council for Community Behavioral Healthcare offers a guide on collaborative documentation available here: https://tinyurl.com/yauf2adf. This resource is targeted to youth, but the majority of the information is applicable to adult populations. Return back to the tool
I.D.2.d	• It is helpful if navigators can readily access information on clients' receipt of recommended health screenings and preventive care such as colonoscopy, mammogram, Pap smear, men's health screenings (e.g. prostate exam), flu vaccination, pneumococcal vaccination, lipid levels, blood pressure, blood sugar / HbA1c, BMI, and waist circumference. • Use release of information to obtain such data from external primary care or other healthcare providers or organizations. Client self-reported data are also helpful when it is difficult or impossible to obtain prior records for these services. • Develop mechanisms for summarizing health screening and preventive care data across clients and regularly sharing this information with navigators for use in their work with clients. This is easier done with an electronic health record system but can also be done with paper records through a system of chart reviews and tallying data for use in client outreach. Return back to the tool

3. Evaluating Services

I.D.3.a	• Examine the organization's existing efforts in data collection and evaluation. Discuss in an upcoming leadership meeting how to ensure that evaluation is emphasized in your efforts to add or expand navigation services. It may be helpful to select an evaluation "point person" to coordinate efforts across departments if this role doesn't formally exist. • With internal expertise, or with the aid of external consultants or learning collaboratives, develop an organizational evaluation plan that clearly states the target outcomes that the organization plans to evaluate, links the target outcomes to organizational goals, specifies the data needed to do so, and outlines how this data will be collected. • Determine resources (staff time and technology) necessary to track and report on each outcome. Ensure that information needed to evaluate outcomes is collected regularly and reported to staff and clients as appropriate. Return back to the tool
I.D.3.b	• Evaluate which existing outcomes in your evaluation plan are relevant to the goals and target outcomes of the navigation program. • Integrate additional goals and target outcomes related to navigation services into your evaluation plan as needed. Potential outcomes may be drawn from external sources such as federal documents, Healthcare Effectiveness Data and Information Set (HEDIS, http://www.ncqa.org/HEDISQualityMeasurement.aspx), CMS health home measures, etc. Some agencies may find measures such as ER usage, hospitalizations, or changes in key physical health measures to be helpful outcomes. • Ensure that you are able to obtain the necessary data for each target outcome measure for a sufficiently large segment of the client population. • Determine resources (staff time and technological) necessary to track and report on any additional outcomes. Return back to the tool
I.D.3.c	• Review the organization's evaluation plan for opportunities to utilize feedback directly from clients (e.g. client self-assessment tools, client satisfaction surveys, client focus groups) to evaluate success on target measures and/or to provide context for why certain measures may be low or high. • Consider sharing the evaluation plan with members of a consumer advisory council or similar body. Return back to the tool

II. Pillars of Navigation Support Services

A. Building Client Relationships

1. Communication

II.A.1.a	• A focus on building trust is critical, and each client interaction is an opportunity to build trust or to diminish it. Navigators and those who supervise them may benefit from trainings focused on the nature of client-navigator relationships, components of therapeutic relationships, motivational interviewing techniques, harm reduction, workplace boundaries, and client-centered care. • Relevant topics for in-service for navigators and other staff might include the following: Principles of the Recovery Model and Patient-Centered Care, Managing Responses to Clients with Challenging Behaviors, Maintaining Appropriate Boundaries in Service Delivery. • Consider conducting occasional observations, with client permission, of navigator-client interactions. Use existing client satisfaction tools or surveys to assess the client's perception of communications with navigators and other staff. Return back to the tool
II.A.1.b	• Navigation services may require greater inter-staff communication than traditional case management. As you add or expand navigation services, assess communication structures for ease of use and efficiency. • Channels of communication assessed may include secure email, in-EHR communication, in-person meetings in conjunction with client visits (e.g. navigator present for behavioral health or primary care visit), separate meetings between navigators and other staff, phone/text messaging, regularly scheduled team meetings, and client case conferences. Return back to the tool
II.A.1.c	• Ensure that the quantity of private space is sufficient for anticipated client volume. Ensure ease of access to bathroom facilities, and consider providing water and healthy snacks. This is particularly true for intensive outpatient services, group events, or times when the anticipated wait for the provider is longer than usual. • Engage the organization's consumer advisory board, if available, in brainstorming to improve organization spaces. Consider the use of décor choices that reflect the identify of various segments of the client population (e.g. client-generated art). • Remediate any problems with on-site security. Consider training in de-escalation techniques (particularly for front desk personnel who are often the first individual a client encounters), improving control of access to the premises, and increasing the presence of security personnel. Return back to the tool

2. Cultural and Linguistic Competency

II.A.2.a	• Review job recruitment materials for navigators and other positions to ensure that they support efforts to recruit and retain a diverse workforce.

	• Use new or existing partnerships with community organizations to assist with recruiting a culturally and linguistically diverse workforce that mirrors the diversity of the client population. • To the extent possible, match the language needs of the organization's client population to the language capabilities of staff members. Return back to the tool
II.A.2.b	• To increase the use of translated health education handouts, visit summaries, and other documents, it may be helpful to first gather in-depth information on languages spoken by your client population. This information may already be stored in the health record or other source. Quantifying the greatest language needs will assist you in knowing where to first invest resources in translation. • If you have an EHR, talk to your vendor about language plug-ins that assist you in generating visit summaries in other languages. • Before translating numerous materials into multiple languages, consider the degree to which you can standardize language across materials. This could potentially allow you to translate fewer documents into more languages. • When translating materials, be sure to work with a reputable organization that understands the dialectical and cultural nuances necessary for a clear and effective translation. Return back to the tool
II.A.2.c	• Using a national framework in your efforts to improve cultural and linguistic competency provides an overall direction and guide for measuring success. National CLAS Standards were published by the Office of Minority Health in 2000 with revisions in 2010. They "provide a blueprint for individuals and health and health care organizations to implement culturally and linguistically appropriate services." Learn more here: https://www.thinkculturalhealth.hhs.gov/clas. Ideas for integrating these standards into your practice are below. • Include data regarding cultural identification and language proficiency in initial assessment tools accessible to navigators. • Revise policies and procedures and job descriptions to reflect organizational standards for providing culturally and linguistically appropriate services. • Incorporate cultural elements into collection of demographic data, policies and procedures, quality improvement programs, outcomes evaluation plans, communication activities, development of community partnerships, and initial and on-going training for navigators and staff. • Leverage community partners for enhancement of cultural and linguistic competence of navigator/staff training. Engage peers from cultural groups less represented in the navigator staff group to provide formal (consumer advisory board) or informal

	information to staff about cultural issues. • Embed recommendations for discussions of cultural factors in templates used for clinical supervision of navigators. Return back to the tool

B. Health Literacy

II.B.1	• Consider using a standardized tool for assessing client health literacy, such as one of the following: Rapid Estimate of Adult Literacy in Medicine—Short Form (REALM-SF) or the Short Assessment of Health Literacy for Spanish Adults (SAHLSA-50) – both at http://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy/index.html or the Newest Vital Sign Health Literacy Assessment Tool http://www.pfizer.com/health/literacy/public_policy_researchers/nvs_toolkit. Return back to the tool
II.B.2	• Clients may benefit from navigators periodically offering group or individual education sessions on the following topics (or others of interest): 1) taking medications correctly and identifying side effects, 2) reading nutrition labels, 3) understanding symptoms that are important to report to providers (e.g. early warning signs or indications of new illness or relapse), 4) understanding how to be an effective consumer of health care (e.g. selecting a PCP, preparing for visits, when to use the ER, importance of preventive care), 5) self-care for minor illnesses and injuries, 6) risks of tobacco, alcohol, and over-the-counter medication use, 7) obtaining and understanding personal health information, and 8) medical and psychiatric advance directives. • Use consulting nurses, if available, to conduct group education sessions. Consider collaboration with an academic institution to provide periodic client education in these areas, using faculty and/or students in nursing, medicine, occupational therapy, or other health disciplines. • Engage social workers, psychology staff, or legal resources to educate clients as well as navigator staff in the implementation of advanced directives. • Consider the need to adapt trainings for populations such as racial and ethnic minorities, LGBT clients, and others. Return back to the tool

C. Health Coaching and Wellness Planning

1. Goal Setting

II.C.1.a	• Opportunities to increase client engagement in the goal setting process include the following: a) add a section related to goals to an existing assessment form (one that prompts the client to articulate goals in their own words), b) provide materials on which clients can record their ideas about health goals prior to a visit, and c) increase staff success in eliciting client goals by training them in the use of motivational interviewing techniques. Return back to the tool
II.C.1.b	• You may find it useful to include navigators directly in settings where health goals are developed or revised, such as navigator participation in client and/or team meetings and navigators accompanying clients for health appointments. • Consider where client goals are stored and whether various staff members can easily access this information and if they have regular prompts to do so outside of client visits (e.g. reviewing goals on a regular basis during team meetings). • It may also be helpful to develop a process for navigators or health coaches to provide updates to healthcare providers on key health parameters related to health goals (e.g. BMI, HgbA1c) as this information might not regularly be viewed by providers outside of a client visit. Return back to the tool
II.C.1.c	• Consider setting aside dedicated time for navigators and nurses or other clinical staff to consult with one another on health goals. This may be a part of regular client meetings, the use of secure messaging in the health record, or other channels. If navigators know that they have support for clinical expertise, they will feel more empowered to support clients in recording and working towards their health goals. Return back to the tool
II.C.1.d	• Develop a process where information from health coaching sessions, including modifications to goals, is available regularly to the rest of the care team. This may take the form of written updates, EHR or paper entries, or periodic meetings. Return back to the tool

2. Self-Management Support

II.C.2.a	• If you are interested in increasing the capacity of your organization to support your clients' efforts to self-manage, see in-depth resources on this topic available at https://www.resourcesforintegratedcare.com/concepts/self-management-support. • Navigators and staff can also promote client self-management skills by ensuring a smoke-free environment onsite (including staff), providing only healthy foods in any nearby vending machines, using appointments as an opportunity to walk when appropriate, etc. Return back to the tool

II.C.2.b	• Explicitly incorporate principles of self-management and self-advocacy into the navigator role. Encourage navigators to see their participation in clients' healthcare appointments as a rehabilitative function, with the goal of increasing client self-advocacy skills. • Include information during navigator training and supervision on how navigators might model self-advocacy behaviors and reinforce such behaviors with clients (e.g. the use of repetition, role-playing, and real world practice). Common scenarios might be asking providers questions, raising concerns with their providers, or requesting a second opinion. Return back to the tool
II.C.2.c	• Review training and supervision practices to ensure that navigators routinely interact with clients in a way that respects their independence, personal preferences, and understanding. Encourage navigators to manage personal reactions to client health behaviors that may be perceived by the navigator as not being in the best interest of the client. • Consider providing a knowledge packet with personal health information to clients to increase their understanding and support self-advocacy. Example contents: names of illnesses, medication dosages and purposes, food and drug allergies, dietary restrictions, recent lab values and blood pressure readings, information on any assistive devices such as pacemakers or dentures, hospitalization and surgical history. • Incorporate the client's understanding of health issues and their level of health literacy when collaboratively developing health goals. Consider sharing hand-outs with clients that provide information on what self-management involves and clarify the roles of client and care team. • Taking into account available resources and evidence-based practices, allow clients to self-select and direct the specific navigation services they receive. For example, those who need less assistance with care coordination might receive more health promotion/wellness services. Return back to the tool
II.C.2.d	• Encourage clients to identify individuals to be involved as natural supports in their efforts to work towards their goals. • Train navigators to assist clients in developing stronger social support systems through participating in group activities sponsored by your own organization or others in the community. Such involvement may take many forms such as group education or counseling, community activities, volunteering, religious activities, reaching out to neighbors, etc. • Develop appropriate policies and procedures for sharing information with natural supports. Return back to the tool

D. Care Coordination

II.D.1	• Assess available tools for information sharing and develop a prioritization plan for obtaining and/or upgrading these tools. Ensure that navigation staff members are trained in the latest technology within the organization. • Ensure that navigators understand applicable legal issues surrounding release of information and that they have a point person to go to with any questions. • Consider conducting outreach to external health organizations to jointly develop plans to improve health information sharing for shared clients. • If you are still using paper records, evaluate the need for a move to an electronic health record system. If you anticipate making this switch soon, take time to think through how your information sharing procedures and policies will need to be revamped. Return back to the tool
II.D.2	• SAMHSA offers extensive documentation and assistance for providers in their efforts to comply with 42 CFR and HIPAA: https://www.samhsa.gov/section-223/governance-oversight/provision-coordination-privacy; https://www.samhsa.gov/laws-regulations-guidelines/medical-records-privacy-confidentiality; https://www.samhsa.gov/about-us/who-we-are/laws/confidentiality-regulations-faqs. Return back to the tool
II.D.3	• Consider implementing training to assist navigators in identifying the need for referrals for additional care. This training will vary depending on the educational/licensure level of navigator staff. For example, training to achieve this competency may need to be extensive for peer navigators or minimal for RN or LCSW navigators. • Navigators that are primarily trained in behavioral health may need additional training in recognizing the need to provide referrals to other sectors of health care. • Navigators with more general health sector experience, such as an RN with mostly inpatient experience, may need additional training in recognizing the need for referral to behavioral health services. Return back to the tool
II.D.4	• Analyze the organization's current referral process, and identify obstacles in the completion of successful referrals. Review the informal workflow for referrals that staff currently follow, and use it to inform your creation of a formalized workflow (e.g. what work-arounds do staff employ? Would it be useful to codify these?). • Since processes and resources may differ according to referral type, consider a wide range of situations in your analysis. Some examples include the following: a) urgent or emergent health need, b) medical intervention by a triage nurse or primary care provider, c) psychiatric intervention by a therapist or psychiatric provider, d) return visit to a specialty provider (including which factors trigger a return visit), e) sexual health education or screening, f) preventive health services, g) health education and wellness activities, and h)

	referral situations that require consultation (including when and how to seek consultation regarding the appropriate provider type and/or level of care). • Establish a consistent process for referrals of each type, and educate team members on available internal and external resources. Clarify when the navigator should provide a service to the client and when the client should be referred to other internal and external resources (e.g. hospital-based diabetic educator or licensed dietician). • Determine if current systems have the capacity to track referrals efficiently. Address any gaps in communication within the process. Consider adding or reallocating resources such as database software, EHR upgrades, or administrative assistant time if necessary. Return back to the tool
II.D.5	• Provide navigators with a list of outstanding referrals that includes a place to track referral completion status. An updated list should be brought to team meetings or shared with the care team in another way, such as in the EHR or a registry. • Encourage navigators to provide context to clients on the importance of referrals and to use motivational interviewing techniques to encourage clients to complete them. • Regularly review referral completion data and generate ideas to change referral patterns and/or improve referral completion rates. Return back to the tool

E. Linkages to Community Services

II.E.1	• Determine who in your organization should have ultimate responsibility for maintaining up-to-date lists of social support resources – usually a navigator. Include "maintenance of an active directory of social support resources" as a part of this individual's job description. • Make sure that wherever this list is stored that it is easily accessible to other team members as needed. Ensure that there is a mechanism for other team members to suggest edits to this list. Return back to the tool
II.E.2	• Evaluate available consumer feedback mechanisms (focus groups, surveys, consumer advisory boards), and schedule a regular opportunity for clients to provide input on the resource list. Take into account client perception and experience when deciding which resources are maintained on the list. Return back to the tool
II.E.3	• Make sure that client needs are a driving force behind the identification and prioritization of relationship-building activities with community resource organizations. • To maintain and grow linkages to meet client needs, regularly set aside time in leadership

staff schedules to meet with identified key leaders in community resource organizations. You may find it helpful to include such liaison activities in leadership job descriptions.

- Consider involving navigator staff in meeting preparation or in community meetings when appropriate. You may also work to connect your navigator staff with similar staff within organizations that are often utilized by your clients. Some agencies have found it "meet and greet" sessions held at their site to be useful for this purpose.

Return back to the tool

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