

Approaches to Navigation Services for Individuals with Serious Mental Illness

***A Guide to Resources, Promising Practices,
and Tools***

Prepared for:

Centers for Medicare & Medicaid Services

Submitted by:

The Lewin Group, Inc.

Institute for Healthcare Improvement

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

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

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

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

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

Table of Contents

Introduction.....	1
What is Navigation?.....	1
Why Navigation is Important?	2
What is in This Guide?.....	4
Components of Navigation	5
Engaging Enrollees in Care and Building Therapeutic Relationship	5
Personalized Health Coaching and Wellness Planning.....	5
Health Assessment and Clinical Interventions.....	5
Care Coordination and Linkages to Community Services.....	6
Advocacy	6
Your Organization’s Context and Considerations	7
Provider Tools to Support Self-management	9
Tools Used by Navigators	9
Tools to Train Navigators.....	10
Tools for Organizations Seeking to Implement Navigation Services.....	11
Acknowledgements.....	13
Appendix A: Brief Psychiatric Rating Scale (Version 4.0)	14
Appendix B: Medication Reconciliation Form.....	15
Appendix C: Navigator Patient Tracking Form.....	16
Appendix D: Behavioral Health Navigator Job Description from The Penn Foundation, a Participating Site of HCHC	17
Annotated Bibliography	18
Provider Organizations Referenced in This Guide.....	19

Introduction

What is Navigation?

Navigation is an approach behavioral health providers can adopt to deliver a greater degree of integrated care to adults with serious mental illness (SMI) and chronic or complex medical conditions. Navigation refers to the function of linking patients (and family members) with essential health and community services. Navigation is



a “barrier-focused intervention” that aims to assist patients in identifying and overcoming barriers to care. It is typically a time-limited service, usually related to an episode of care, for example follow-up on an abnormal colorectal cancer screening examination.

In the past several decades, patient navigation has been used to increase the receipt of effective care and services for individuals with a developmental disability, cancer, HIV, diabetes, and asthma.¹ Although navigation services have mainly been used among underserved individuals, they have also been used among the general population. As navigation services and programs have proliferated, so have the definitions, program descriptions, roles, and job titles associated with these services.^{2,3} Today, patient navigation reflects quite heterogeneous program designs and is delivered by lay and professional workers including nurses, social workers, certified case managers, community health or outreach workers, and trained mental health peers.

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



¹ Agency for Healthcare Research and Quality, Outcomes of Community Health Worker Interventions. AHRQ Publication n No. 09-E014, June 2009.

² Rosenthal EL, Wiggins N, Brownstein JN, et al. The Final Report of the National Community Health Advisor Study: Weaving the Future. Tuscon, AZ: University of Arizona; 1998.
<http://crh.arizona.edu/sites/default/files/pdf/publications/CAHsummaryALL.pdf>

³ Centers for Disease Control, Addressing Chronic Disease Through Community Health Workers: A policy and systems level approach.

Table 1: Key Functions and Services that may be Provided by Navigators

Health Education and Coaching	Advocacy	Linkages to Health System and Community Services	Health Assessment and Triage	Outreach-patient and Care Team
<ul style="list-style-type: none"> ● Goal setting with consumers ● Personalized wellness planning ● Interpreting instructions from PCP and specialists ● Provide education to promote health literacy. ● Increase skills for self-management and wellness 	<ul style="list-style-type: none"> ● Provide social support and informal counseling ● Attend visits and meetings with consumers ● Culturally appropriate support ● Increase self-advocacy 	<ul style="list-style-type: none"> ● Coordination of care with various service providers ● Appointment scheduling ● Assistance with housing ● Referral support ● Employment support ● Transportation services- providing and/or coordinating ● Assessing and maintaining insurance coverage ● Arranging or providing language translation services 	<ul style="list-style-type: none"> ● Health indicator monitoring (e.g., blood pressure, weight) ● Mental status assessments: PHQ-9, Consumer Health Inventory, Brief Psychiatric Rating Scale Version 4.0 ● Risk Assessments 	<ul style="list-style-type: none"> ● Engages consumers to participate in navigation ● Communicates with case manager at health plans ● Facilitates communication with large treatment team providers ● Establishes strong partnerships with PCP, specialists, therapists, and family members

Why Navigation is Important?

Navigation coordinates care, providers, and services across siloed mental, behavioral, and physical health care delivery systems, leading to greater holistic and person-centered care; navigation also assists individuals in overcoming other barriers to care and to increase their engagement and active participation in care. Poverty, discrimination, uneven access to medical



care (and high quality medical care), cognitive impairment, and other environmental factors (e.g., distance to health care, language differences) create barriers to timely and appropriate care for individuals with SMI. Behavioral health agencies and providers adopting navigation will expand their capacity to provide care that is more integrated and

reduce gaps in care for individuals with SMI.

Navigation is associated with increased use of ambulatory primary and specialty care and reduced

use of inpatient and crisis services.^{4,5,6,7,8} From a health plan perspective, the up-front costs of a navigation program may be offset by reductions in the use of high cost services. A navigation program developed by Molina Health plan of New Mexico in 2005 saved \$7,676 across 15 members with multiple chronic conditions during a six-month period.⁹ The program paired community health workers with social workers to deliver navigation services.



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

Consumers receiving navigation services report increased feelings of recovery, independence, and the ability to manage their illness.¹⁰ They also note improved care experiences and increased overall satisfaction with care.¹¹ In addition, family medicine physicians at SUNY’s Primary Care Institute found that SMI consumers receiving navigation services had greater connections with primary care.¹² In the Montgomery County



HealthConnections program, participating individuals had improved mental health and physical health when measured using the validated Short Form (SF-36) Health Survey.¹³

For health systems, navigation can reduce missed appointments, increase efficiency of specialty care use, and reduce duplication of diagnostic services and medicines. For health systems,

⁴ Paskett ED, Harrop P, Wells KJ. Patient Navigation: An update on the state of the science. *CA Cancer J Clin.* 2011. 61:237-249.

⁵ Center for Health Care Strategies. Policy Brief: Early Lessons from Pennsylvania’s SMI Innovations Project for Integrating Physical and Behavioral Health in Medicaid, 2012.

⁶ Magellan Health Services, Montgomery County HealthConnections: Report to the community, Montgomery County, Pennsylvania. Publication No. P-B106(11/11). June 2011.

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

⁸ Navigation delivered by professional health care workers, trained lay health workers, or trained peer supports have all demonstrated a reduction of high-costs services.

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

¹⁰ Davidson L et al. Peer support among persons with severe mental illnesses: a review of evidence and experience *World Psychiatry* 2012;11:123-128

¹¹ Paskett ED, Harrop P, Wells KJ. Patient Navigation: An update on the state of the science. *CA Cancer J Clin.* 2011. 61:237-249.

¹² Griswold KS, Pastore PA, Homish GG, Henke A. Access to Primary Care: Are Mental Health Peers Effective in Helping Patients After a Psychiatric Emergency? *Primary Psychiatry.* 2010;17(6):42-45.

¹³ Magellan Health Services, Montgomery County HealthConnections: Report to the community, Montgomery County, Pennsylvania. Publication No. P-B106(11/11). June 2011.

another benefit of navigation may be increased information sharing across providers to support coordination. This is particularly true for navigation delivered by nurses and mental health clinicians, clinically trained staff who are empowered to communicate with a range of health care providers.

What is in This Guide?

This guide offers resources that may assist providers seeking to develop navigation programs. In the sections that follow, readers will become familiar with key components of navigation. Included are examples of how behavioral health leaders and provider agencies in the Montgomery County, PA HealthConnections program implemented these components to integrate care using navigation. Factors and features associated with successful navigation as identified by experts in this field are also described. Finally, this guide includes tools and other resources to help providers get started.

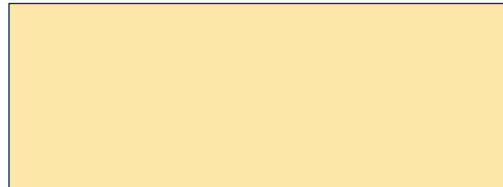


Components of Navigation

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

Engaging Enrollees in Care and Building Therapeutic Relationship

Navigator teams engage in active outreach to enroll individuals into the HealthConnections



program since mailings about the new navigation service alone were found to be insufficient. Navigators explain the program in-person to individuals – an approach that was effective in engaging individuals. In-person outreach also helps navigators and consumers begin to establish and build therapeutic relationships. In some

cases, peer supports provide outreach to individuals to explain the program.

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

Personalized Health Coaching and Wellness Planning

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

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



Health Assessment and Clinical Interventions

Navigators also conduct health status monitoring and risk assessments (e.g., mental health and drug and alcohol assessments) in the HealthConnections program. Monitoring a consumer's progress can inform the care team about whether or not an intervention is working, leading to further treatment personalization. Risk assessments are critical to guiding treatment and

preventative care priorities and guides client referrals to other resources. LeeAnn Moyer, Deputy Administrator in the Department of Behavioral Health and Disabilities in Montgomery County, says that the clinical expertise and training of the navigators enables these assessments and clinical interventions, such as medication reconciliation and medication administration.

Care Coordination and Linkages to Community Services

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

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

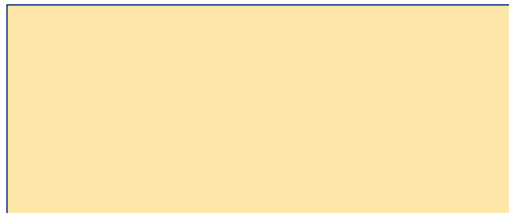
Advocacy

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

Your Organization's Context and Considerations

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

Identify Consumers for Participation in Navigation. Initially, establishing criteria for selecting who will be most appropriate for navigation is important to ensure staff time and organizational resources are used where needed most. Not all individuals with SMI will need or benefit from navigation. Amistad, a non-profit, consumer-run



organization launched the Peer Coaching Initiative at Maine Medical Center in November 2011 to provide alternative treatments targeted to individuals with SMI with frequent emergency room (ER) use for psychiatric crisis. Peer navigators were placed in ERs to engage

clients and then provided navigation over time. The program was successful in reducing the average number of ER visits from 17 to 9 in the first three months.¹⁴ In the HealthConnections program, potential consumers were first identified by Montgomery County health plans using risk stratification models to predict who was likely to use significant health care services.¹⁵

Consider Registered Nurses with Experience in Primary Care or Physical Health Care. Your organization can determine the appropriate health worker to deliver navigation services to adults with SMI. This may be related to your program goals and consumers you want to participate.



Registered nurses may be particularly effective navigators if goals include integrating care across multiple providers and settings and performing health assessments that encompass physical health. In the Montgomery County HealthConnections navigation program, registered nurses formed half of a navigator team for consumers with SMI.

¹⁴ Grantham, S; John Snow Inc., Healthy Amistad. December 2011 and Brimmer K. Maine program aims to lower ED visits for psychiatric crisis. *Healthcare Finance News*. April 05, 2012.

¹⁵ Magellan Behavioral Health Plan of Pennsylvania, Inc. and Keystone Mercy Health Plan participated in the Montgomery County HealthConnections program. See provider appendix for more details.

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

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

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

Director Clark Bromberg, PsyD, at Central Montgomery MH/MR noted that the HealthConnections navigation program “filled a gap in our organization, offering a holistic approach to care. We were able to infuse a sense of accountability for physical health into our organization and support the navigator role as an additional service for our consumers.”

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

Provider Tools to Support Self-management

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

Tools Used by Navigators

Medication reconciliation form*

This form was developed by Central Montgomery MH/RC and can be used by navigators to keep prescribing physicians and care team members aware of a client's complete medication list.

[See appendix item B.](#)

Weekly Navigator Status Tracker Report*

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

[See appendix item C.](#)

Second Generation Antipsychotic Tip Sheet*

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

https://www.magellanprovider.com/media/11781/second_gen_antipsychotic.pdf

PHQ-9*

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

http://www.cqaimh.org/pdf/tool_phq9.pdf

Brief Psychiatric Rating Scale Version 4.0*

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

[See appendix item A.](#)

Consumer Health Inventory (CHI)*

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

https://www.magellanprovider.com/media/11839/chi_english.pdf

Care Transition Toolkit for Persons with Mental Health & Co-Occurring Conditions Overview and Webinar

This Care Transition Toolkit will help persons with mental health conditions to navigate transition between care locations or providers. The Toolkit can be useful even if you are not moving. It has tools to keep track of personal health information, be part of your own care planning process, and share your medical preferences with the provider support team.

Introduction to the Care Transition Toolkit Webinar:

https://www.resourcesforintegratedcare.com/behavioral_health/care_coordination/tool/overview

Care Transition Toolkit:

https://www.resourcesforintegratedcare.com/Care_Transition_Toolkit/Webinar

Serious Mental Illness Comorbidity Tip Sheets

The Resources for Integrated Care tip sheets below can assist navigation staff in supporting clients with serious mental illness (SMI) in their management of smoking, hypertension, asthma/COPD, congestive heart failure, and HIV/AIDS.

Smoking:

<https://www.resourcesforintegratedcare.com/IDD/Navigation%20Services/Tip%20Sheet/Smoking%20and%20Serious%20mental%20Illness>

Hypertension:

https://www.resourcesforintegratedcare.com/behavioral_health/navigation_services/tipsheets

Asthma/COPD:

https://resourcesforintegratedcare.com/behavioral_health/navigation/tipsheet/COPD_Asthma_SMI

Congestive Heart Failure:

https://resourcesforintegratedcare.com/behavioral_health/navigation/tipsheet/CHF_SMI

HIV/AIDS:

https://resourcesforintegratedcare.com/behavioral_health/navigation/tipsheet/HIV_AIDS_SMI

Tools to Train Navigators

Certificate Program in Primary Care Behavioral Health*

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

<http://www.umassmed.edu/cipc/pcbh/overview/>

Colorado Patient Navigator Training Program

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

<http://www.patientnavigatortraining.org/>

Patient Navigator/ Community Health Worker Conference

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

<https://chwtraining.org/blog/pn-chw-conference-2016>

Providing Navigation Services to Clients with Serious Mental Illness and Chronic Physical Health Conditions Webinar

This webinar focuses on how behavioral health organizations and providers can provide navigation services to their clients with serious mental illness (SMI) and common chronic physical health conditions. The webinar explores components of navigation services including personalized health coaching and wellness planning as well as actions navigators can take to link these individuals and their families to essential health and community services. The webinar features six condition-specific navigation tip sheets that highlight considerations related to the management of SMI and other physical conditions including diabetes, hypertension, congestive heart failure, HIV/AIDS, and COPD and asthma and smoking cessation.

https://resourcesforintegratedcare.com/Behavioral_Health/2017_Navigation_Services_Webinar_Series/Providing_Navigation_Services

Tools for Organizations Seeking to Implement Navigation Services

Consent to Release Protected Health Information*

This form was developed by Magellan Behavioral Health of Pennsylvania, Montgomery County Department of Behavioral Health and Developmental Disabilities, Keystone Mercy Health Plan, and the Department of Public Welfare, and can be used by health plans to obtain consent to share health information with both the physical and behavioral health providers.

<https://www.magellanprovider.com/media/11959/consenttoreleasephi.pdf>

Behavioral Health Navigator Job Description*

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

[See appendix item D](#)

Navigation Services in Behavioral Health - Organizational Assessment Tool

The 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.

https://resourcesforintegratedcare.com/Behavioral_Health/Navigation_OAT

Acknowledgements

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

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

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- Lori Marshall, RN HealthConnections Navigator
- LeeAnn Moyer, Deputy Administrator of Behavioral Health, Montgomery County Department of Behavioral Health and Developmental Disabilities

Appendix A: Brief Psychiatric Rating Scale (Version 4.0)

Brief Psychiatric Rating Scale (Version 4.0)

Name/ID # _____ Date _____ Rater _____
 Hospital/Location _____ Period of assessment _____

	NA	1	2	3	4	5	6	7
	Not Assessed	Not Present	Very Mild	Mild	Moderate	Moderately Severe	Severe	Extremely Severe

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

1. Somatic Concern	NA	1	2	3	4	5	6	7
2. Anxiety	NA	1	2	3	4	5	6	7
3. Depression	NA	1	2	3	4	5	6	7
4. Suicidality	NA	1	2	3	4	5	6	7
5. Guilt	NA	1	2	3	4	5	6	7
6. Hostility	NA	1	2	3	4	5	6	7
7. Elevated Mood	NA	1	2	3	4	5	6	7
8. Grandiosity	NA	1	2	3	4	5	6	7
9. Suspiciousness	NA	1	2	3	4	5	6	7
10. Hallucinations	NA	1	2	3	4	5	6	7
11. Unusual Thought Content	NA	1	2	3	4	5	6	7
12. Bizarre Behavior	NA	1	2	3	4	5	6	7
13. Self-neglect	NA	1	2	3	4	5	6	7
14. Disorientation	NA	1	2	3	4	5	6	7

Rate items 15-24 on the basis of observed behavior or speech of the patient during the interview.

15. Conceptual Disorganization	NA	1	2	3	4	5	6	7
16. Blunted Affect	NA	1	2	3	4	5	6	7
17. Emotional Withdrawal	NA	1	2	3	4	5	6	7
18. Motor Retardation	NA	1	2	3	4	5	6	7
19. Tension	NA	1	2	3	4	5	6	7
20. Uncooperativeness	NA	1	2	3	4	5	6	7
21. Excitement	NA	1	2	3	4	5	6	7
22. Distractibility	NA	1	2	3	4	5	6	7
23. Motor Hyperactivity	NA	1	2	3	4	5	6	7
24. Mannerisms and Posturing	NA	1	2	3	4	5	6	7

Sources of information (check all applicable):

Patient

Parents/Relatives

Mental Health Professionals

Chart

Explain here if validity of assessment is questionable:

Symptoms possibly drug-induced

Underreported due to lack of rapport

Underreported due to negative symptoms

Patient uncooperative

Difficult to assess due to formal thought disorder

Other _____

Confidence in assessment:

1 = Not at all- 5 = Very confident

Appendix B: Medication Reconciliation Form

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

Patient's Name: _____

DOB: _____

Directions:

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

ALLERGY/INTOLERANCE

Table with 6 columns: MEDICATION, REACTION, MEDICATION, REACTION, MEDICATION, REACTION. Rows 1-2.

Table with 5 columns: MEDICATION, DOSE, FREQUENCY, INDICATION, ORDERING PHYSICIAN. Multiple rows for medication entry.

Source: [] Patient [] Family [] PCP [] Specialist(s) [] Central's Medical Record [] Other _____

Form completed by: _____ Date: _____

Signature indicates review: _____ Print name: _____ Date: _____

Appendix C: Navigator Patient Tracking Form

HealthChoices Health Connections - Montgomery County's Navigator Status Report

PHASE II

Provider: _____

Week Ending: _____

a	b	c	d = (b-c)	e	f	g	h	i = (d-(f+g))		
# Members Assigned	Engagement Activity	Members Contact Pending (begin of week)	Member Status Change	Expected Members to Engage	# Members Outreached	Members consented to program	Members refusing consent	Members Unable to Contact	Members Contact Pending (end of week)	Members Referred to Plans (no further contact)
	This Week									
	Cumulative									

Member Status Change (c above)

Last Name	First Name	MA / CIS #	Moved out of County	Lost Eligibility	Transferred	Deceased	Incarceration

Member Refusals (g)

Last Name	First Name	MA / CIS #	Reason	Re-engage Y/N	Refer to Plan Y/N

Member Unable to Contact (h)

Last Name	First Name	MA / CIS #	Reason	Re-engage Y/N	Refer to Plan Y/N

Member Referred to Recovery Coach

Last Name	First Name	MA / CIS #	Reason	Date Referred	Date Assigned

Appendix D: Behavioral Health Navigator Job Description from The Penn Foundation, a Participating Site of HCHC

Behavioral Health Navigator

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

Position Overview

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

Essential Job Responsibilities/Requirements

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

Hours

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

Education/Experience/Training

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

Annotated Bibliography

Agency for Healthcare Research and Quality, *Outcomes of Community Health Worker Interventions*. AHRQ Publication n No. 09-E014, June 2009.

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

Rosenthal EL, Wiggins N, Brownstein JN, et al. *The Final Report of the National Community Health Advisor Study: Weaving the Future*. Tuscon, AZ: University of Arizona; 1998.

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

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

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

Peer support among persons with severe mental illnesses: a review of evidence and experience *World Psychiatry* 2012;11:123-128.

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

Center for Health Care Strategies. *Policy Brief: Early Lessons from Pennsylvania's SMI Innovations Project for Integrating Physical and Behavioral Health in Medicaid*, 2012

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

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

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

Paskett ED, Harrop P, Wells KJ. Patient Navigation: An update on the state of the science. *CA Cancer J Clin.* 2011. 61:237-249.

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

Griswold KS, Pastore PA, Homish GG, Henke A. Access to Primary Care: Are Mental Health Peers Effective in Helping Patients After a Psychiatric Emergency? *Primary Psychiatry.* 2010;17(6):42-45.

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

Magellan Health Services, Montgomery County HealthConnections: Report to the community, Montgomery County, Pennsylvania. Publication No. P-B106(11/11). June 2011.

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

Grantham, S; John Snow Inc., Healthy Amistad. December 2011 and Brimmer K. Maine program aims to lower ED visits for psychiatric crisis. *Healthcare Finance News.* April 05, 2012.

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

Provider Organizations Referenced in This Guide

Amistad Inc.

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

Address: 66 State St # 2 Portland, ME 04101

Phone: (207) 773-1956.

Website: <http://www.amistadinc.com/>

Montgomery County HealthConnections Magellan Health Services

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

Phone: 877-769-9782

Website: www.MagellanofPA.com

Penn Foundation

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

Address: 807 Lawn Avenue, Sellersville, PA 18960

Phone: (215) 257-6551

Website: <https://www.pennfoundation.org/>

Creative Health Services

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

Address: 929 Willow Street, Pottstown, PA

Phone: (610) 326-7734

Website: <http://www.creativehs.org/>

Central Montgomery MH/RC

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

Address: 1100 Powell Street, Norristown, PA 19401

Phone: (610) 277-4600, X119

Website: <https://www.centralbh.org/>

Horizon House

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

Address: 3275 Stokley Street, Philadelphia, PA 19129-1128

Phone: (215) 386-3838

Website: www.hhinc.org

Abington Memorial Hospital

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

Address: 1200 Old York Road, Abington, PA 19001

Phone: (215) 481-2000

Website: <http://www.abingtonhealth.org>

NHS Montgomery County

NHS Montgomery County is a division of NHS Human Services, Inc, which is a non-profit organization dedicated, directly or indirectly to the provision of health and human services for children and adults. NHS provides innovative solutions to support the unique needs of the individuals we serve by striving to create a caring and responsive environment that promotes the highest standards of integrity and care. NHS Montgomery has community roots in Lansdale, Pennsylvania, dating back to the 1970's, providing a continuum of behavioral health and addiction services to over 3,000 individuals each year.

Address: 400 N. Broad Street, Lansdale, PA 19446

Phone: (215) 368-2022

Website: www.nhsonline.org