

RECOVERY SUPPORT SERVICES:

Behavioral Health Peer Navigator

Target Population	Adults with serious mental illness and/or a chronic substance use disorder; and/or adults who self-identify as having a mental health or substance use problem; and/or transitional aged youth with severe emotional disturbance and/or substance use disorder and Chronic Health Conditions; Family Members/Caregivers.
Expected Outcomes	<p>This service helps to remove personal and environmental obstacles to health care access. Individuals receiving this service should demonstrate the following outcomes:</p> <ul style="list-style-type: none"> • Decrease in time between diagnosis and treatment • Decrease in use of emergency room services • Decrease in health symptoms • Increase in physician visits and medical appointments • Increased adherence to agreed-upon protocols, medication regimens, and/or recovery strategies • Increase in knowledge by the individual about their health conditions • Increase in knowledge by the individual about how to manage their physical and behavioral health conditions • Increase in knowledge and use of prevention activities • Improved feelings of wellness • Improved quality of life Indicators • Increase in knowledge of the health-care system(s) • Reduction in relapse
Service Definition	<p>This service is a set of non-clinical activities that engage, educate and offer support to individuals, their family members, and caregivers in order to successfully connect them to culturally relevant health services, including prevention, diagnosis, timely treatment, recovery management, and follow-up. This service includes working with the patient to develop and implement an individualized action plan:</p> <ul style="list-style-type: none"> • Coordinating physician visits and other medical appointments • Arranging transportation to and from medical services • Accessing and maintaining insurance coverage • Providing education about medical conditions and recovery strategies • Facilitating communication with health care providers. • Maintaining telephone contact between patients and health-care

Service Requirements	<p style="text-align: center;">providers</p> <p>This service is designed to be a one-to-one, primarily face-to-face service. However, Peer Navigators may be involved in caregiver/family consultations, and in some cases may lead emotional support groups. Additionally, peer navigators may advocate on behalf of the individual with his or her permission.</p> <p>Service activities include:</p> <ul style="list-style-type: none"> • Identifying and Addressing Barriers to Health-care for Health Disparate populations • Maintain telephone contact between patients and health-care providers • Coordinate Physicians visits and other medical appointments • Motivate and educate individuals and their family/caregivers about the importance of preventive services • Assisting Individuals/Families/Caregivers in completing medical, financial, and other forms that are necessary for health care access and services. • Arranging or providing transportation to and from medical appointments • Coordinating care among Providers (such as screening clinics, diagnosis centers, tech labs, and allied health services) • Arranging for Translation Services, where necessary • Providing education to improve health literacy • Providing emotional support to alleviate fears of and barriers to accessing quality health-care • Assists with medication financing and management • Coordinate child-care , elder-care, and respite services when necessary
Staffing Requirements	<p>H.S diploma or equivalent. Must be able to communicate verbally and in writing. This service area requires skill in communicating with and facilitating dialogue between health care professionals and of individuals and their families. Core competencies include:</p> <ul style="list-style-type: none"> • Knowledge of communities they serve • Competency in active listening and relationship-building • Ability to communicate with empathy • Ability to actively participate as a team member of a health-care team • Knowledge and ability to integrate health information, about prevention/management of disease and the health system, into the culture and language of the community • Ability to assist the individuals to utilize the health care system in a

	<p>more knowledgeable, empowered, and effective manner</p> <ul style="list-style-type: none"> • Knowledge and ability to navigate the health care system • Ability to bridge the communication gap between the health care system and the individual receiving the services • Knowledge and lived experience of mental and/or substance use disorders and recovery • Ability to translate medical terminology and concepts in lay terms <p>Supervision should be provided one-to-one, on a weekly basis by professional social service/health care staff trained to supervise peer workers. Additionally, a health-care team should review the individual action/recovery plans developed by the staff monthly.</p> <p>The case load ratio recommended is 1-12.</p>
Location Requirements	<p>The services should take place in natural community settings where the individual feels most comfortable and is able to involve caregivers/family members/friends who are involved in care (i.e. the individual’s home or a recovery community center). The environment in which the service is provided should foster a familiar and non-threatening atmosphere, where the individual, caregivers, and family are able to be actively involved. Some services (social, emotional support) may be provided by electronic communication.</p> <p>This service should not be delivered in environments where:</p> <ul style="list-style-type: none"> • The individual does not feel comfortable • Confidentiality cannot be assured • The individual is not safe • Public transportation is not easily accessible
Recommended Duration	<p>The recommended duration and frequency of this service is dependent on the health-care status of the individual. Services should be delivered at a minimum, bi-monthly when delivered as a preventative service. In a diagnosis and acute treatment status, the individual should receive services daily or at a minimum, weekly.</p>
Service Exclusions	<p>This services should not include:</p> <ul style="list-style-type: none"> • Providing physical assessments, diagnoses, or treatments • Ordering care, treatments, or medications • Attending to or becoming involved in any direct patient care (e.g., changing dressings, providing direct financial assistance) • Providing physical, occupational, speech therapy, or any other forms

	<p>of medical therapy</p> <ul style="list-style-type: none"> • Making health-care decisions for the individual and/or family members/caregivers
<p>Documentation Requirements</p>	<p>Required documents should include:</p> <ul style="list-style-type: none"> • Written Recovery Plan that specifies the activities of the navigator and updated progress notes, that includes initial assessment, objectives and outcomes as well as the identification of barriers to care • Documentation of all contact(s) with health-care professionals, allied service providers, and family members/caregivers • Evidence of Written Recovery/Wellness/Health-care Plans by Supervisor and Health-care Team • Evaluation reports from individual, family member/caregiver, and health-care providers