Mental Health Navigator Program Description

The Mental Health Navigator program addresses Grand County’s behavioral health needs: improving access to behavioral healthcare, including transportation needs; educating and empowering patients with high health needs and their families; and improving behavioral healthcare through innovative methods of care delivery and care transition. The MHN program includes three basic components:

1) An Integrated Mental Health Navigator (MHN), a hybrid model of Northwest Colorado Community Health Partnership’s (NCCHP) Integrated Behavioral Health program in Routt and Moffat Counties and the Grand County Rural Health Network’s (the Network) Patient Navigation program, to provide brief intervention, serve as a MH coach, and remove barriers and navigate MH care;

2) A lay Mental Health Transport Navigator (MH transport navigator), modeled after a program in the San Luis Valley, to transport emergency mental health patients and provide immediate transition of care back into the community; and

3) Technical Assistance to primary care and mental health providers as well as community partners in utilizing the program to its maximum potential.

Our target populations in Year One are patients with cardiovascular disease (CVD), coronary artery disease (CAD), and diabetes (high health needs). In Years Two and Three, we will expand to patients on Medicaid (low-income), utilizing P.A.I.N.S. vouchers (uninsured or underinsured), and in Home Health care.

The MHN will be a master’s level clinician, licensed or pursuing licensure, capable of providing brief intervention. Brief intervention improves access to behavioral healthcare in primary care provider (PCP) and other community settings, educates patients on the importance of MH services, and navigates patients to a long-term provider. The MHN will focus on behavioral health coaching (e.g. brief intervention), removing barriers to care (stigma, insurance status), navigating to long-term behavioral healthcare, educating and empowering the patients on behavioral health intervention and screening, and advocating for and coordinating patient care with PCPs and behavioral health providers.

The program will have two MHNs: one employed by Middle Park Medical Center (MPMC MHN) and housed within their facilities in Granby and Kremmling, primarily in the clinics; and one employed by Mind Springs Health (MSH), housed at the Network for the remaining PCPs in the community (community MHN) and primarily working off-site at PCP and partner facilities. Due to the size of our county, the community MHN will work at each private clinic at least half a day each week and be available for telephone discussions or on-call with PCPs two half days per week. One half day will be devoted to follow-up, making phone calls, and connecting the patient, PCP, and mental health provider and/or psychiatrist.

PCPs may develop procedures internally to refer patients to the MHN. However, best practices modeled after the NCCHP dictates we screen patients to have an unbiased introductory discussion with the patient. In Year One we will use the Patient Tools App to implement the Patient Health Questionnaire-9 (PHQ-9) depression screening in all primary care clinics to patients with CVD, CAD, or diabetes during their annual well exam. If a patient flags on the
screening, PCPs will follow the referral road map to determine the best referral and/or anticipatory guidance. PCPs may then refer to the MHN for brief intervention. The MHN will know local and regional MH providers and PCPs and have a good grasp on their expertise and personalities to make appropriate referrals, assuring patient choice, to a provider who will best fit the patient. The MH providers will communicate via the App back to the PCP and the MHN about services and a care plan. The App is HIPAA compliant and assures the patient has the power to determine who sees his/her protected information. The patient may request to use the paper referral process instead. In Years Two and Three utilizers of Medicaid, P.A.I.N.S. vouchers for low-income, uninsured and Home Health clients will be screened as well.

This program is modeled after the Network’s existing Patient Navigator program where nurse navigators conduct high level, medical-specific navigation services and a lay navigator conducts lower-level services. The MHN will work in tandem with the PN team. Oftentimes, a patient enters the PN program with medical comorbidities and behavioral health illness or undiagnosed needs. The navigator cannot educate and empower the patient without first addressing behavioral health. The MHN and PN will support each other and ensure continuity of care. The PN program provides community linkages and a general structure for the MHN program to succeed. The PN program was created from a community planning process similar to the planning of the MHN program. MPMC is a partner in the PN program and employs a PN with similar supervision.

The MHN program is also modeled after the NCCHP’s Integrated Behavioral Health model which incorporates a high- and low-level navigator and uses screenings in clinics to refer patients to the MHN. The NCCHP collaborative implements the program; MSH employs the staff.