Introduction

There is a growing interest and demand for coordinated care across health and human service delivery systems to better meet the needs of individuals with complex physical and mental health issues. Research shows that person-centered interventions that emphasize education, empowerment, and self-management are effective and beneficial. In addition, many studies document the benefit of physical, mental health, and employment support to help individuals with chronic conditions maintain their employment.

Understanding the Role of Navigation in the Stay Well, Stay Working Program

October 2010

“You can never get enough accountability. I really look forward to meeting with my Navigator to talk about what I want out of my life. My life has transformed and my Navigator has helped me to build confidence.”

Background

Minnesota was one of five states that participated in the Demonstration to Maintain Independence and Employment funded by the Centers for Medicare and Medicaid Services. Under this research Demonstration, the Minnesota Department of Human Services (DHS) developed an intervention – Stay Well, Stay Working (SWSW) – that offered working persons with a serious mental illness (SMI) a comprehensive set of health, behavioral health, and employment support services. The goals of the research Demonstration were to:

1. Create a comprehensive and coordinated set of health care, behavioral health, and employment based supports for employed individuals with SMI;
2. Determine how access to and utilization of these services and supports influences the progression of potentially disabling conditions; and
3. Prevent or delay a person with SMI from becoming disabled and no longer able to work.

Stay Well, Stay Working Outcomes

The three-year SWSW evaluation used a randomized design and found the following participant outcomes:

- Fewer applications to Social Security Disability Insurance (SSDI)
- Improved functioning, reductions in limitations in ADLs/IADLs
- Improved mental health status
- Higher earnings
  - overall
  - for lower functioning participants who used intensive employment supports
  - for participants who were more engaged with their Navigators and reviewed their goals annually
- Achieved more than half of the goals related to employment within the first year
(DMIE) sought to augment an expanded health benefit set with a person-centered care support provider to prevent or delay enrollment in government programs (e.g., SSDI) due to disability. Central to the Minnesota model — Stay Well, Stay Working — was a Wellness and Employment Navigator who was responsible for person-centered planning and care coordination to address health, behavioral health, and employment needs.

**About this Brief**

This research brief will describe the SWSW Navigation model, including the role and function of the Navigator and participant experiences. To differentiate how Navigation was defined in the SWSW program, the brief compares Navigation to traditional case management models in Minnesota, as well as the person-centered care support interventions implemented by the other states (Hawaii, Kansas, and Texas) that participated in the DMIE.

**Description of the SWSW Wellness and Employment Navigator**

The purpose of the Wellness and Employment Navigator was to educate, support and empower participants to manage their physical and mental health as well as their employment issues, and to learn how to access multiple service providers throughout the community more effectively to meet their needs.

**Navigator Functions**

In the SWSW program, Navigators served as neutral guides in assessing enrollees’ physical, behavioral and employment status and matching identified needs to available resources. The role of the Navigator was conceptualized as a “coach” who encouraged the participant and provided a seamless interface with the health care system, community mental health, and employment and social service providers. Participants were encouraged to contact their Navigator regularly for assistance and guidance. Participant contact with Navigators (after the initial assessment, goal setting and periodic check-ins) was voluntary.

---

**Primary Responsibilities of the Navigator**

- Orienting participants to the benefits of the SWSW program, including reviewing provider network services, disseminating the SWSW Wellness and Employment Planner, and providing participants with contact information to access needed services
- Assessing physical, behavioral health and employment needs during the initial meeting between Navigators and participants, using the standard Initial Assessment of Enrollee Form
- Developing a Wellness and Employment Success Plans with participants to document their wellness and employment goals, including suggestions for service referrals
- Answering questions and educating enrollees about how to access needed services
- Identifying needed educational/training topics for workshops
- Making direct referrals to the provider network for health and employment services
- Communicating with all relevant provider organizations about access issues or grievances that need resolution
- Monitoring (at least monthly and annually) participant progress and providing ongoing support

**Administrative Tasks of the Navigator**

- Coordinating eligibility and enrollment with DHS
- Tracking initial assessments, success plans, annual reviews and monthly contacts on a caseload spreadsheet, to help manage caseloads and scheduling
- Documenting service encounters with participants
- Attending regular Navigator team and network meetings
- Tracking disengaged/non-responsive, and unemployed participants
- Preparing monthly reports on caseload and related activities
Navigator Role and Impact

The Wellness and Employment Navigator was a key component of the SWSW intervention. Through the comprehensive assessment and goal setting process, Navigators established strong relationships and rapport with participants that facilitated engagement and overall success in the program. Participants often described the Navigators’ role as providing structure, advocacy, social support, empowerment, and assistance with goal setting. Navigators provided motivation, enhanced self-discipline, fostered accountability, and educated participants on how to advocate multiple service systems. SWSW participants shared the following statements about the role and impact of their Navigator:

“You can never get enough accountability. I really look forward to meeting with my Navigator to talk about what I want out of my life. My life has transformed and my Navigator has helped me to build confidence.”

“My Navigator gave me the power to advocate for myself. I was reminded that I have choices and that I can ask my doctor questions about my care.”

“I’ve gained a lot of insight by talking things through with someone. It’s easy to give up when you’re all alone, but when you have someone positive to support you, you can get empowered pretty quickly.”

“Since I’ve been in SWSW I’ve been more proactive. My Navigator has really helped me. I was never interested in learning how to manage my mental health before her.”

Participants also reported several strengths of the Navigation component of the SWSW program. They appreciated the tailored, client-driven approach because individuals have different service needs and learning styles, and respond differently to various supports. SWSW program participants recognized the strong connection between health and employment, and valued the positive focus on work. Another theme highlighted by participants was that the SWSW program empowered them to take greater responsibility for their health, mental health and employment conditions, to more actively engage in health care decision-making, and to explore resources and support services previously unknown to them to maintain their independence.

“Usually when you are so down on yourself from a job loss you can slip back into depression. It is hard to think positive. Stress causes confusion. Motivation decreases. You can spiral down. But my Navigator helped me stay on track.”

“It’s nice to have the option of changing providers if I’m not satisfied with the medical care. Just because you’re low income doesn’t mean you shouldn’t have a choice about your health care.”

“I’m no longer settling. I’ve increased my own expectations for my quality of life. I realize now that I deserve to thrive.”

“I feel validated by being in this program – I know that I’m not alone. A program like this can help reduce the stigma of mental illness and reduce disparities for mental health treatment.”

Comparison of Navigation to Traditional Case Management in Minnesota

Many have asked how Navigation compares to traditional case management. Several of the functions performed by Wellness Employment Navigators appear similar to those of traditional case managers. According to a 2003 report to the State DHS’ Disability Services Division, case management in this setting is defined as “…the systematic process of ongoing assessment, planning, referral, service coordination, monitoring, consultation and advocacy assistance through which multiple service needs of clients are addressed.” The State’s Mental Health Division defines adult public mental health case management services to include “…a functional assessment, individual community support plan, referral and assistance in getting needed mental health and other services, coordination of services and monitoring of the delivery of services.” The Federal Medicaid program defines case management services as...
“...services that will assist individuals, eligible under the State plan, in gaining access to needed medical, social, educational, and other services. ‘Targeted’ case management services are those aimed specifically at special groups of enrollees such as those with developmental disabilities or chronic mental illness; case management services will be comprehensive and coordinated, and will include an assessment of an eligible individual; development of a specific care plan; referral to services; and monitoring and follow-up activities.”

All of these definitions of case management services call for assessment, planning, referral, service coordination, and monitoring, which were primary functions of the Navigators.

Table 1 provides observations on the differences between Navigation and traditional case management.

---

**Table 1: Observations on the Differences between Navigators & Traditional Case Managers**

<table>
<thead>
<tr>
<th>Navigator Service Coordination Spanned Multiple Service Systems</th>
</tr>
</thead>
<tbody>
<tr>
<td>By design, Navigators approached case management holistically. In collaboration with SWSW network providers, Navigators assisted participants in navigating across different systems of care that promote wellness and employment. In some traditional models, case managers operate within one service system (health plan, employment, mental health). It is not unusual in traditional models for persons presenting with multiple disabilities to have more than one case manager to address their needs.Navigator service coordination spanned multiple care settings, including medical, behavioral health, and employment support services, and all three care domains were of equal importance.</td>
</tr>
</tbody>
</table>

**Navigation Covered Broader Scope of Wellness and Employment Needs and Supports**

The concept of “wellness” in the SWWS model was broad and holistic, and included physical health, mental health, nutrition, exercise, stress management, substance use, smoking cessation and overall quality of life. Traditional case managers tend to focus more narrowly on chronic and persistent physical or mental health conditions. In addition, Navigation also had a broader scope than job status or job skill development, because it included debt management, financial planning, tax preparation, household budget development, resolving conflict in the workplace and learning how to disclose a mental health condition to an employer.

**Navigation Emphasized Self-Direction**

Unlike some case management models, Navigators made suggestions for the participant rather than prescribing or requiring follow through on provider network referrals. The development of the Wellness Employment Success Plan was a joint effort between the Navigator and the enrollee, and goal setting and referrals (as well as how they were prioritized) changed over time. Care was self-directed. Once referrals were made, it was up to enrollees to follow through.

**Navigators Served as Neutral Navigators Across Systems**

Education and advocacy are important components in Navigation that may or may not appear in traditional case management services. Navigators are knowledgeable about vocational rehabilitation as well as the physical health and mental health provider and payer systems. In addition, they have significant knowledge of community and peer resources. Navigators help enrollees to empower themselves to seek needed care by educating and helping them navigate the system of care and benefits, advocating on their behalf to overcome any access barriers, and offering support to make the most effective use of the resources available. Benefits to enrollees include self-navigation and help-seeking behaviors, wellness promotion, and ultimately independence from reliance on the system to manage life and work.

**Navigators Were Not Gatekeepers**

Navigators did not perform the gate-keeping function included in some case management services. Medica, the contracted health plan, was responsible for authorizing utilization of enhanced benefit services. The Navigator remained independent of these decisions.

**Navigators Were Not Medical or Behavioral Health Direct Care Providers**

Compared to case managers in some programs, e.g., intensive case management, Navigators did not provide direct health care, mental health care or vocational rehabilitation services.
Comparison of Navigation to Other DMIE Approaches to Person-Centered Care

The other three states that participated in the DMIE each developed Person-Centered Care Support functions as part of their interventions to delay or prevent at-risk individuals from applying for disability. Table 2 presents details of the similarities and differences between these models and the Minnesota Navigation model.

In each state, the person-centered support provider enabled individuals to prioritize and address the range of health, behavioral health, and employment issues affecting their quality of life and independence. Other similarities across the four interventions included using a collaborative approach with the participant to identify needs, provide education about and referrals to health, employment, and community based resources and services, and empower individuals to increase self-management or self-navigation skills. In each state, the person-centered support provider was a recognized “go-to” person who assisted participants in resolving issues with providers and also addressed a range of potential questions concerning benefits, eligibility for other services, correspondence from insurers or state agencies, etc.

The SWSW Navigation model differed from the other state models in several important ways. For one, Navigators were independent from the health, mental health, and vocational support systems, and served as neutral guides in assessing participants’ range of needs and connecting them to services. In the other states, the person-centered support provider was embedded in a specific system, such as health care or a health plan. In addition, the Minnesota DMIE program had the strongest connection to employment, with greater coordination between the Navigators and employment support providers, and higher referral and utilization rates for employment support services.

Another important difference between Minnesota and the other states was that Minnesota did not use the Navigator as a gatekeeper to services. In Kansas and Texas, DMIE participants were required to receive prior-authorization for enhanced medical services, hospitalizations, and surgeries from the person-centered support provider, which potentially conflicted with their role as the advocate for their cases. Finally, the Minnesota DMIE implemented a formal goal setting and tracking process, which enabled a clear focus on addressing participants’ goals and progress.

Conclusion

The growing incidence of individuals with complex health, behavioral health, and employment issues requires innovations in cross-system coordination and care. Given rising health insurance costs, unemployment, and demand for vocational rehabilitation and other government programs, it is critical to support the current and future workforce with services and interventions that assist in the promotion of healthy lifestyles, job retention, and maintaining independence from public programs.

With its person-centered, strengths-based, neutral approach, the SWSW Navigation model is an example of a successful approach to supporting workers with mental illness. A clear strength of the program was the connection between overall wellness (health and mental health) and employment. The Navigator was less focused on programs and services, than on empowering participants with the tools to prioritize their wellness, and proactively engage in improving their health, mental health, and employment situations. Having comprehensive health care coverage is not always enough. Many individuals with complex conditions benefit from additional support and education to understand how best to use available services to maintain or improve their health and employment.

Author Information

This research brief was a joint collaboration of The Lewin Group and DMA Health Strategies. Author collaborators included Karen W. Linkins, PhD and Jennifer J. Brya, MA, MPP.
### Table 2: Reimbursement Method Comparison

<table>
<thead>
<tr>
<th></th>
<th>Hawaii (N=190)</th>
<th>Kansas (N=500)</th>
<th>Minnesota (N=1,495)</th>
<th>Texas (N=1,616)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Shared Overarching Program Goal</strong></td>
<td>To help working individuals with potentially disabling physical and mental health conditions maintain their independence and employment</td>
<td>To help participants make changes that would positively impact their health, employment and quality of life</td>
<td>To educate, support and empower participants to manage their physical, mental health and employment issues and to learn how to access multiple service providers in the community to more effectively meet their needs</td>
<td>To educate, empower, and support participants in all ways necessary to maintain their employment and prevent dependence on federal disability benefits</td>
</tr>
<tr>
<td><strong>DMIE Target Population</strong></td>
<td>Working individuals diagnosed with diabetes or those with a Hemoglobin A1c ≥ 6.5</td>
<td>Working individuals in the state high-risk insurance pool with a variety of physical and mental health conditions</td>
<td>Working individuals with serious mental illness (primarily depression, anxiety and bipolar disorders)</td>
<td>Working individuals participating in an indigent health care system with co-occurring serious mental illness/ behavioral health condition and serious physical health condition (e.g., diabetes, hypertension)</td>
</tr>
<tr>
<td><strong>Model/Intervention Focus (Strongest point of integration)</strong></td>
<td>Self-Management to improve diabetes using: a) pharmacist counseling and diabetes education and b) life coaching Most integrated with health system, (pharmacy, diabetes educator, PCP) Service Authorization Self-Management Most integrated with the state high-risk pool and health system through benefit clarification and authorization</td>
<td>Self-Navigation to understand how to better navigate the health/mental health and employment support service systems Self-Management: Use goal setting to proactively manage mental health and job issues Most integrated with employment support providers</td>
<td>Service Authorization for DMIE enhanced services; Health-Navigation of indigent care system Self-Management education and training Case Managers integrated with health care system via access to participants’ electronic medical record and coordination with other medical providers</td>
<td></td>
</tr>
<tr>
<td><strong>Provider Education and Qualifications</strong></td>
<td>Registered Nurse (RN) or Certified Case Managers (AA, BA or MA trained); minimum 15 years experience Preferred: Experience in medical/surgical inpatient unit, broad experiences across patient populations (maternity, mental health, geriatrics)</td>
<td>Minimum of BA in rehabilitation counseling, psychology, social work or similar human service field; 2 years experience working with SMI population Preferred: MA degree, knowledge of ADA and accommodations, EAP services, health care field, and working with people of diverse cultural/ethnic backgrounds</td>
<td>Registered Nurse, Certified Case Manager, or Licensed Master of Social Work; experience in case management and knowledge of medical and vocational issues Preferred: Self-motivated, autonomous worker, business acumen, timely and accurate documentation, organized and able to prioritize</td>
<td></td>
</tr>
<tr>
<td>Hawaii (N=190)</td>
<td>Kansas (N=500)</td>
<td>Minnesota (N=1,495)</td>
<td>Texas (N=1,616)</td>
<td></td>
</tr>
<tr>
<td>---------------</td>
<td>---------------</td>
<td>---------------------</td>
<td>-----------------</td>
<td></td>
</tr>
<tr>
<td>Live Healthy - Work Well</td>
<td>Stay Well, Stay Working</td>
<td>Working Well</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Caseload Size
- **Hawaii**: 16
- **Kansas**: 100-125 average
- **Minnesota**: 100-125 caseload average
- **Texas**: 70 caseload average

### Average Time in Program
- **Hawaii**: 12 months
- **Kansas**: 15 to 41 months depending on when recruited
- **Minnesota**: 12-24 months
- **Texas**: 21 month average (range=15 to 29 months)

### Primary Role and Function
- **Hawaii**: Assist with setting, tracking and attaining self-selected goals using an empowerment approach; focused on SMART goals (specific, measurable, attainable, realistic and timed); provided access to Pharmacist, or secondary intervention component (Certified Diabetes Educator, Registered Dietician, fitness membership, workforce centers and community supports as needed)
- **Kansas**: Provide authorization of Demonstration services, coordination of care, health services navigation, one-on-one support, and provide service referrals to vocational rehabilitation services
- **Minnesota**: Assess participants’ physical, behavioral health and employment needs; develop plans with participants to document wellness and employment goals; provide education about benefits; make service referrals and coordinate with providers as needed; provide ongoing support, advocacy and empowerment, and document client progress
- **Texas**: Review requests for enhanced benefits (dental, vision, psychiatric, durable medical goods, substance abuse treatment), evaluate care options and coordinate needed services; assist with navigating the health care system; develop individual care plans, provide direct support and counseling; coordinate and intervene with appropriate service systems, connect clients to community resources (vocational counseling, medical services, support groups)

### Person-Centered Planning Approach
- **Hawaii**: Motivational Interviewing; coaching sessions used an empowerment and self-determination approach to facilitate goal setting and action planning
- **Kansas**: N/A
- **Minnesota**: Motivational Interviewing; used a strengths-based approach to assessment and treatment planning
- **Texas**: Motivational Interviewing to facilitate participants’ ability to self-direct change

### Goal Setting Process and Individualized Care Plans
- **Hawaii**: SMART Goals; online coaching tool developed specifically for the project to track goals and progress
- **Kansas**: N/A
- **Minnesota**: Develop Wellness and Employment Success Plan in collaboration with the navigator; identify areas going well, areas of focus, strategies to maintain wellness/employment; document specific goals, anticipated challenges, and referrals needed
- **Texas**: Goals were participant-driven based on needs; no formal process used to document and evaluate

www.staywellstayworking.com
<table>
<thead>
<tr>
<th>State</th>
<th>N</th>
<th>Program</th>
<th>Engagement</th>
<th>Initial Contact</th>
<th>Service Referrals and Coordination with Other Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hawaii</td>
<td>190</td>
<td>Live Healthy - Work Well</td>
<td>Over 80% client contacts were in person, less than 20% were phone sessions or via email; clients averaged 10.8 contacts/year; 4 Pharmacy sessions; contacts were client-driven</td>
<td>Initial Assessment and Wellness and Employment Success Plans were completed in person; 90% of follow up was telephonic or by email; contact was based on client level of need; most clients had approximately 10 contacts/year</td>
<td>Nurse Case Managers authorized all enhanced services including: dental, vision, smoking cessation, obesity management, and health promotion activities, as well as pool-covered hospitalizations and surgeries; referrals to and coordination with Voc Rehab services was minimal</td>
</tr>
<tr>
<td>Kansas</td>
<td>500</td>
<td>Stay Well, Stay Working</td>
<td>Engagement with case managers was variable from monthly contact to several times/day when service authorization was needed; most contact was by phone, with some email/in-person contact</td>
<td>Initial contact was in person to conduct a needs assessment, explain program benefits; subsequent encounters were made by phone; average contact was 1-2 times/month; participants had to get approval for enhanced medical benefits (including expedited appointments) so engagement was required to access services</td>
<td>Navigators provided referrals to the contracted managed care organization for mental health services, primary care, dental and psychiatry services; 35% of participants were referred to and used intensive employment support services that were offered through the SWSW program; Navigators regularly coordinated with employment support providers</td>
</tr>
<tr>
<td>Minnesota</td>
<td>1,495</td>
<td>Stay Well, Stay Working</td>
<td>Initial contact was in person to conduct a needs assessment, explain program benefits; subsequent encounters were made by phone; average contact was 1-2 times/month; participants had to get approval for enhanced medical benefits (including expedited appointments) so engagement was required to access services</td>
<td>Initial contact was in person to conduct a needs assessment, explain program benefits; subsequent encounters were made by phone; average contact was 1-2 times/month; participants had to get approval for enhanced medical benefits (including expedited appointments) so engagement was required to access services</td>
<td>Program Case Managers were part of an existing treatment team and coordinated with other providers within the health care system to ensure timely access to services; also made community referrals for employment support services</td>
</tr>
<tr>
<td>Texas</td>
<td>1,616</td>
<td>Working Well</td>
<td>Initial contact was in person to conduct a needs assessment, explain program benefits; subsequent encounters were made by phone; average contact was 1-2 times/month; participants had to get approval for enhanced medical benefits (including expedited appointments) so engagement was required to access services</td>
<td>Initial contact was in person to conduct a needs assessment, explain program benefits; subsequent encounters were made by phone; average contact was 1-2 times/month; participants had to get approval for enhanced medical benefits (including expedited appointments) so engagement was required to access services</td>
<td>Program Case Managers were part of an existing treatment team and coordinated with other providers within the health care system to ensure timely access to services; also made community referrals for employment support services</td>
</tr>
</tbody>
</table>

**Participant Satisfaction**

- Program participants were highly satisfied with life coaching, goal setting process, and being accountable for their progress
- Participants appreciated having a single point of contact to obtain information about their benefits, obtain service authorizations and to contact for advice and support
- Most cited responses for the benefits of the navigator included: provided accountability, advocacy, social support, empowerment, structure, assisted with goal setting, enhanced self-discipline, provided education about community resources and the benefit of being proactive and involved in healthcare decision-making
- Participants valued the education provided about health conditions and enhanced medical benefits, linkage to needed services and emotional support

**Participant Outcomes**

- Improved diabetes self efficacy and Body Mass Index (BMI)
- Program participants maintained their health status (SF-12 PCS scores) compared to significant declines in the control group
- Improved mental health and functional status, higher earnings, lower medical debt, increased access to needed health/mental health services, fewer applications for disability benefits
- Increased utilization of health care services, fewer applications for federal disability benefits


