Behavioral Health Home for People with Mental Health and Substance Use Conditions
Weber Human Services

Research literature has repeatedly documented that persons with a serious mental illness die younger than the general population, mainly due to preventable risk factors (e.g., smoking) and treatable conditions (e.g., cardiovascular disease and cancer). Other studies around the country have found that Medicaid beneficiaries with serious mental illness represent about 10% of the total Medicaid population but account for 26% of total Medicaid expenditures. This research has led the behavioral health field to seek ways to improve access to preventive services, wellness programs, and medical care. A key component of this work has focused on how to improve access to primary care, either by strengthening linkages to community primary care providers or by bringing primary care providers in-house.

In 2010, Weber Human Services, in partnership with Midtown Community Health Center, became the first community mental health center in Utah to open an in-house primary care clinic (The Wellness Clinic). Since its opening, the Wellness Clinic has served over 1000 clients with a serious mental illness and the impact on their overall health outcomes has been significant—decreases in smoking rates, diabetes risk factors, and cardiovascular disease risk factors. But continued analysis of this integrated model has shown that more effective change in outcomes will require a major shift in the roles, processes, and care provided in this integrated setting. To achieve this shift, Weber Human Services proposes the implementation of a behavioral health home for individuals with mental health and substance use conditions that is proactive and coordinated, that includes financial support and accountability for a defined population of clients.

The Model

**Staffing** (see attached job descriptions for details of duties)

<table>
<thead>
<tr>
<th>Position</th>
<th>Year 1 FTEs</th>
<th>Year 2 FTEs</th>
<th>Year 3 FTEs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Goal: 250 Enrollees</td>
<td>Goal: 500 Enrollees</td>
<td>Goal: 750 Enrollees</td>
</tr>
<tr>
<td></td>
<td>Eligibility Criteria: SMI/SED + 1 other chronic condition</td>
<td>Eligibility Criteria: SMI/SED + 1 other chronic condition</td>
<td>Eligibility Criteria: SMI/SED or SUD + 1 other chronic condition</td>
</tr>
<tr>
<td>Director</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Primary Care Consultant</td>
<td>250 Hours</td>
<td>500 Hours</td>
<td>750 Hours</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>250 Hours</td>
<td>500 Hours</td>
<td>750 Hours</td>
</tr>
<tr>
<td>Nurse Care Manager</td>
<td>1.5</td>
<td>2</td>
<td>2.5</td>
</tr>
<tr>
<td>Care Coordinator</td>
<td>1</td>
<td>1</td>
<td>1.5</td>
</tr>
<tr>
<td>Care Manager</td>
<td>8.25</td>
<td>12.5</td>
<td>18.75</td>
</tr>
<tr>
<td>Peer Specialists/Family Support Specialists</td>
<td>2.5</td>
<td>5</td>
<td>7.5</td>
</tr>
<tr>
<td>Administrative Support</td>
<td>2</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Eligible chronic health conditions: asthma, cardiovascular disease, diabetes, overweight BMI>25
<table>
<thead>
<tr>
<th>Time of Day</th>
<th>Staff Available</th>
<th>Services Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00 am – 5:00 pm</td>
<td>Entire Team</td>
<td>Comprehensive care management services:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Identification and targeting of high-risk individuals</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Monitoring of health status and adherence</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Development of treatment guidelines</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Individualized planning with client</td>
</tr>
<tr>
<td>5:00 pm – 10:00 pm</td>
<td>Mobile Response Team</td>
<td>Mobile Crisis Outreach</td>
</tr>
<tr>
<td></td>
<td>• Nurse Care Manager</td>
<td>• Crisis resolution services for anyone experiencing, or at risk of, a physical health</td>
</tr>
<tr>
<td></td>
<td>• Care Manager</td>
<td>or mental health crisis, and who requires intervention</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Rapid response - face to face assessment and crisis intervention</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Follow-up services including information and referrals, linkage with appropriate services for ongoing treatment</td>
</tr>
<tr>
<td>10:00 pm – 8:00 am</td>
<td>Crisis Phone Coverage</td>
<td>Consultation and support to individuals, families and treatment providers</td>
</tr>
</tbody>
</table>

Goals

1. Screen for general health with priority for high risk conditions, and identify related care gaps.
2. Ensure that clients receive treatment per practice guidelines: e.g., heart disease, diabetes, smoking cessation, use of novel anti-psychotics.
3. Offer prevention and intervention for modifiable risk factors and care gaps.
4. Track and improve performance through patient disease registry.

Step 1 – Create Disease Registry
- Collect historic information on enrollees
- Get Clinical Baseline Values from Metabolic Screening and other assessment, screening required annually:
  - Obesity - weight height
  - Cholesterol
  - Triglycerides
  - Blood pressure
  - Blood sugar
  - Smoking
- Combine into EHR Disease Registry

Step 2 – Identify Care Gaps and ACT!
- Compare Disease Registry Data to accepted Clinical Quality Indicators
- Identify Care Gaps
• Sort patients with care gaps into agency specific To-Do lists
• Send to nurse care manager
• Set up PCP visit and pass on info with request to treat

Step 3 – Follow-up
• Implement plan of care with treatment team
• Support client wellness through self-management using Peer Specialists and Case Managers
• Monitor that clients are attending appointments
• Monitor that clients are adhering to prescribed medications

Outcomes
• Cost
  o reduced hospital admissions
  o reduced hospital emergency department visits
• Medication adherence
• Clinical Outcomes
  o Obesity – weight/height
  o Cholesterol
  o Triglycerides
  o Blood pressure
  o Blood sugar
  o Smoking
• Experience of care
Budget
## Existing Staff & Expenditures

<table>
<thead>
<tr>
<th>Department</th>
<th>Year One</th>
<th>Year Two</th>
<th>Year Three</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admin. Fee</td>
<td>$443.047</td>
<td>$443.047</td>
<td>$443.047</td>
</tr>
<tr>
<td>Building Maintenance</td>
<td>$587.883</td>
<td>$587.883</td>
<td>$587.883</td>
</tr>
<tr>
<td>Dep. &amp; Equipment</td>
<td>$573.940</td>
<td>$573.940</td>
<td>$573.940</td>
</tr>
<tr>
<td>Liability Insurance</td>
<td>$570.000</td>
<td>$570.000</td>
<td>$570.000</td>
</tr>
<tr>
<td>Training</td>
<td>$565.000</td>
<td>$565.000</td>
<td>$565.000</td>
</tr>
<tr>
<td>Lab Work</td>
<td>$560.000</td>
<td>$560.000</td>
<td>$560.000</td>
</tr>
<tr>
<td>Dental</td>
<td>$555.000</td>
<td>$555.000</td>
<td>$555.000</td>
</tr>
<tr>
<td>Housing</td>
<td>$550.000</td>
<td>$550.000</td>
<td>$550.000</td>
</tr>
<tr>
<td>Telephones</td>
<td>$545.000</td>
<td>$545.000</td>
<td>$545.000</td>
</tr>
<tr>
<td>Office Supplies</td>
<td>$540.000</td>
<td>$540.000</td>
<td>$540.000</td>
</tr>
<tr>
<td>Travel &amp; Transportation</td>
<td>$535.000</td>
<td>$535.000</td>
<td>$535.000</td>
</tr>
<tr>
<td><strong>Total Cost</strong></td>
<td>$17,904</td>
<td>$17,904</td>
<td>$17,904</td>
</tr>
</tbody>
</table>

## Weber Human Services

Behavioral Health Centered Medical Home
Job Descriptions
WEBER HUMAN SERVICES
Job Description

Employee: ___________________________ Classification: ___________________________

Program Name & Number: Health Home Director

A. General Job Function: General oversight of the Health Home (HH) Team Members; oversight of the daily operation of the health home; tracks outcome data in support of quality of care and cost saving measures; and, provides oversight of training opportunities and skill building.

B. Key Job Duties:

1. General oversight of the Health Home Team Members % of time
2. Oversight of the daily operation of the health home % of time
3. Track outcome data % of time
4. Oversight of training opportunities and skill building % of time

C. Minimum Education/Experience/License/Special Requirements:

D. Line of Supervision (Position Titles): Executive Director of LMHC

EMPLOYEE PERFORMANCE REQUIREMENTS

Minimum Agency Standards: (Additional items may be added by the relevant Agency Director. Such additions must meet or exceed the agency minimum standards.)

A. Performance Requirements

1. Performance: Spend at least 80% of time performing key job duties.
2. Attendance: Be on time and fully prepared for all appointments and meetings. Work the regular schedule assigned, unless an exception is pre-approved.
3. Communication: Interact with clients, WHS employees, and community partners in a positive and professional manner.
4. Accuracy: Cultivate a high level of accuracy in all work.

B. General Behavior

1. Dress Code: Dress appropriately for a professional work environment.
2. Use of Time: Focus on priority tasks, minimizing personal conversations that distract from job duties.
3. Compliance: Be familiar with, and observant of, all agency policies, procedures, rules, and protocols.
4. Boundaries with Staff and Clients: Follow all agency policies and the Code of Ethics in maintaining appropriate boundaries with clients and other staff members.
5. Team Player: Complete your assigned work and assist others when time allows.
6. Character: Maintain a professional demeanor; use professional language.
7. Solution-Focused: Cultivate a problem solving approach by presenting options when identifying issues.

C. Positive Attitude

1. Respectful: Be considerate of others’ time and responsibilities; avoid gossip.
2. Willing to Learn: Be proactive in learning new skills and becoming more familiar with all aspects of the organization.
3. Willing to Change: Be open to constructive feedback and willing to try new approaches. Communicate new ideas with supervisor.
4. Willing to Teach: Openly share information, knowledge, and skills with other staff.

_________________________________  ___________________________________  ___________
Print Employee Name                  Employee Signature                 Date

_________________________________  ___________________________________  ___________
Print Supervisor Name                Supervisor Signature                Date
WEBER HUMAN SERVICES
Job Description

Employee: ____________________________ Classification: ____________________________

Program Name & Number: Health Home Primary Care Physician (PCP) Consultant

A. General Job Function: Assures that HH (Health Home) enrollees receive care consistent with appropriate medical standards; consults with HH enrollees’ psychiatrists as appropriate regarding health and wellness; consults with nurse care manager (NCM) and related team regarding specific health concerns of individual HH enrollees; assists with coordination of care with community and hospital medical provider; documents individual client care and coordination in client chart; and, maintains a monthly HH log.

B. Key Job Duties:

1. Assures that HH enrollees receive care consistent with appropriate medical standards % of time
2. Consults with nurse care manager and related team regarding specific health concerns of individual enrollees % of time
3. Assists with coordination of care with community and hospital medical provider % of time
4. Documents individual client care and coordination in client chart and maintains a monthly HH log % of time

C. Minimum Education/Experience/License/Special Requirements:

D. Line of Supervision (Position Titles): HH Director, Executive Director of LMHC

EMPLOYEE PERFORMANCE REQUIREMENTS

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Print Employee Name ____________________________ Employee Signature ____________________________ Date ____________________________

Print Supervisor Name ____________________________ Supervisor Signature ____________________________ Date ____________________________
WEBER HUMAN SERVICES
Job Description

Program Name & Number: Health Home Care Coordinator

A. General Job Function: Ensuring each enrollee has a care team and the primary care physician (PCP) is engaged; meeting with each enrollee individually and setting meetings between them and all care team members; reviewing reports and ensuring each enrollee has an appropriate treatment plan; documenting care in each enrollee’s chart; responding to alerts received about each enrollee; checking to ensure each enrollee has necessary medication; and, coordinating transportation to and from labs, doctor appointments, etc.

B. Key Job Duties:

1. Ensures enrollee has a care team and PCP is engaged % of time
2. Meeting with each enrollee individually and setting meetings between them and all care team members % of time
3. Reviewing reports and ensuring each enrollee has an appropriate treatment plan % of time
4. Documenting care in each enrollee’s chart
   - Responding to alerts received about each enrollee
   - Checking to ensure each enrollee has necessary medication
   - Coordinating transportation to and from labs, doctor appointments, etc.

C. Minimum Education/Experience/License/Special Requirements:
- Social Service Worker License preferred
- Certified Case Manager within 1 month of hire date and renewal every 3 years
- Valid Utah Driver’s license, Defensive Driving and clearance to operate WHS vehicles

D. Line of Supervision (Position Titles): HH Director, Executive Director of LMHC

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_________________________________________  _____________________________  ___________________________
Print Employee Name  Employee Signature  Date

_________________________________________  _____________________________  ___________________________
Print Supervisor Name  Supervisor Signature  Date
WEBER HUMAN SERVICES
Job Description

Employee: ____________________________ Classification: ____________________________

Program Name & Number: Health Home Nurse Care Manager/s

A. General Job Function: Champion healthy lifestyles and preventive care; provide individual care for enrollees on their caseload; consult with care coordinators’ about identified health conditions of their enrollees; coordinate care with external health care providers (pharmacies, PCPs, etc.); and, document individual client care and coordination in client records.

B. Key Job Duties:

1. Champion healthy lifestyles and preventive care % of time
2. Provide individual care for enrollees on their caseload % of time
3. Consult with care coordinators’ about identified health conditions of their enrollees % of time
4. Coordinate care with external health care providers (pharmacies, PCPs, etc.) % of time
   Document individual client care and coordination in client records

C. Minimum Education/Experience/License/Special Requirements:

D. Line of Supervision (Position Titles): HH Director, Executive Director of LMHC

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Print Supervisor Name ____________________________ Supervisor Signature ____________________________ Date ___________