

**Composition of Health Home Team, SMI
For 500 Client teams ***

* The health home team provides consistency and continuity of care for the member. While this chart depicts the typical health home team, the composition of the team of health care professionals is flexible and is expected to change as the needs of the health home member changes over time, (Chart revised 10-7-14)

Role	FTE	Functions
Health Home Director	1.0	<ul style="list-style-type: none"> • Engages and works with community partners; • Plans community wellness and prevention events and activities; • Supervises health home; • Tracks enrollment, declines, discharges and transfers; • Coordinates management of HIT tools; • Develops MOUs with hospitals and coordinates hospital admissions and discharges with nurse care manager.
Nurse Care Manager (RN or LPN)	2.0	<ul style="list-style-type: none"> • Processes referrals; • Gathers all pertinent health and mental health information; • Conducts initial appointments - does initial health screenings; • Completes healthcare goals and contributes to comprehensive care plan in partnership with team; • Develops member registries; • Supervises Wellness Coach(es); conducts face to face interviews with clients to discuss wellness goals; • Coordinate care with external providers (e.g. FQHCs, pharmacies, PCP); • Inputs all pertinent health information into electronic health record.
Consulting PCP (Physician, PA or APRN that is embedded, or may be a partnership with multiple PCMHs, an FQHC or I/T/U facility)	1 hr./ enrollee/yr	<ul style="list-style-type: none"> • Provides input into care planning; • Consults with team psychiatrist; • Consults regarding specific consumer health issues; • Assists with external medical providers; • Consults with members of team as necessary; • Contributes input into the comprehensive care plan.
Psychiatric Consultant (Board Certified /Eligible Psychiatric, PA or APRN w/psychiatric specialty)	.26	<ul style="list-style-type: none"> • Consults with team PCP; • Consults regarding specific behavioral health issues; • Consults with team members as necessary; • Contributes input into the comprehensive care plan.
LBHP Supervisor	.50	<ul style="list-style-type: none"> • Serves as primary lead in clinical behavioral health; • Participates in health home meetings and planning;

		<ul style="list-style-type: none"> • Contributes input into the comprehensive care plan; • Consults with all team members as necessary.
Certified Behavioral Health Case Manager II	4.00	<ul style="list-style-type: none"> • Serves as primary liaison to all team members; • Coordinates between all members of team as necessary; • Coordinates input from all team members into the comprehensive care plan; • Coordinates behavioral health referrals and follows up to ensure linkages; • Ensures that each member is aligned with a PCP; • Ensures transportation to appointments.
Hospital Liaison/HH Specialist	1.00	<ul style="list-style-type: none"> • Serves as primary contact with hospitals; • Helps to ensure smooth transitions to and from hospital
Wellness Coach	1.0	<ul style="list-style-type: none"> • Engages person in wellness process; • Reminds person receiving services of appointments; • Contributes input into comprehensive care plan; • Conducts a variety of wellness activities and groups; • Coaches on wellness goals in comprehensive care plan; • Interacts with team members.
Administrative Support (Medical Assistant)		<ul style="list-style-type: none"> • Serves as first point of contact; • Assists with electronic health record entry; • Assists with scheduling appointments; • Supports core team; • Assists with wellness and community connections.

**Composition of Health Home Team, SMI
Team of 100
Average Consumer to Staff Ratio 10:1
PACT and High Intensity Service Coordination**

Role	FTE	Functions
Team Lead (LBHP) Ass't Team Lead	1.0	<ul style="list-style-type: none"> • Supervises and monitors the activities of the individual treatment teams; • Oversees development of comprehensive care plan; • Provides individual supportive therapy; • Ensures immediate revisions to the care plan as the consumer's needs change, and advocates for the consumer's rights and preferences; • Engages and works with community partners; • Plans wellness and prevention events and activities; • Supervises team; • Asst. team lead shares tasks related to coordinating care and is responsible to perform them when the team lead is absent.
Nurse Care Manager (RN and LPN)	3.0	<ul style="list-style-type: none"> • Arranges and coordinates the consumer's medical care with community medical providers; • May carry out some physical assessments and treatment; • Processes referrals; • Sets initial appointments; • Gathers all pertinent health and mental health information ; • Conducts initial appointment - does initial health screenings; • Completes healthcare goals for the comprehensive care plan; • Develops member registries; • Supervises Wellness Coach(es); • Inputs all pertinent health information into electronic health record.
Licensed Behavioral Health Professional (LBHP)	2.00	<ul style="list-style-type: none"> • Participates in comprehensive care planning; • Completes behavioral health assessment; • Provides behavioral health therapy.
Consulting PCP (Physician, PA or APRN that is embedded, or may be a partnership with multiple PCMHs, an FQHC or I/T/U facility);	1 hr./enrollee/yr.	<ul style="list-style-type: none"> • Participates in treatment planning; • Consults with team psychiatrist; • Consults regarding specific consumer health issues; • Assists with external medical providers; • Serves as core team lead for health care; • Consults with all members of team as necessary; • Contributes input into the comprehensive treatment plan.
Psychiatric Consultant (Board Certified /Eligible Psychiatric, PA or APRN w/psychiatric specialty)	.33	<ul style="list-style-type: none"> • Participates in team meetings; • Contributes to care plan development; • Collaborates with team members; • Arranges behavioral health referrals.

Certified Behavioral Health Case Manager II Hospital Liaison/HH Specialist	4.00 1.00	<ul style="list-style-type: none"> • Serves as primary liaison for all team members; • Coordinates between all members of team as necessary; • Coordinates input from all team members into the comprehensive care plan; • Coordinates behavioral health referrals, follows up to ensure linkages; • Ensures transportation to appointments; • Provides interventions to assist consumers to identify substance use, effects and patterns; • Helps consumer develop motivation for decreasing substance use; • Helps consumer develop alternatives to minimize substance use and achieve periods of abstinence and stability; • Provides work-related services as needed to help consumers find and maintain employment in community-based job sites.
Wellness Coach	1.0	<ul style="list-style-type: none"> • Engages person in wellness process; • Reminds consumer of appointments; • Provides various wellness programs; • Conducts a variety of wellness activities and groups; • Coaches on wellness goals in comprehensive care plan; • Works under supervision of nurse manager; • Interacts with all team members as needed.
Program Assistant (Medical Assistant)		<ul style="list-style-type: none"> • Serves as first point of contact ; • Assists with electronic health record entry; • Assists with scheduling appointments; • Supports core team; • Assists with wellness and community connection.

Composition of Health Team, SED
Average Member to Staff Ratio 10:1 Highest Intensity
Average Member to Staff Ratio 20:1 Medium Intensity
Wraparound and Service Coordination

Role	FTE	Functions
Care Coordinator (Bachelor's Level or higher)	1.0	<ul style="list-style-type: none"> • Under the direct leadership of the Project Director, the Care Coordinator is responsible for coordinating the development of child and family teams, facilitating child and family team meetings, and facilitating the development and implementation of the individualized Comprehensive Care Plan ; • Consult and cooperate with community systems to facilitate linkage, referral, crisis management, advocacy, and follow up with the focus on attaining goals; • Provides direct services to children and families; • Assesses the strengths and needs of families; • Monitors the progress in meeting established goals; • Assists families with accessing community resources; • Provides individual case management and activity of daily living services as needed.
Project Director (Wraparound Supervisor; responsible for Community Team for children's HH)	.20 (1/8 CC)	<ul style="list-style-type: none"> • Supervises and assists with planning activities, such as convening Child and Family Teams, providing guidance and assisting as necessary with wraparound facilitation and comprehensive care plan development processes; • Provides guidance and consultation for Care Coordinators (Wraparound Facilitators) as they work with child/youth, family (or the child/youth's authorized healthcare decision maker) and others to identify strengths, needs and goals of the child/youth and family as needed.
Psychiatric Consultant	.14	<ul style="list-style-type: none"> • Consults with team and provides recommendations and referrals related to complex diagnostic, psychopharmacologic and other treatment needs; • Contributes to comprehensive care plan; • Consults and provides psychiatric support to PCPs.
Nurse Care Manager (RN or LPN)	.20	<ul style="list-style-type: none"> • Communicates with the primary caregiver regarding the need for youth to be seen by their PCP; • Tracks data for consumer compliance with visits and medical care recommendations and ensures EPSDT screenings in accordance with periodicity schedule; • Integrates PCP consent into the electronic medical record; • Trains Project Director and Care Coordinator to integrate medical domain in comprehensive care plan; • Ensures that children taking multiple psychotropic medications are seen by PCP at least once per year;

		<ul style="list-style-type: none"> • Helps implement team recommendations; • Develops member registries; • Communicates with members' parents and guardians.
Peer to Peer Family /Youth Support Provider (H.S. Diploma or Equivalent)	1.0	<ul style="list-style-type: none"> • Participates in team meetings; • Creates a family plan and course of action based on the individual needs of a family, with input to the comprehensive care plan; • Advocates for the family in the agency setting, and with other agencies and organizations identified; • Uses personal judgment to identify available options for agencies and organizations as appropriate to meet a particular family's needs; • Guides the family concerning agency interactions, benefits and programs; • Ensures child/ youth involvement in Wraparound meetings, family teams and other meetings involving the child/youth; • Conducts presentations to community groups or other agencies regarding local resources, services, and youth group activities; • Provide supervision to youth, demonstrate leadership skills, serve as a role model and involve youth in all activities
Children's HH Specialist	.25	<ul style="list-style-type: none"> • Assists with the individuals' physical wellness plan development, implementation, assistance and support; • Conducts support, exercise, and other groups for children and for adult caregivers and identified natural supports; • Provides prevention, support, and group activities for interested individuals, not necessarily participants in HH; • May provide the Live Longer, Live Stronger Program; • Assists the child and family regarding behavioral, interpersonal, communication, self help, safety, substance use decisions, and specific goal-setting and problem-solving activities; • May assist with understanding Crisis Plans and Comprehensive Care Plan process. May provide assistance with understanding medication side effects and possible effects on overall health and wellness.
Consulting Primary Care Practitioner	.5 hour/ per enrollee per year	<ul style="list-style-type: none"> • Contributes to comprehensive care planning; • Consults with team psychiatrist; • Consults regarding specific consumer health issues; • Assists with external medical providers; • Serves as team member for health care; • Serves as consultant for team; • Consults with all members of team as necessary.
Administrative Support Staff		<ul style="list-style-type: none"> • Assists with electronic health record entry; • Assists with scheduling appointments; • Supports core team; • Assists with wellness and community connections.