Behavioral Health Integration Collaborative

“Assembling the BHI Care Team: Roles and Responsibilities”

July 21, 2022
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About the BHI Collaborative

The BHI Collaborative was established by several of the nation’s leading physician organizations** to catalyze effective and sustainable integration of behavioral and mental health care into physician practices.

With an initial focus on primary care, the Collaborative is committed to ensuring a professionally satisfying, sustainable physician practice experience and will act as a trusted partner to help them overcome the obstacles that stand in the way of meeting their patients’ mental and behavioral health needs.

TODAY’S SPEAKERS

Dr. Sarah Coles, MD, FAAFP
Program Director
Colorado Plateau Family and Community Medicine Residency at North Country HealthCare

Jennifer Schwartz, LMSW
Behavioral Health Program Manager & Therapist
Corner Health Center (Michigan)
Assembling the Care Team: Roles and Responsibilities

SARAH COLES, MD FAAFP
PROGRAM DIRECTOR
COLORADO PLATEAU FAMILY AND COMMUNITY MEDICINE RESIDENCY
I do not have any actual or potential conflicts of interest in relation to this program or presentation.
Learning Objectives

1. Identify roles and responsibilities of members of the Collaborative Care team
2. Discuss strategies to recruit and maintain Collaborative Care team members to enhance patient care and integrate behavioral health
3. Increase confidence in successfully implementing Collaborative Care Model in your practice setting
The Need

Primary care providers prescribe 79% of antidepressant medications and see 60% of people being treated for depression in the United States.

50% of patients referred to mental health do not follow through
  ◦ 80% of those who do follow through are only seen once

Depression is a leading cause of worldwide disability.

Only 40.3% of adults with mental illness in Arizona receive any form of treatment from either the public system or private providers.
  ◦ 59.7% receive no mental health treatment.

50-70% of patients need at least one change in the treatment plan in order to achieve remission of depression.
WHO GETS TREATMENT?

No Treatment

Primary Care Provider

Mental Health Provider
A Solution: Collaborative Care!

- Better access to care
- Better outcomes
- Decreased costs
- Improved patient experience
- Improved provider experience
Roles

Patient
- Chooses treatment and identifies goals

PCP
- Primary provider of all care

Psychiatrist
- Indirect care provided via consultation with Care Manager

Care Manager
- Coordinates behavioral healthcare, performs initial assessments and systematic follow-up of patients, provides patient education, creates and updates treatment plan, performs brief psychotherapy, completes majority of documentation.
### Core Principles

<table>
<thead>
<tr>
<th>Patient Centered Team Care</th>
<th>Population Based Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incorporates <em>patient goals and choice</em> of treatment into the plan</td>
<td>Defined group of patients</td>
</tr>
<tr>
<td><em>Direct</em> collaboration between primary care and behavioral health providers</td>
<td>Tracked over time (electronic patient registries)</td>
</tr>
<tr>
<td><em>Shared</em> care plans</td>
<td>Focus on those not improving as expected or at risk to fall out of care</td>
</tr>
</tbody>
</table>
Core Principles

<table>
<thead>
<tr>
<th>MEASUREMENT BASED TREAT TO TARGET</th>
<th>EVIDENCE BASED CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use of clinical outcome measures to treat to target</td>
<td>Treatments utilized are backed by credible research</td>
</tr>
<tr>
<td>Standardized assessments like GAD-7, PHQ-9</td>
<td>◦ Pharmacotherapy</td>
</tr>
<tr>
<td></td>
<td>◦ Psychotherapy</td>
</tr>
<tr>
<td></td>
<td>Education to PCPs regarding evidence based treatment</td>
</tr>
<tr>
<td></td>
<td>◦ Included in the consultation note</td>
</tr>
</tbody>
</table>
# Registry

1) **EVERY** time this worksheet is used, ensure all other versions of the template are CLOSED, and press "Ctrl+1" to refresh the page.

2) Do NOT use the Caseload Overview if fewer than 2 ACTIVE patients are entered on the Patient Tracking worksheet.

3) Do NOT change the number of rows or columns. If you need to make any changes to the table whatsoever (other than sort and filter), use the de-identified template provided at the link to the right.

4) Be aware that at least one PHQ-9 score must be entered for a given record in order for that record's GAD-7 scores to display properly in the Caseload Overview.

<table>
<thead>
<tr>
<th>Name</th>
<th>Initial Assessment Date</th>
<th>Date of Most Recent Contact</th>
<th>Number of Follow-Up Contacts</th>
<th>PhQ-9 Score</th>
<th>Last Available PhQ-9 Score</th>
<th>% Change in PhQ-9 Score</th>
<th>Date of Last PhQ-9 Score</th>
<th>GAD-7 Score</th>
<th>Last Available GAD-7 Score</th>
<th>% Change in GAD-7 Score</th>
<th>Date of Last GAD-7 Score</th>
<th>Psychiatric Case</th>
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</thead>
<tbody>
<tr>
<td>John Doe</td>
<td>1/15/2016</td>
<td>12/15/2016</td>
<td>12</td>
<td>20</td>
<td>0</td>
<td>-100%</td>
<td>11/16/2016</td>
<td>14</td>
<td>1</td>
<td>-93%</td>
<td>11/16/2016</td>
<td>-1</td>
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<tr>
<td>Susan Test</td>
<td>5/20/2016</td>
<td>1/20/2017</td>
<td>10</td>
<td>22</td>
<td>15</td>
<td>-32%</td>
<td>1/2/2017</td>
<td>18</td>
<td>14</td>
<td>-22%</td>
<td>1/2/2017</td>
<td>9/12</td>
</tr>
<tr>
<td>Joe Smith</td>
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<td>15</td>
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<td>1/9/2017</td>
<td>11</td>
<td>7</td>
<td>-36%</td>
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<td>10/2</td>
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<tr>
<td>Albert Smith</td>
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<td>1/20/2017</td>
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<td>18</td>
<td>18</td>
<td>0%</td>
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<tr>
<td>Bob Dolittle</td>
<td>11/2/2016</td>
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<td>-17%</td>
<td>1/19/2017</td>
<td>-1</td>
</tr>
<tr>
<td>Nancy Fake</td>
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<td>1/15/2017</td>
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<td>No Score</td>
<td>No Score</td>
<td></td>
<td>No Score</td>
<td>No Score</td>
<td>No Score</td>
<td></td>
<td></td>
<td>-1</td>
</tr>
<tr>
<td>Betty Test</td>
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<td>12</td>
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<td>-92%</td>
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<td>9</td>
<td>3</td>
<td>-67%</td>
<td>1/15/2017</td>
<td>-1</td>
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</tbody>
</table>
Workflow and Roles

- Identify qualifying mental health disorder
- Intake to program/screens

Warm Handoff from PCP (IM and FM)

Active Treatment in Collaborative Care
- Follow up with RN
- Staffing with psychiatry consultant
- Communication with PCP

Maintenance Care and Relapse Prevention
- Develop plan for monitoring/relapse
- Graduate to routine care with PCP
Time to remission

Usual primary care: 614 days
Collaborative Care: 86 days
Develop Goal:
- Implement evidence-based program to improve behavioral health care in our primary care setting
- Partners: IMC, FMC, and Psychiatry

Research models
- University of Washington AIMS Model

Build the Team
- Identify roles and responsibilities

Create Stakeholder Buy In:
- PCPs, Staff, Psychiatric Consultant, Residents, Administration, Care Manager, Pharmacy, Social Worker, Navigators

Develop workflow

Training
- Rationale, Workflows, Billing and Coding, Behavioral Health Management
Building Your Team
Our Practice

Sites:

- Family Medicine Residency
  - 3 office sites in same building
  - Psychology with limited availability
  - Large, interprofessional practice
- Internal Medicine Residency programs
  - 1 office site in same building as Family Medicine
  - No access to in house behavioral health
  - Large, interprofessional practice
- Psychiatry Residency:
  - 1 office site in same building as IM and FM
  - Previously not integrated with primary care
Our Team
Finding the Right Folks

Identify champions

Recruit broadly

Create stakeholder buy in and Actively engage all members of the team

Use behavioral based interviewing for culture, fit, and skills

Seek diversity, inclusion, and equity

Focus on the mission

Creatively problem solve barriers and reinforce and reward successes

Train and train again

Allow for psychological safety
Key Steps

- Frequent Team Meetings to Review
- Reinforcement of shared mission and development to culture of integrated behavioral health care
- Iterative Training
- Frequent Process Changes: PDSA
- Identify both challenges and successes
- Work across silos: Billing and coding, EHR, admin, health information exchanges
- Build partnerships with local behavioral health facilities and establish referral patterns
Collaboration

Champion at each site involved at all stages of development and implementation

Build workflows to accommodate all needs/goals

Regular communication using agreed upon format

Frequent touch points

Get specific, actionable feedback

Dynamic nature of the panel
CoCM Results as of March 31, 2022
175 patients have received care

<table>
<thead>
<tr>
<th>PHQ9 - DEPRESSION</th>
<th>GAD7 - ANXIETY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean initial PHQ9 score: 16.0</td>
<td>Mean initial GAD7 score: 11.2</td>
</tr>
<tr>
<td>Current mean PHQ9 score: 7.0</td>
<td>Current mean PHQ9 score: 5.6</td>
</tr>
<tr>
<td>Symptom reduction: 56.3%</td>
<td>Symptom reduction: 50.0%</td>
</tr>
</tbody>
</table>

Reflects pts in active tx or relapse prevention

Reflects pts in active tx or relapse prevention
## Benefits to Practice

<table>
<thead>
<tr>
<th>CLINICIANS</th>
<th>PATIENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase comfort with behavioral health screening, diagnosis, and management</td>
<td>Remain in primary care home</td>
</tr>
<tr>
<td>Increase scope of practice</td>
<td>Increased touch points with patient</td>
</tr>
<tr>
<td>◦ Support from psychiatry for more complex cases</td>
<td>Improved access to behavioral health care</td>
</tr>
<tr>
<td>◦ Support from care manager</td>
<td>Improved behavioral health outcomes</td>
</tr>
<tr>
<td>Office visit decompressed</td>
<td>Possibly improved physical health outcomes</td>
</tr>
<tr>
<td>Billable service</td>
<td>Coordination with multiple services</td>
</tr>
<tr>
<td>Improved detection of SDoH and other factors</td>
<td>◦ PCP, SW, pharmacy, psychology, RD, community services</td>
</tr>
<tr>
<td>Increase capacity</td>
<td>Increase access to primary health care</td>
</tr>
<tr>
<td></td>
<td>Safer medication management</td>
</tr>
</tbody>
</table>
Clinician Comments

Check ins for mood during visit were definitely shortened allowing more time for other chronic issues.

Provides a great opportunity for residents to learn how to manage more complex behavioral health problems.

Patients seem more comfortable with engaging in mental health treatment because they get to keep their care in our clinic.

I like that I can call a psychiatrist for advice on med management for meds that I used to just refer out.

It has been particularly nice for more complicated patients that I may have tried to refer outside the office.

Pt's get started on meds earlier and seeing earlier stabilization.

I have treated severe depression, mild-moderate bipolar, and even early psychosis that I would never have started meds on before.

Passively suicidal patient had great support and many check ins that helped her get through a very hard time without needing care outside of our office.
Resources

University of Washington AIMS Center https://aims.uw.edu/collaborative-care


Healthy People 2020 https://www.healthypeople.gov/


Unutzer, J., Katon, W et al. Collaborative Care Management of Late Life Depression In The Primary Care Setting: A Randomized Control Trial. JAMA.2002 Dec;288(22):2836-45

Garrison GM, Angstman KB, O'Connor SS, Williams MD, Lineberry TW. Time to Remission for Depression with Collaborative Care Management (CCM) in Primary Care. JAM Board Fam Med, 2016 Jan-Feb;29(1):10-7


Thank You!

Please contact scoles@nchcaz.org if you have any questions!
Assembling the BHI Care Team: the Role of the Care Manager

JENNIFER SCHWARTZ, LMSW
BEHAVIORAL HEALTH PROGRAM MANAGER & THERAPIST
CORNER HEALTH CENTER, YPSILANTI, MI
I do not have any actual or potential conflicts of interest in relation to this program or presentation.
Participants will:

- Briefly review the Collaborative Care Model, including the interaction between the Care Manager and patient, as well as other team members.
- Learn about several examples of adaptations of this model, which are currently in use in non-profit clinic settings.
- Review the primary job functions of the Care Manager, and connect the skills inherent to the Care Manager's role to those of job-seekers, to help ensure a good fit.
- View examples of coordination documents/tools used by a Care Manager.
What is collaborative care?

The image on the right represents the AIMS Center’s conceptualization of an integrated Behavioral Health model they call the Collaboration of Care Model.

Traditionally, the consultant would be a psychiatrist, who would review patient cases and advise prescribers.

I encourage you to adapt this model, and similar tools, for the purpose of increasing clinic efficiency, lowering costs, and improving patient outcomes.
Adaptation scenario #1: Busy Doc

This image represents the model in place at my previous employer.

This is the team I previously lead, wherein I was tasked to implement CoCM with an existing staff, where therapists, not Care Managers, were already in place.

We made use of the AIMS model, with as much fidelity as possible, but also adapted to suit our psychiatric consultant, who preferred team meetings via Zoom to relying solely on the registry. We recognized that including the PCP wasn’t feasible, and defaulted to chart updates.
Adaptation Scenario #2: Group Love

This image represents the configuration of my current team at Corner Health Center, where I am the Behavioral Health Manager, supervising a team of clinical social workers, with various roles (Therapists, MIHP, Case Mgmt).

I facilitate a weekly integration meeting with all SW staff present. We also invite our team of multidisciplinary prescribers (NPs, OBs, MDs/residents), and 1-2 psychiatric staff. SW staff are expected to come prepared with cases for review.

We utilize time to coordinate cases across the entire team, focusing on mental health and socio-medical needs. We do not currently use a registry for patient management, but do use EBP tools for monitoring.
What are the main functions of the Care Manager?

The care manager is the *star* of the coordination team. This individual is responsible for:

1. Maintaining a strong connection between the client and the organization.
2. Advocating/communicating on the client’s behalf to the medical provider.
3. Accurate documentation of client progress, in order to guide the Consultant’s focus.
4. Robust recording of client services/communication with Medical Provider to drive billing.
Breakdown of skills within the CM role

Role:

Maintaining a strong connection between the client and the organization.

Advocating/communicating on the client’s behalf to the medical provider.

Accurate documentation of client progress, in order to guide the Consultant’s focus.

Robust recording of client services/communication with Medical Provider to drive billing.

Associated Skills:

- Warmth, ability to build and maintain rapport
- Mental health experience; various therapy techniques including MI, Behavioral Activation, BFST, CBT/DBT skills, Suicide response framework.
- Knowledge of MH treatment, ability to provide patient psychoeducation.
- Excellent soft skills and correspondence, including timely responses, proficiency using multiple modes of HIPAA-compliant communication.
Breakdown of skills within the CM role

Role:
Maintaining a strong connection between the client and the organization.

Advocating/communicating on the client’s behalf to the medical provider.
Accurate documentation of client progress, in order to guide the Consultant’s focus.

Robust recording of client services/communication with Medical Provider to drive billing.

Associated Skills:
- Skills of assessment and discernment regarding prioritizing client needs.
- Proficiency with medical language, as well as translation between client and provider.
- Comfort and skill working within a Team setting.
- Creative problem solving skills.
Breakdown of skills within the CM role

**Role:**
Maintaining a strong connection between the client and the organization.
Advocating/communicating on the client’s behalf to the medical provider.

**Accurate documentation of client progress, in order to guide the Consultant’s focus.**
Robust recording of client services/communication with Medical Provider to drive billing.

**Associated Skills:**
- Proficiency with data, and use of EHRs, registry tools, reporting tools, spreadsheets, etc.
- Mental health assessment skills, including discernment/differential diagnostic capability.
- Must “speak the language” of psychiatry
- Training in the use and interpretation of evidence-based assessment tools
Breakdown of skills within the CM role

Role:
Maintaining a strong connection between the client and the organization.
Advocating/communicating on the client’s behalf to the medical provider.
Accurate documentation of client progress, in order to guide the Consultant’s focus.

Robust recording of client services/communication with Medical Provider to drive billing.

Associated Skills:
- Accurate, detail oriented recording of client services rendered and provider effort, including referrals, multidisciplinary consultation, patient follow-up, etc.
- Basic knowledge of billing, grant tracking, etc.
- Good time management.
- Strong documentation skills.
The PHQ-9 is considered the gold standard assessment tool, around which depression-focused CoCM was designed. That said, you can select any valid, reliable assessment tool to track progress and validate decision-making. My current team uses the GAD-7, as well. While assessments cannot take the place of good clinical judgement, they are an efficient way to steer clinical focus.
## Tools: Registry Examples

### Diabetes Tracking Worksheet

<table>
<thead>
<tr>
<th>Patient name</th>
<th>Sex</th>
<th>Date of birth</th>
<th>ID number</th>
<th>Provider</th>
<th>A1c</th>
<th>Date of last A1c</th>
<th>Date of last eye exam</th>
<th>Date of last foot exam</th>
<th>Date of last BMP</th>
<th>LDL</th>
<th>Date of last Lipids test</th>
<th>Systolic BP</th>
<th>Diastolic BP</th>
<th>Date of last BP</th>
<th>Co-morbidities</th>
</tr>
</thead>
</table>

### Active Patients

<table>
<thead>
<tr>
<th>FLAGS</th>
<th>PATIENT_ID</th>
<th>MRN</th>
<th>NAME</th>
<th>STATUS</th>
<th>PHQ-9</th>
<th>GAD-7</th>
<th>I/A/B</th>
<th>F/U</th>
<th>P/N</th>
<th>CONTACTS</th>
<th>R/P</th>
<th># Sess</th>
<th>Wks since I/A/B</th>
<th>Minutes This Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>000001</td>
<td>12345</td>
<td>Demo, Frederico</td>
<td>T</td>
<td>18</td>
<td>15</td>
<td>11</td>
<td>11</td>
<td>8/20/17</td>
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<td>11/8/17</td>
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<td>39</td>
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<td>20</td>
<td>10</td>
<td>2/20/17</td>
<td>3/11/18</td>
<td>8/5/17</td>
<td>12/26/17</td>
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MH Care Manager should present the following information when meeting with the psychiatrist:

- Demographic Information: including age, race, gender, living situation, and other salient identities. Include the circumstances of their referral to Tx. Possible environmental or cultural factors that impact the course of treatment.
- Key Findings: Include current Dx if available, assessment scores, client insight, and observational (MSE) data from your interactions
- History: Chronological list of prior psychiatric Dx, Hx and medication Hx. Other relevant medical data, including SÚ, family/personal Hx.
- Intervention: Engagement and progress within the current integration program
- Reason for case consultation: Meets criteria for review via the registry, case is up for discharge, etc.

*Please remember this is not the CM’s personal case formulation, but should be comprised of objective data for the psychiatrist to make their own recommendations.*
AIMS Center CoCM BH Care Manager Sample Job Description: https://aims.uw.edu/sites/default/files/CareManagerJobDescription_0.pdf

AMA’s EdHub Registry Development Toolkit: https://edhub.ama-assn.org/steps-forward/module/2702745


Thank you for your time!

Please feel free to address questions to jschwartz@cornerhealth.org
DISCUSSION QUESTIONS

• Has your practice/organization experienced issues of BHI workforce retention? If so, what steps has your practice/organization taken to address retention?

• How has your practice/organization recruited (or trained current staff) to fill these important BHI roles?

• What closing thoughts would you like to leave physicians with?
BHI Collaborative “On Demand” Webinars

Check out other webinars from the Overcoming Obstacles series such as:

- Advancing Health Equity through Behavioral Health Integration
- Addressing Behavioral Health in Primary Care: Non-Pharmacological Services & Treatments
- Beating Physician Burnout with Behavioral Health Integration

Watch all these webinars and more on the [Overcoming Obstacles YouTube playlist](https://www.youtube.com/playlist) now!
Collaborative Resource – **BHI Compendium**

The **BHI Compendium** serves as a tool to learn about behavioral health integration and how to make it effective for your practice and patients.

**Download Now** to learn how to make the best decisions for the mental health of your patients.
AMA Resources – How-To Guides

Access AMA’s BHI practice guides for practical strategies, actionable steps and evidence-based resources on four specific areas of effective integrated care: pharmacological treatment, substance use disorder, suicide prevention, and workflow design.
Thank you for joining!