The Collaborative Care Model (CoCM)

The Behavioral Health Care Manager

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MI-CCSI
Center for Clinical Systems Improvement

Michigan Collaborative Care
IMPLEMENTATION SUPPORT TEAM

Disclosure

The organizations, or the presenters, do not have any financial interest, relationships, or other potential conflicts, with respect to the material which will be covered in this presentation.

Objectives

At the conclusion of this presentation, the participant will be able to:

- Identify patients for CoCM
- Review the referral process for CoCM
- Discuss Pre-screening and triage assessment components
- Understand the requirements for patient consent
- Review key components of the comprehensive assessment
- Review the value of the self-management action plan

Starting the Day

- Let’s take a poll!
- 2 Burning Questions before we start the day

Poll

BCBSM CoCM Designation 2022

In 2022, only two capabilities will be needed for a practice to be eligible for CoCM designation.

- Capability 1.1 – The practice must have assembled their care team and understand the interactions within the provider triad.

Then one of these two capabilities:

• Capability 1.2 – A practice member from each of the three roles attends the PGIP-sponsored training.

• Capability 1.3 – A practice is deemed to be delivering CoCM with fidelity to the model. Fidelity means that the CoCM delivery to the original model as described by University of Washington's AIMS Center.

**Review the BCBSM CoCM Designation Program Criteria for details

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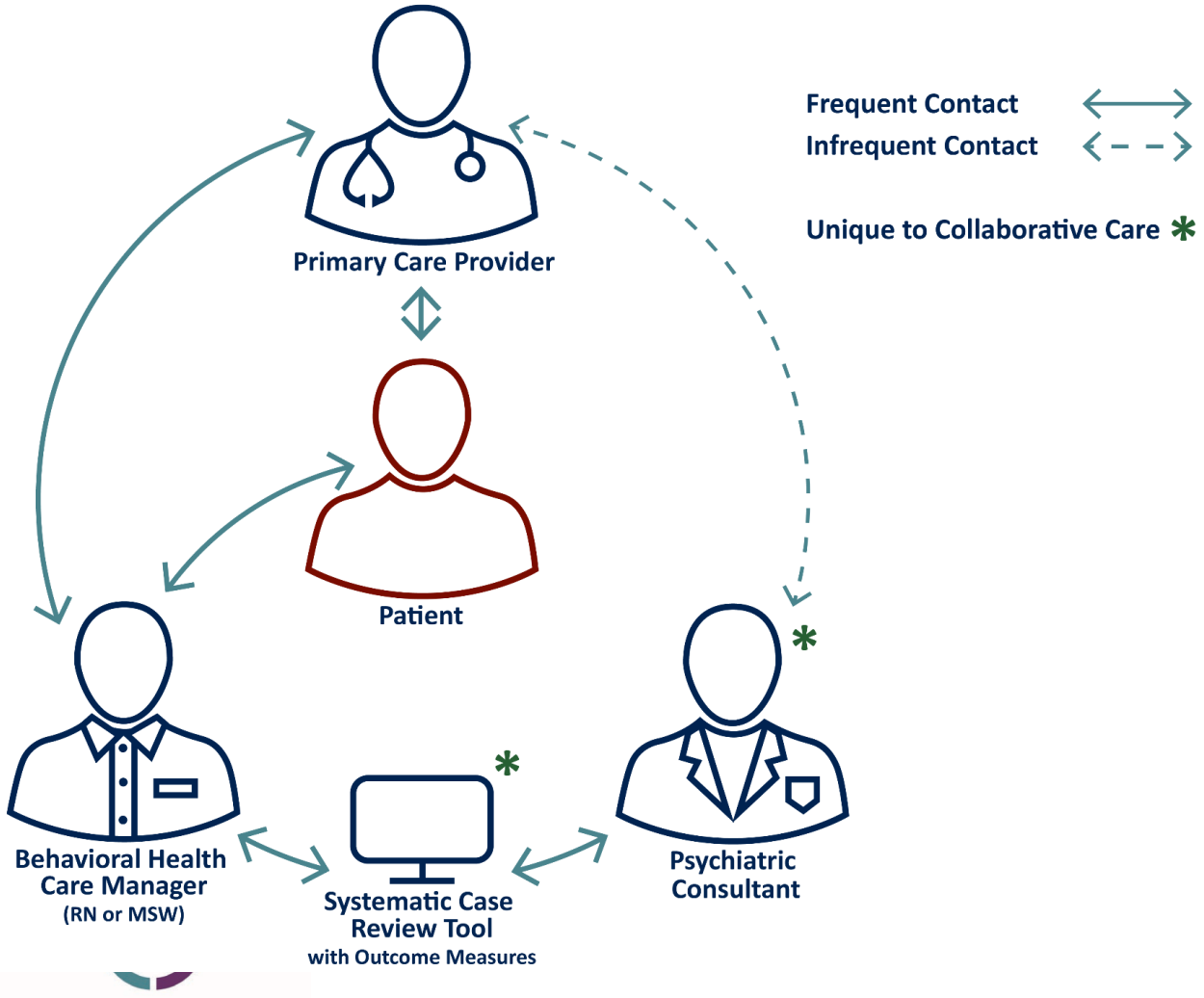
The Collaborative Care Treatment Team



The BHCM is the Glue that keeps the TEAM together

Qualifications for the Behavioral Health Care Manager

- State license
- Formal education or specialized training in behavioral health
  - Problem-solving
  - Behavioral activation
  - Motivational Interviewing

What the BHCM Does…….

- Coordinates the overall effort of the treatment team and ensures effective communication among team members
- Provides the psychiatrist advice to the patient's provider, and based on the final decision of the provider shares the treatment plan with the patient
- Between provider visits, regular medication monitoring and psychoeducation
- Offers brief behavioral health interventions (using evidence-based techniques such as motivational interviewing, behavioral activation, and problem-solving treatment)
- Co-creates the relapse prevention plan with the patient
- Participates in systematic case review; Close collaboration with the provider and psychiatric consultant
- Works under the oversight and direction of the PCP by providing:
  - Proactive follow-up of treatment response
  - Alerting the PCP when the patient is not improving, S
  - Supporting medication management
  - Facilitating communication with the psychiatric consultant regarding treatment changes
- Tracks patient management activities for billing

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The Process of Collaborative Care

- Screening – identify eligible patients from the general practice population
- Referral – connect eligible patients to the CoCM program
- Engage with the patient – introduce your role and value of CoCM to the patient
- Screening Assessment -
  - Assess appropriateness for CoCM
  - If appropriate, complete biopsychosocial assessment including diagnostic criteria, medical/medication history
- Initiate treatment – identify available treatment interventions, develop care plan and self-management goals, set stage for relapse prevention planning
- Track treatment progress over time – administer PHQ-9 and GAD-7 throughout treatment
- Adjust treatment as needed – for patients who are not improving
- Conclude treatment – review relapse prevention plan, confidence with self-management and resources if indicated

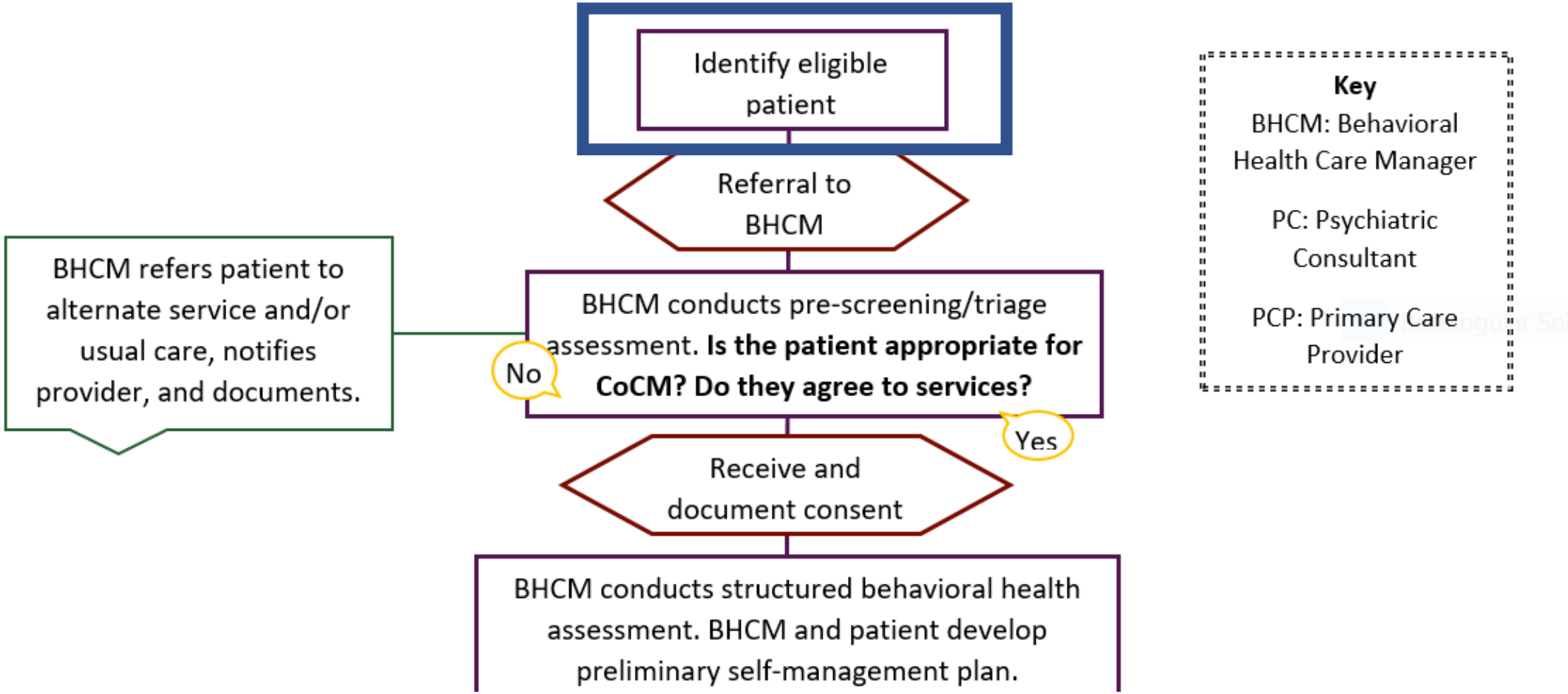
Our Patient

Jasmine presents to the clinic for her annual wellness visit. As part of the routine visit, she has a number of screening tools to complete, to include the PHQ 9 and GAD 7.

Jasmine scores a 15 on the PHQ and a 3 on the GAD 7.

Where do we go from here?

Starting with Identification



Identifying Eligible Patients

- Referrals from PCP, (warm hand-offs are ideal when available)
- Use of the disease registry

Defining the target population:

- PHQ-9 and/or GAD-7 of 10 or more
- Diagnosis of depression and/or anxiety
- Just started on a new antidepressant, regimen was changed,
- Where PCP is only seeking prescribing guidance and the psychiatrist is willing, consider an e-consult (as a billable service)

Definitions

Data is an active member of the treatment team allowing to identify patients, track treatment progress, and trend impact of CoCM services.

Disease Registry

- List of patients with a diagnosis of depression, anxiety, or other behavioral health condition
- Could be incorporated with existing chronic disease registry
- Used to identify patients who are eligible for the CoCM services

Systematic Case Review Tool

- Summary of key treatment information (e.g., outcome measure scores, dates of contacts) for each patient
- Used by behavioral health care manager (BHCM) and psychiatric consultant to regularly review the CoCM caseload

Systematic Case Review

- Weekly meeting between the psychiatric consultant and BHCM to review the caseload and provide expert treatment recommendations
- Fundamental component of CoCM

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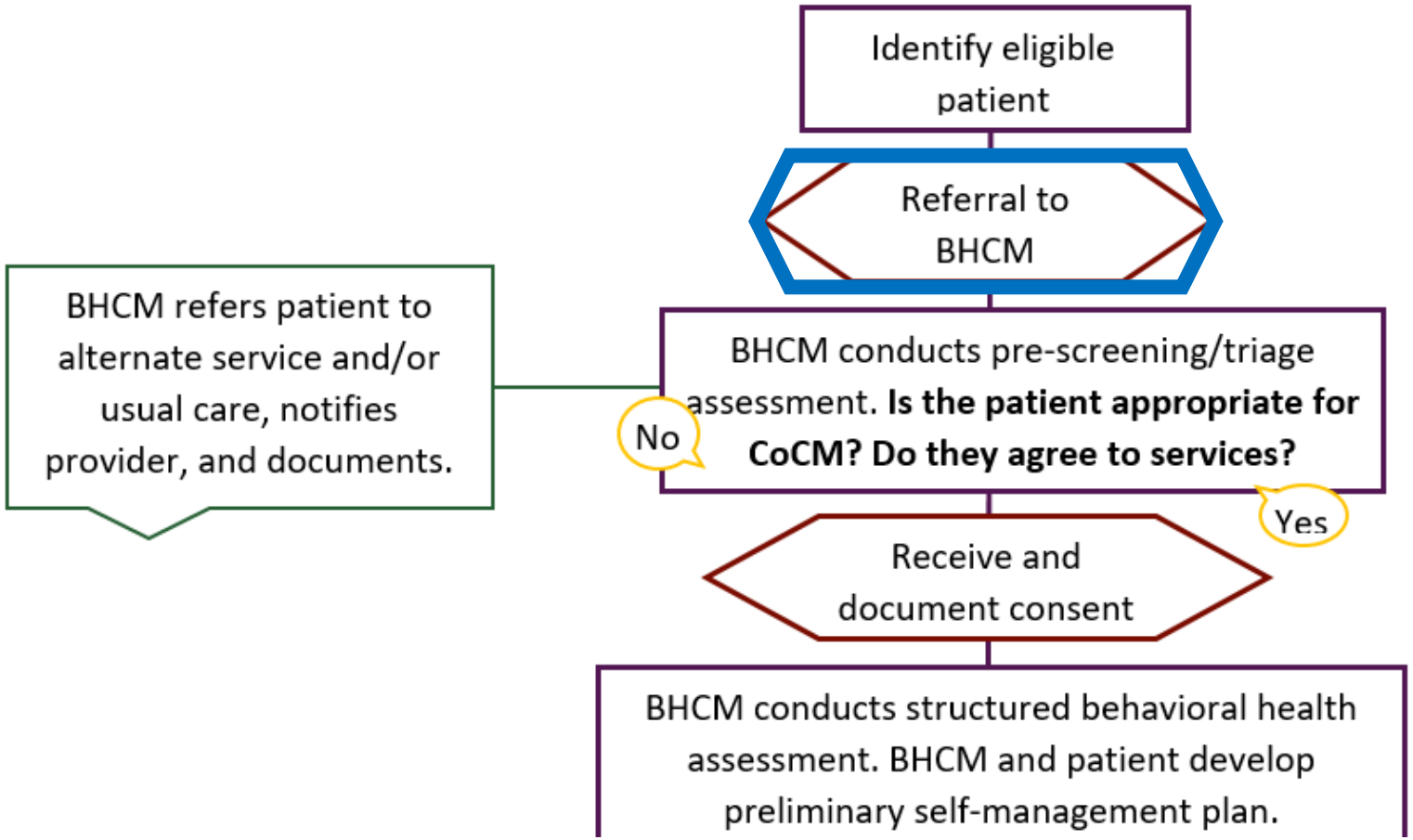
Engaging the Patient

Jasmine's provider reviews the results of the PHQ and verifies a diagnosis of depression. She refers Jasmine to you, the Behavioral Health Care Manager.

If you were Jasmine, what would you want to hear from the provider in making the decision to participate in CoCM?

How will you share these ideas with the practice and provider?

The Process: Referral to CoCM



Key

BHCM: Behavioral Health Care Manager

PC: Psychiatric Consultant

PCP: Primary Care Provider

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Introduce	Personalize	Introduce	Emphasize	Describe
If possible, introduce via a warm-handoff from the PCP	Personalize the script based on the patient, personal style, and clinical judgment	Introduce the team-based approach, reviewing the role of each team member	Emphasize the importance of the patient's role in: •treatment planning and ongoing care •completing screening tools •participating in meeting with the BHCM	Describe the time-limited approach of interventions from the BHCM explaining that this is not therapy

**See patient handout tools pages 3-5

Tips in Introducing CoCM to Patients

Activity: In groups of 2 – create your introduction

Creating An Introduction – CoCM Model

Patient Introduction to CoCM Scripting

- Warmly greeting and obtaining permission to continue
- Review patient understanding of the referral to CoCM
- Share the value of CoCM to the patient and their role in CoCM
- What to expect in frequency, timelines, communication

Breakout in Pairs: Putting it in your own words

Sharing experience

Homework

****Work with your team in developing an introduction to CoCM.**

See handout #9 as a guide.

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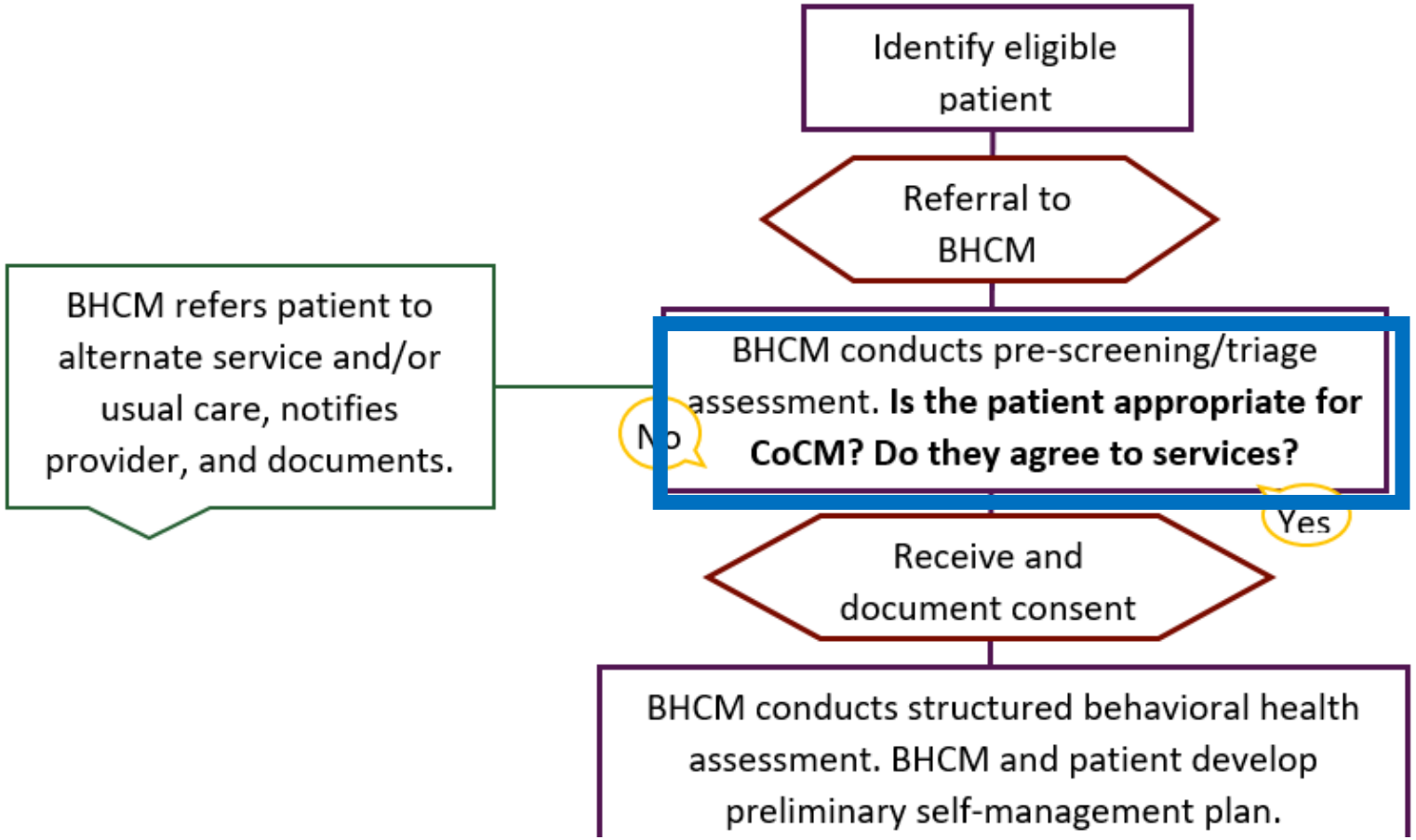
Conducting the Prescreening/triage assessment

You are introduced to Jasmine, and she has agreed to meet with you to hear more about the CoCM program. You have introduced yourself and are preparing to conduct the prescreening otherwise known as the triage assessment.

What key information will you gather to prepare for the systematic case review with the psychiatrist?

What will be helpful to the psychiatrist in advising treatment recommendations for the primary care provider to consider?

The Process: Prescreening/Triage Assessment



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Screening, Triage and the Comprehensive Assessment: The Why

- Screen using evidence-based valid outcomes measures such as PHQ, GAD, etc.
- Provide comprehensive behavioral health assessment (substance abuse and mental health history included) both over the phone and in-person
- Evaluate and assign level of care needed based on assessment and resources
- Have knowledge of behavioral health resources internal and external, along with eligibility and access criteria
- Conduct risk assessments and safety planning when indicated
- Provide crisis management when needed

Pre-Screen and Triage Assessment: The How

- Used to determine whether a patient is appropriate for Collaborative Care
- Modality:
  - ❑ Chart review
  - ❑ Discussion(s) with providers
  - ❑ Discussion with psychiatric consultant
  - ❑ Direct patient assessment
- When:
  - At time of referral
  - Later on in clinical care- it's an ongoing process!

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The What

Triage Assessment

- ☐ Presenting symptoms of concern
- ☐ Psychiatric treatment history
  - ☐ Has patient been a Community Mental Health (CMH) consumer?
  - ☐ Psychotic disorder diagnosis?
  - ☐ Confirmed or likely personality disorder diagnosis?
- ☐ History of psychosis/hallucinations (auditory/visual)?
- ☐ Prior medications
  - ☐ Mood stabilizers?
  - ☐ Antipsychotics?
  - ☐ Other:
- ☐ Administer core outcome measures (PHQ-9, GAD-7, AUDIT-C)
  - ☐ High-risk AUDIT-C score? Is inpatient or residential treatment indicated
  - ☐ PHQ-9 and GAD-7 both <10?

Considerations for a Higher Level of Care

Patients with:

- Severe substance use disorders
- Active psychosis
- Severe developmental disabilities
- Personality disorders requiring long-term specialty care
- Bipolar is challenging and requires consideration

Introducing the Patient Health Questionnaire Screening (PHQ)

- INTRODUCE: “Along with your physical vital signs like your blood pressure and heart rate, I am also going to ask you some questions about your mood.”
- NORMALIZE: “These are questions we ask all of our patients.”
- EXPLAIN: “Your answers will help your doctor know what to focus on so he/she can give you the best care possible” or “Your answers will help us know if your treatment is working so that we can do everything possible to help you recover/feel better.”
- Normalize: The tool will be revisited throughout the treatment to measure progress.

PHQ - 9

- Conducting the Patient Health Questionnaire
- A screening tool
- Commonly used and validated screening tool for depression in adults
- As a monitoring tool
- Frequency

See Handout #10

Generally a score of 10 or above and/or a positive answer on question 9 of the PHQ-9, a screening for suicidal symptoms necessitates intervention.

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

GAD-7

- The GAD 7 is a seven-question form used to screen for signs and symptoms of anxiety and monitor changes in symptoms.

- *"Much like taking your blood pressure or temperature, this screening will give us information about your overall health and well-being over the past 2 weeks."*

See Handout #11

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

Additional Screenings to Consider

- Alcohol screening
- Drug screening
- CIDI-based bipolar questionnaire
- MoCA (mild cognitive dysfunction)
- PC-PTSD (PTSD screening)
- PCL 5 (PTSD screening)

Drugs, Alcohol and Depression

Considerations for Treatment

CIDI-Based Bipolar Disorder Screening Scale

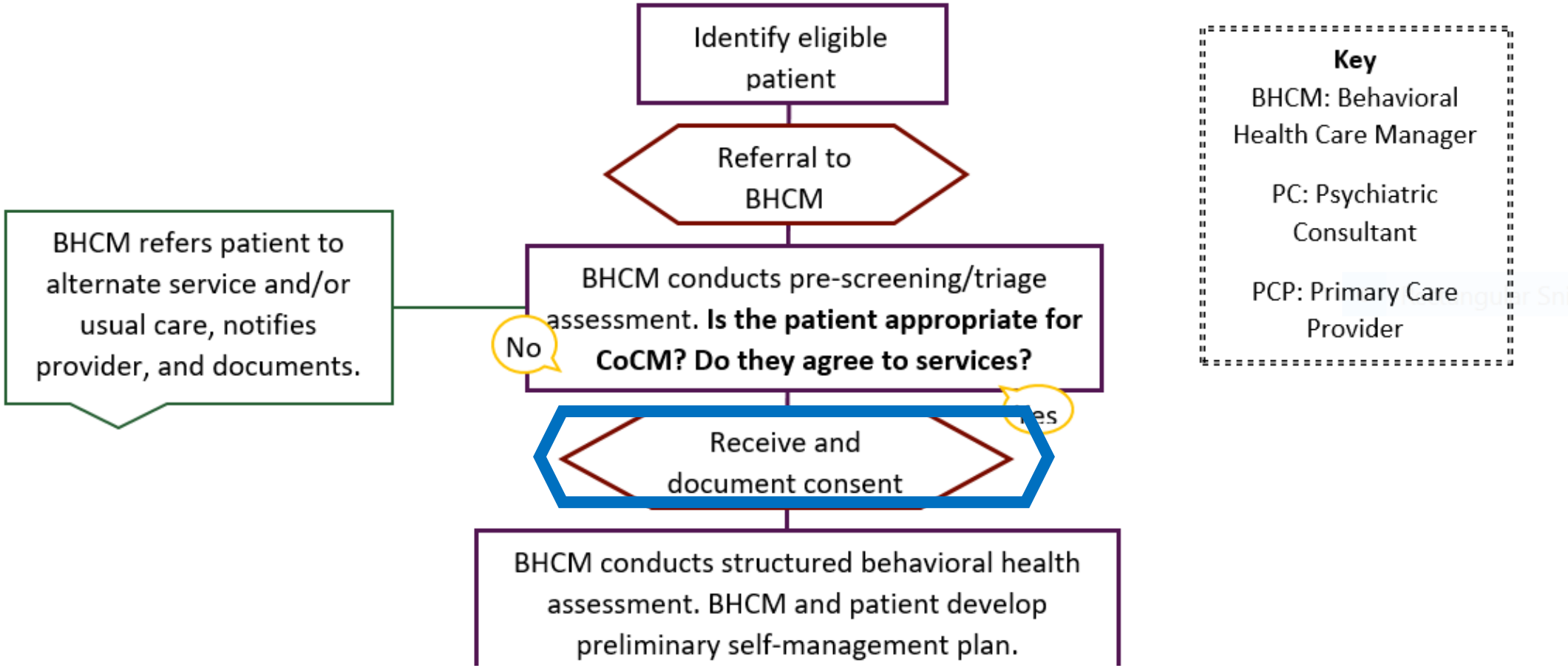
Stem Questions:

1. Some people have periods lasting several days or longer when they feel much more excited and full of energy than usual. Their minds go too fast. They talk a lot. They are very restless or unable to sit still and they sometimes do things that are unusual for them, such as driving too fast or spending too much money. Have you ever had a period like this lasting several days or longer?

2. Have you ever had a period lasting several days or longer when most of the time you were so irritable or grouchy that you either started arguments, shouted at people, or hit people?

McCormick, U., Murray, B., & McNew, B. (2015). Diagnosis and treatment of patients with bipolar disorder: A review for advanced practice nurses. *Journal of the American Association of Nurse Practitioners*, *27*(9), 530–542. https://doi.org/10.1002/2327-6924.12275

Consent


Identify eligible patient
Referral to BHCM
BHCM conducts pre-screening/triage assessment. Is the patient appropriate for CoCM? Do they agree to services?
No
BHCM refers patient to alternate service and/or usual care, notifies provider, and documents.
Receive and document consent
BHCM conducts structured behavioral health assessment. BHCM and patient develop preliminary self-management plan.
Key
BHCM: Behavioral Health Care Manager
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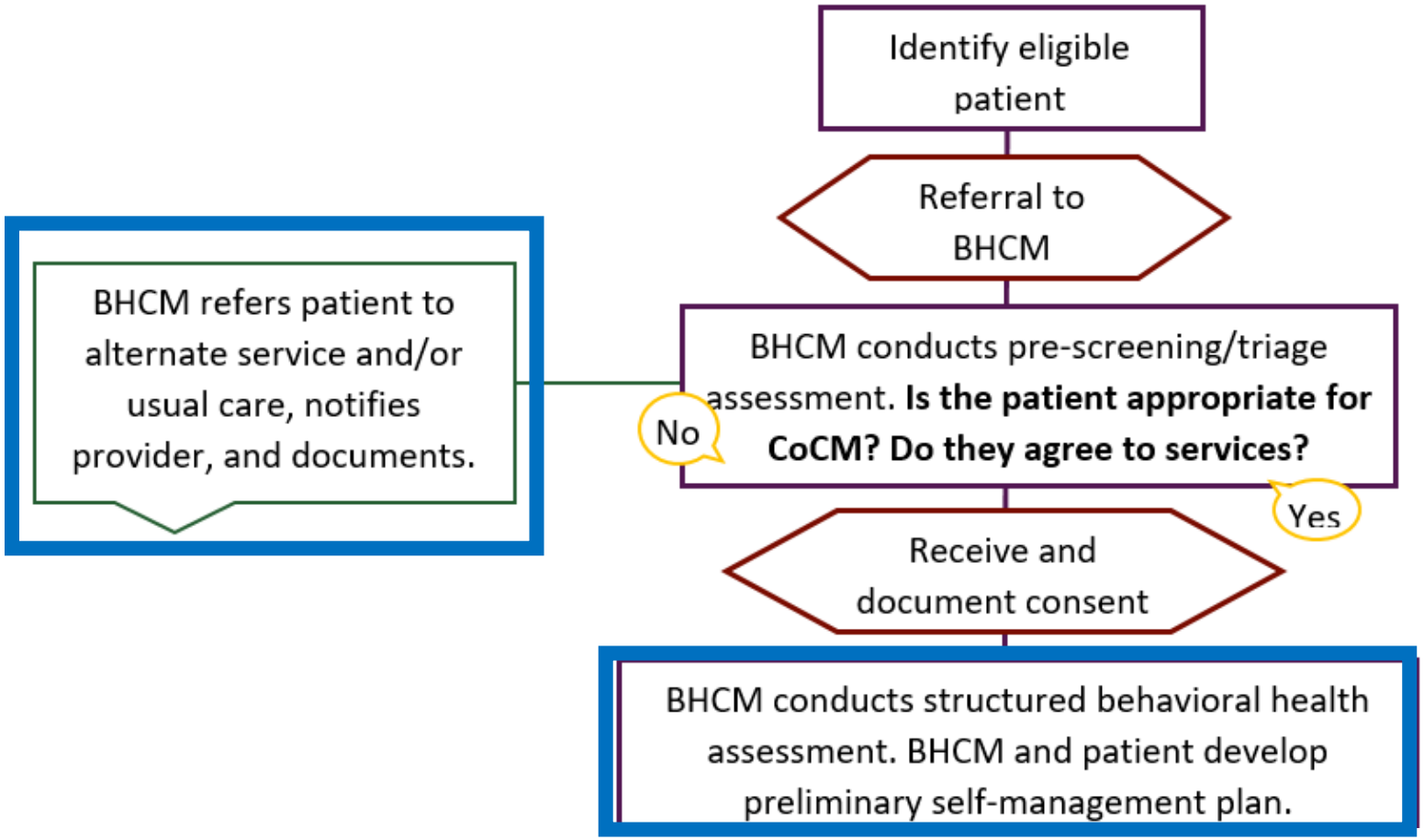
Patient Agreement

- Verbal or written (depending on payer requirements)

- Documented in EHR before services begin
- If billing CMS (Medicare and Medicaid) Key items:
  - Permission to consult with psychiatric consultant and relevant specialists
  - Billing information (cost sharing), if applicable
  - Disenrollment can occur at any time (effective at end of month, if billing)

The Process: Structured Assessment



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Structured Assessment

See Handout #12 "EPIC Care Coordination Template"

Address any questions and prepare for the assessment.

- "So far, we've talked a bit about what Collaborative Care will look like, including your role, my role, and the other team members' roles. You've also shared a bit with me about what's been going on with you. Given everything we've talked about so far, I'd like to **check in** regarding anything that might be on your mind.

Set expectations for the patient and provide choice

- 30-60 minutes, on average – may take place over more than one contact
- Telephone or face-to-face

The Comprehensive Assessment

Includes:

- Behavioral Health
- Social Needs
- Medical Status

Incorporates the patients:

- Ability
- Knowledge
- Desire

Presenting Symptoms

- Assess the patient's current symptoms of concern and understanding of the diagnosis, linking to the PHQ-9/GAD-7
  - "Tell me more about what's been going on."
  - "You mentioned you've been feeling down; could you share more about how that's been impacting your daily life?"
  - "What has been your experience with depression/anxiety in the past?"

Behavioral Health History

- Course of illness
  - “How long has this been going on?”
  - “Is this something that is always present for you, or does it come and go?”
  - “What tends to bring on these feelings, if anything?”
- Diagnostic history
  - “What mental or behavioral health diagnoses, if any, have you received from a health care provider?”
  - What is your understanding of your diagnosis of depression/anxiety?
  - “Who was it that gave you that diagnosis? When?”
  - Screen for history of psychosis (AH/VH)
- Trauma history – consider timing, comfort and engagement when addressing this
  - It is often appropriate to wait until a trusting relationship is established before screening for trauma
  - Screening tools include the PC-PTSD and the PCL-5

Treatment History- Medications

- Current and past medication names and dosages, (both medical and psychotropic) – what is/was the medication for?
- Prescriber(s) of the medication(s)
- Length of medication trials
  - “How long did you take that medication?”
  - “What made you decide to stop the medication?”
- Effectiveness and side effects
  - “What did you notice when you took that medication?”
  - “Was it helpful? Why/why not?”
  - “What side effects, if any, did you experience?”
- Perceptions and beliefs – about taking medications?

Treatment History - Therapy

- Current and past engagement in therapy
- Where
- Type
  - “What kinds of things did you work on? What did you learn?”
- Length
- Effectiveness
  - “What was helpful about it? What wasn’t?”

Substance Use

- Engage, ask permission, and be nonjudgmental
  - “Would it be okay if I asked you a few questions about how you use substances?”
- Current and past substance use
- Screening tools can be helpful
  - AUDIT-C, Drug Use, etc..
- Treatment history
- Gain initial understanding of how they feel about their substance use
  - Brief assessment, Intervention/referral to treatment
  - “You’re not worried about how this is impacting you right now.”

Physical Health

- Physical health diagnosis and history
- Sleep
- Functioning status
- Activity level / exercise
- Health literacy

Social Determinants of Health Screening

In addition to the PHQ and GAD7, Jasmine also completed a social needs screening during her annual visit.

She indicated she will need assistance with finances.

Does the practice you are supporting complete social needs screenings? If yes – who?

How will this information get to you, that you can take this in consideration when developing the treatment plan with the psychiatrist and provider?

Psychosocial Needs

Detailed information to include in the assessment.

- Support system
- Financial issues
- Disability/work status
- Transportation
- Living situation
- Access to phone and adequate minutes for phone-based care management contacts

Response to Question 9 on the PHQ9 Screening

Jasmine gave a score of 2 to question 9:

“Thoughts that you would be better off dead or hurting yourself in some way”

Does the practice you are supporting have a suicide policy?

Do all members of the team know what to do if a patient indicated they are suicidal and have the means to carry it out?

Suicide Risk Assessment

- Thoughts of death, harming oneself, and suicide can be common within this population
- When clinically indicated, risk assessments and safety planning should be completed
- Consider your organization's suicide protocol
- Engage in further training if needed

Strategies for Suicide Risk Assessment

- Normalize the conversation (“thoughts of suicide are a common symptom of mental health disorders”)
- Be direct
- **You won’t increase the risk of suicide by asking directly about it**. Use specific language, such as:
- *“Are you feeling hopeless about the present or future?”*
- *“Thoughts of suicide, even very fleeting thoughts such as not wanting to wake up in the morning, are common in people with depression and anxiety. Is this something that you’ve experienced?”*
- *“Have you had thoughts of taking your life?”*
- *“Do you have a plan to take your life?”*

*****See Handout #13 Suicide Policy**

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Key Acute Risk Factors and Behaviors

- Current ideation, intent, plan, and access to means
- Rehearsing a plan (e.g., holding a gun, loading a gun, counting pills)
- Previous suicide attempt/s
- Alcohol/substance use
- Recent discharge from an inpatient psychiatric unit

Example: Columbia – Suicide Severity Rating Scale (C-SSRS)

Patient Safety Plan Template

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. _____
2. _____
3. _____

Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Place_____ 4. Place_____

Step 4: People whom I can ask for help:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Name_____ Phone_____

Step 5: Professionals or agencies I can contact during a crisis:

1. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact # _____
2. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact # _____
3. Local Urgent Care Services_____
   Urgent Care Services Address_____
   Urgent Care Services Phone_____
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe:

1. _____
2. _____

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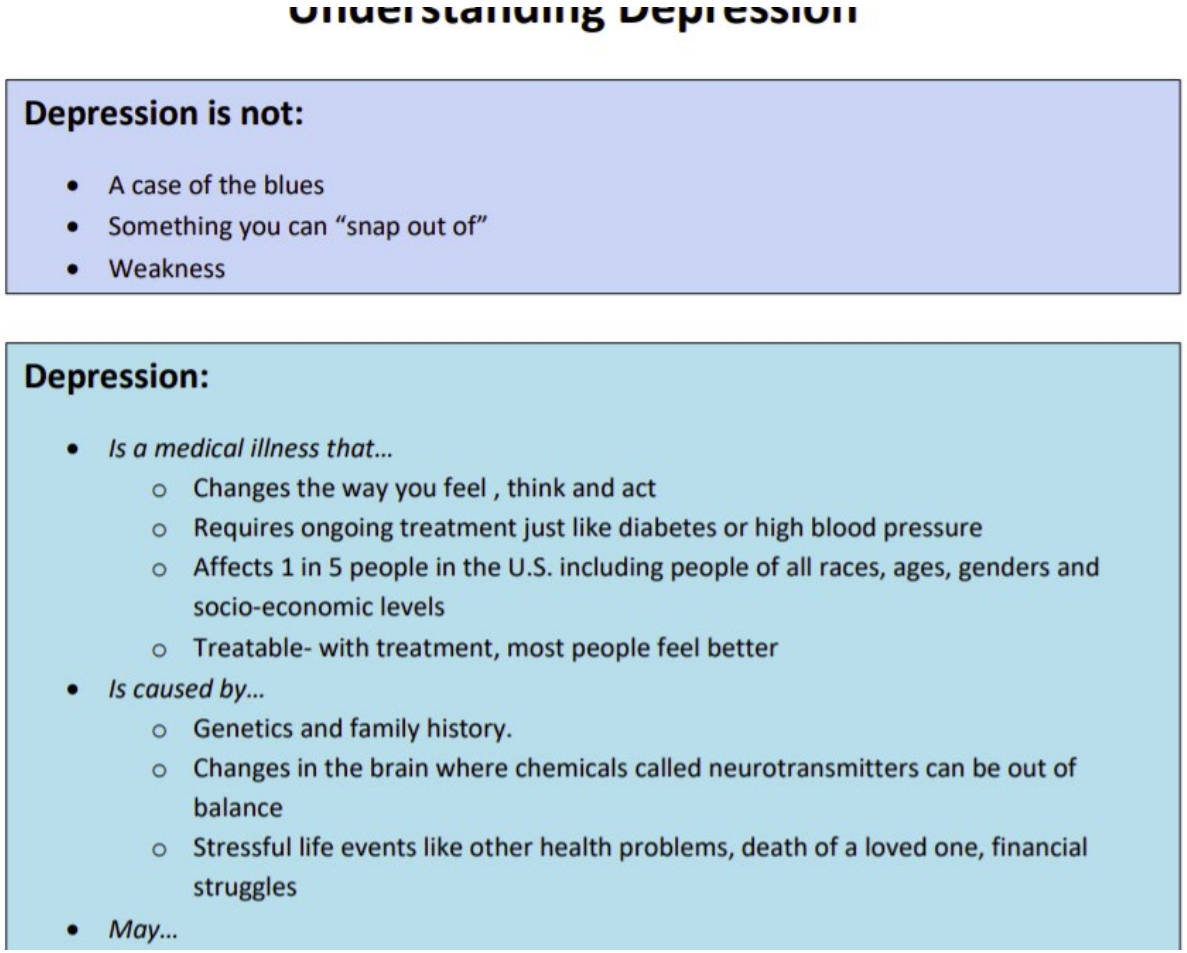
The one thing that is most important to me and worth living for is:

#14 Safety Plan Template

Understanding Depression – Patient Tool



Understanding Depression

Depression is not:

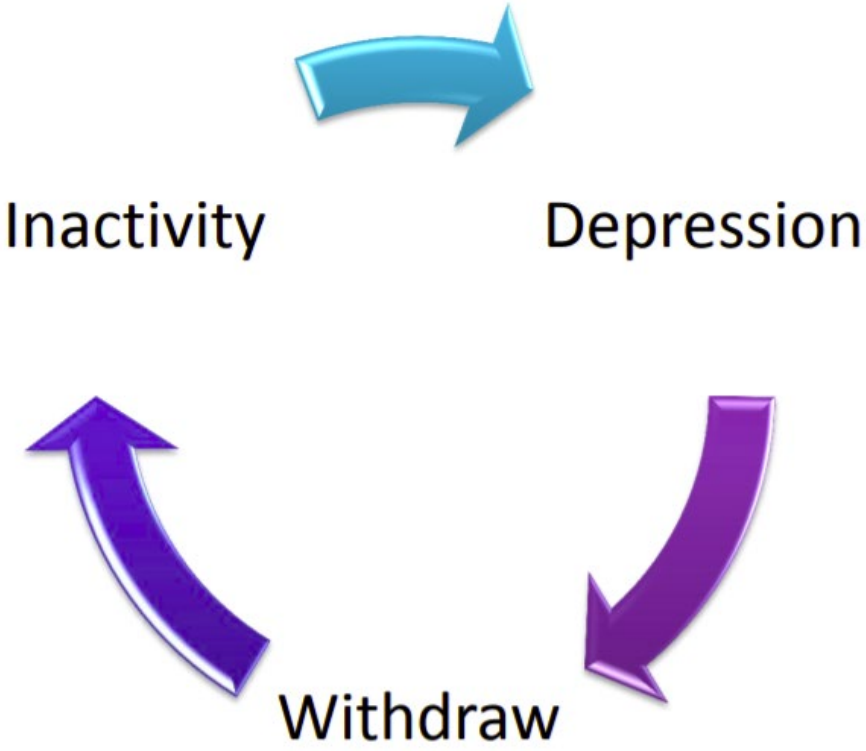
- A case of the blues
- Something you can "snap out of"
- Weakness

Depression:

- *Is a medical illness that…*
  - Changes the way you feel , think and act
  - Requires ongoing treatment just like diabetes or high blood pressure
  - Affects 1 in 5 people in the U.S. including people of all races, ages, genders and socio-economic levels
  - Treatable- with treatment, most people feel better
- *Is caused by…*
  - Genetics and family history.
  - Changes in the brain where chemicals called neurotransmitters can be out of balance
  - Stressful life events like other health problems, death of a loved one, financial struggles
- *May…*

See Patient Support Tools Pages 6-7

Cycle of Depression – A Patient Communication Tool



**See Patient Support Tools – Pages 8-9

Moving Forward With The Patient

- Acknowledge that this might have felt like a lot of information; elicit any questions or feedback
- Discuss next steps
  - Self-management goals
  - Reminder of upcoming psychiatric consultation as appropriate
  - Frequency of monitoring and next contact
- Contact information
  - Best time to call, permission to talk to others and/or leave a voicemail, confirm mailing address, obtain email address if secure email contacts are allowed by your organization, discuss patient portal
  - Share your contact information and hours
  - Emergency contacts
- Share relevant patient materials

Consider a Patient Welcome Packet

www.miccsi.org

Intake packet example

Care Plan

Remember that discharge planning/preparation starts from the beginning (relapse prevention)

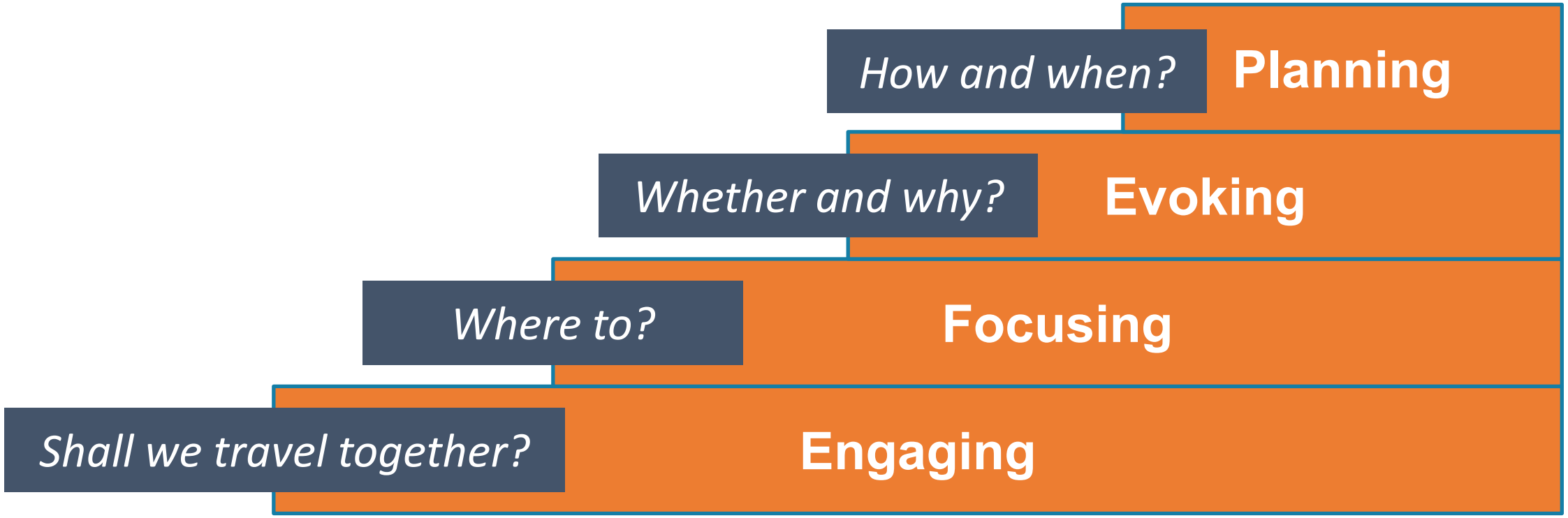
- Developed by the Care Team *with* the Patient
- Goals have observable, measurable outcomes (SMART)
- Outcomes are routinely measured
- Treatment to target
- Treatments are actively changed until treatment goals are achieved (Treatment Intensification)
- Clinical outcomes are routinely measured by evidence-based tools (PHQ and GAD)

Self-Management

- A “management style” where patients use the best treatments provided by health care professionals **AND** also approach their illness in a proactive manner, leading to a healthier life
- Self-management teaches skills that continue to work above and beyond the short-term relief that may be gained from self-help strategies
- See 2.5 of the PCBSM CoCM Designation Program Criteria for future requirements

POLL #14 – Self-management Action Planning

Planning: First, lay your foundation of MI



Engagement

To Plan: Start with a Focus

"You've discussed some difficulties in your marriage, your desire to cut back on your drinking, as well as your goal to lose some weight. We also know that you've been noticing your depression is feeling more difficult to manage lately. Where do you feel is the most important place to focus on first?"

Evoking

- Drawing out patient's own ideas and reasons for change
- The patient is the expert: Elicit, provide, elicit

- Current and past self-management strategies
  - "What have you tried so far that's been helpful?"
  - "What have you tried that hasn't worked so well?"

- Knowledge about their symptoms, diagnosis, and/or treatment
  - "What do you know about depression and how it impacts people?"
  - "What do you know about treatment for depression and anxiety?"
  - "What kinds of things have you already been thinking about trying?"
  - "What would be some benefits if you made this change?"

Self-management Plan: Goal Setting

- Summarize what you've talked about and transition into a discussion about goals
  - "I've been able to learn a lot about you, including your history with depression, what you're currently struggling with, and some ideas that you have about where you'd like to go from here. Now we can move toward some self-management goals and treatment that might feel right to you. Where would you like to start?"
- Provide psychoeducation, as appropriate
  - "You're familiar with medication as a possible treatment for depression. Would it be okay if I shared some more information about treating depression?"
  - Behavioral activation, problem-solving, psychotherapy, medication, self-management strategies
- Elicit patient goals
  - "Given everything we've discussed, what do you think you might like to try?"

Creating a Specific Plan that Reflects the Focus

SMART goals

- Specific
- Measureable
- Attainable
- Relevant
- Time-specific

Depression and self-management action planning (Breaking the cycle)

- Where would you like to start to improve your depression?
  - “I want to exercise more,” or “I’ll go to the gym every day.”
  - Let’s get specific – what exercise? How often? When? Where?
  - SMART version: “I want to go for a 30 minute walk three days per week for the next two weeks.”

Goals Important to You

-
-
-
-

Healthy Lifestyle

- Exercise regularly
- Avoid addictive substances
- Make healthy food choices and eat at a regular time in a comfortable space
- Get regular sleep

Relationships

- Spend time with others
- Go to social events or get coffee with friends
- Build supportive relationships

Stick With Your Plan

- Take medications as directed
- Keep appointments
- Participate in groups/counseling
- Stay in touch with your care manager
- Work on your goals

Productivity

- Get involved in workplace projects or community events
- Start or keep working on a regular basis
- Get involved in personal or family activities

Self-Reward

- Plan weekly activities that are relaxing or that you have enjoyed in the past like reading or listening to music
- Take up an old hobby or attend a special event

Spiritual

- Connect with a spiritual community
- Look for ways to meet your spiritual needs such as quiet study, meditation, services/ceremonies

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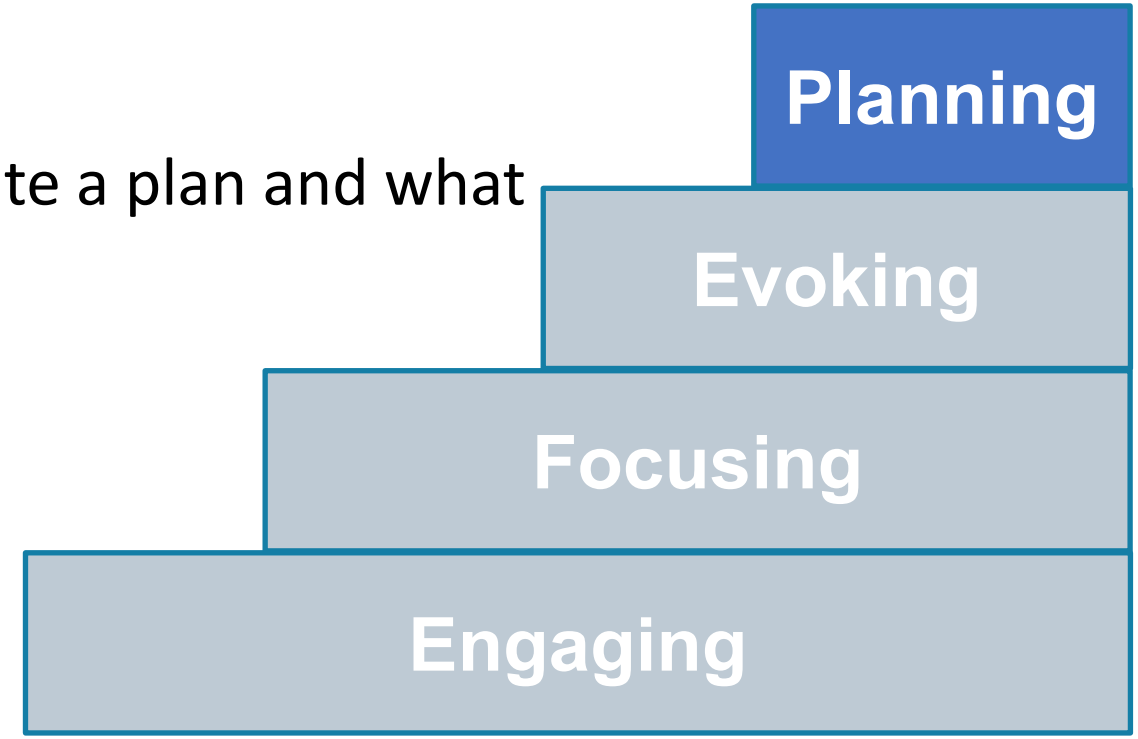
- What would be a reasonable next step toward change?
- What would help this person to move forward?
- Am I remembering to evoke rather than to prescribe a plan?
- Am I offering needed information or advice with permission?
- Am I retaining a sense of quiet curiosity about what would work best for this person?
- What if the patient is not ready to create a plan and what might it mean?
- Provide hope – we can get through it.



Intake and Self-management Reminders

- Use of motivational interviewing is key
  - The patient is the expert; they are more likely to engage in a self-management plan if they believe it is important, right for them, and are confident they can succeed
- Self-management plans will change over time
- Establish next steps, including a plan for follow-up

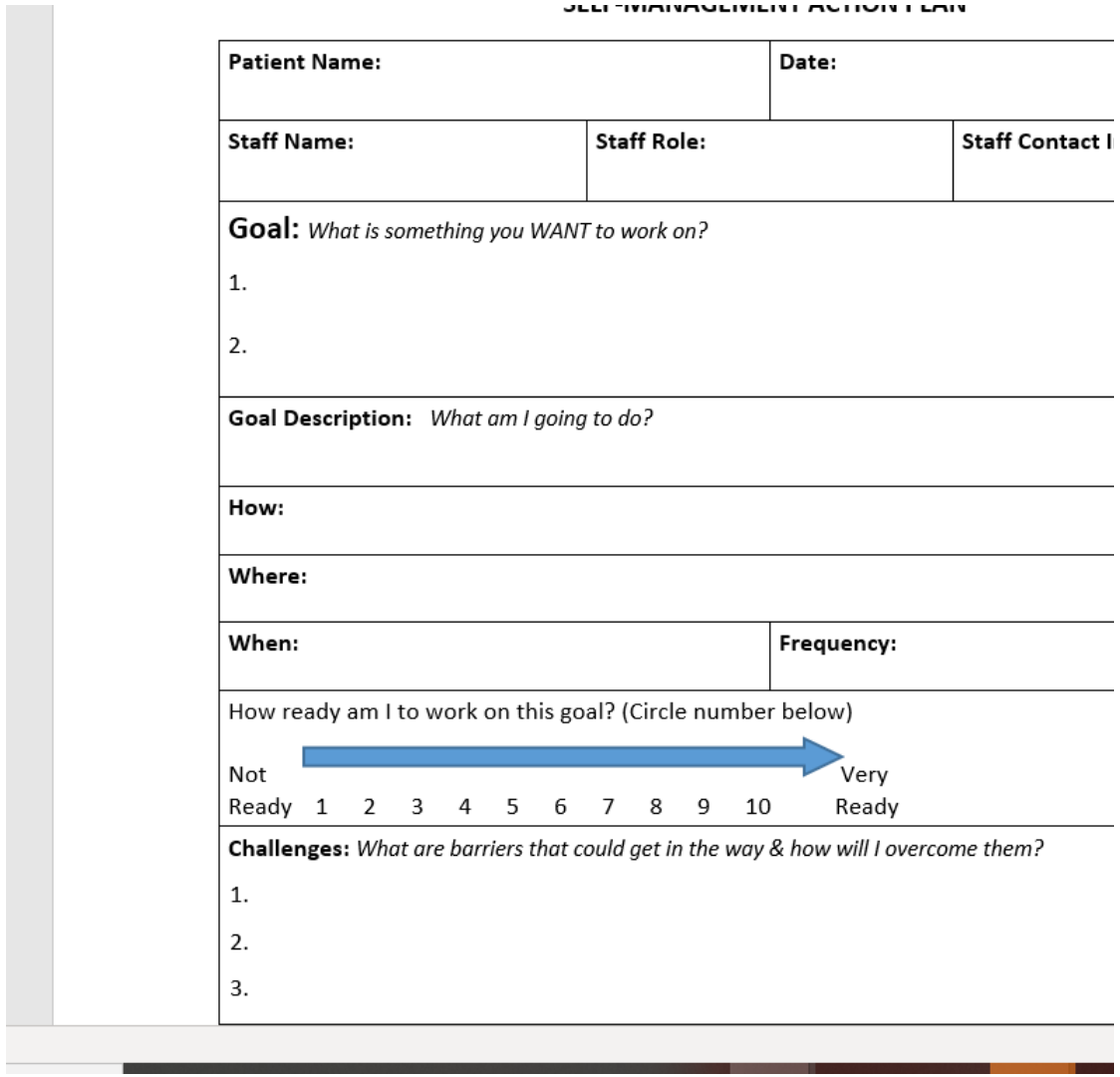
Give the patient a copy of the plan!

Creating the Self-management Action Plan

Jasmine agrees to CoCare. You have conducted the triage and comprehensive assessment and are now ready to involve Jasmine in creating a self-management action plan.

Breakout into groups of 2.

Activity Self-management Action Plan



SELF-MANAGEMENT ACTION PLAN

Patient Name:		**Date:**
Staff Name:	**Staff Role:**	**Staff Contact I**

Goal: *What is something you WANT to work on?*

1.

2.

Goal Description: *What am I going to do?*

How:

Where:

When:	**Frequency:**

How ready am I to work on this goal? (Circle number below)

Not Ready 1 2 3 4 5 6 7 8 9 10 Very Ready

Challenges: *What are barriers that could get in the way & how will I overcome them?*

1.

2.

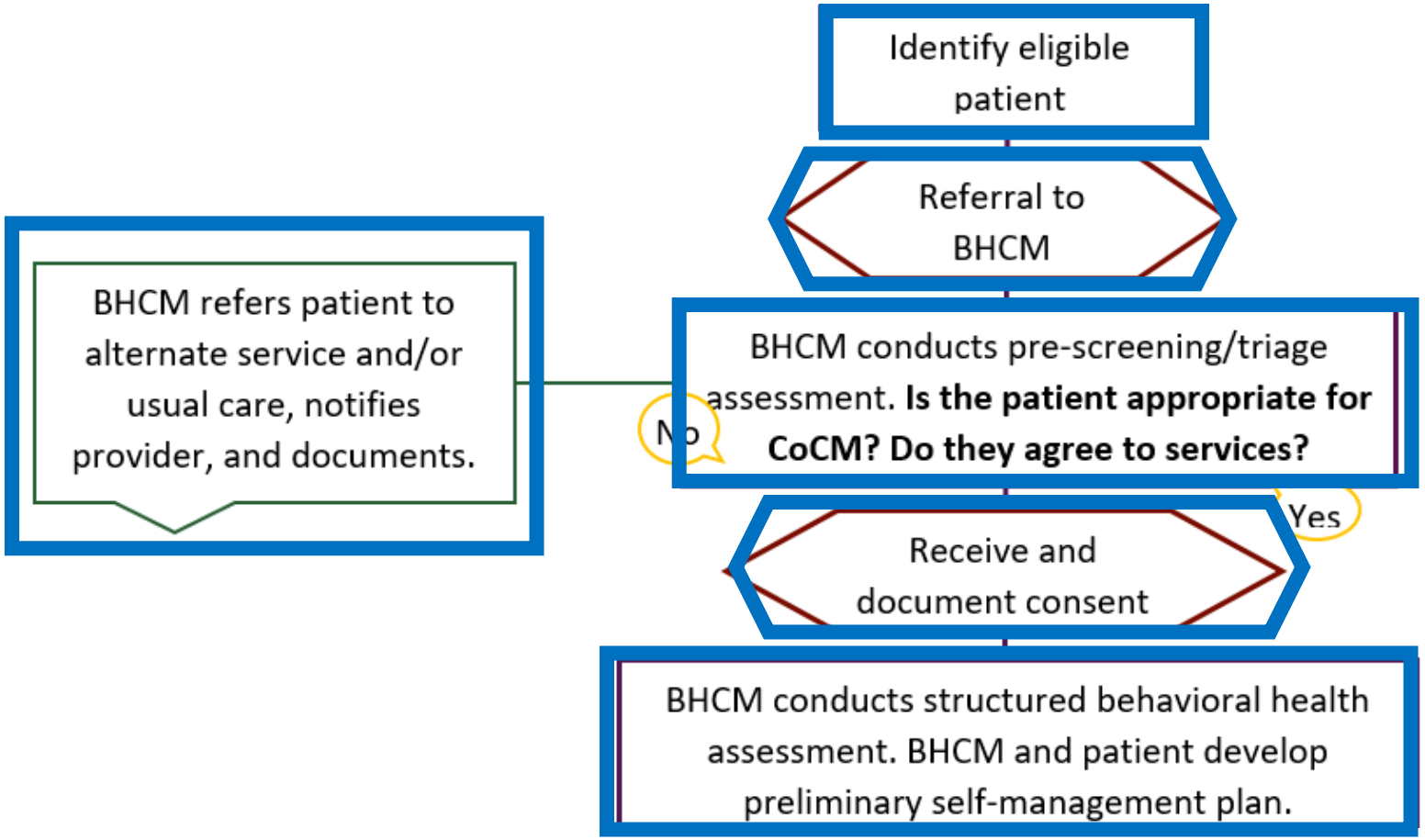
3.

See Patient Support/Educational Tool Kit page 22

"Real Play"
In groups of 2 take on the role of the patient and BHCM'er.

- Something you'd like to do to improve your health in the next 2 weeks
- SMART Goals
- Assess readiness
- Commitment Statement
- Follow up Plan

Overview



Key

BHCM: Behavioral Health Care Manager

PC: Psychiatric Consultant

PCP: Primary Care Provider

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Questions