Integrating MH/SA Treatment in Primary Care Firm Clinics:
The Behavioral Health Clinic

John D. Dingell VA Medical Center
VISN 11 - Detroit, MI
Objectives

Upon completion of this session, participants will be able to:

■ Describe the Behavioral Health Laboratory (BHL) program, core structure, and software

■ Define the BHL components/modules, and describe how this program was adapted in Detroit

■ Identify Detroit’s PC-MH Integration program (consult flow, utilization data, clinical practices), common challenges to implementation, and areas for growth
BHC Mission

- To deliver high quality depression and alcohol misuse treatment in Primary Care clinics.

- A variety of assessment, educational, and clinical services are offered both face-to-face and by telephone by a team comprised of:
  - a psychiatrist, psychologist, addiction therapist, two behavioral nurse specialists, and an administrative clerk.
Why did Detroit select the BHL model?

- It is recognized as a “best practice” for identification and early intervention of MH/SA symptoms in PC patients.

- consistent with the 2006 Institute of Medicine Report’s goal to improve the MH and Substance Abuse care in this country, and aligned with the Presidential New Freedom Commission Report’s key principles:
  - MH is a key component to overall physical health.
  - Early MH screening, assessment, and referral to services needs to be common practice.
  - Technology is used to access MH care.
  - Practice is research informed and evidence-based.
BHL Components to Successful Care

1. Identification
   - Outreach
   - Screening
2. Assessment and triage to appropriate level of service
3. A spectrum of services
   - Monitoring
   - Brief therapies
   - Pharmacotherapies
   - Psychotherapies
4. Follow-up and monitoring
5. Quality control and efficiency
BHL Modules/Components

- Core Assessment – comprehensive
- Depression Monitoring
  - 2, 6, 9 Weeks
  - Adherence, Depressive symptoms, Side effects
- Watchful Waiting
  - 8 weekly calls
- Alcohol Misuse Monitoring
  - Follow-up at 3 months
- BHL Clinical Treatment Options
  - Depression and anxiety disease management
  - Brief Alcohol Intervention
  - Referral Management
Watchful Waiting Module

- Limited evidence for pharmacotherapy or psychotherapy in subsyndromal or minor depression
- Efficiency and effectiveness of tx may be enhanced if symptoms are persistent or cause disability
- 8 Weeks of prospective monitoring by telephone using the PHQ-9
- Patient choice for treatment engagement is also allowed. Those with persistent symptoms or who choose are enrolled in depression disease management
Depression Monitoring

- A service designed to help PCP’s give evidence-based care to patients receiving new antidepressant prescriptions.

- Monitoring consists of 3 brief, structured assessments (after the Core Assessment) at 2, 6, and 9 weeks.

- Adherence, side-effects, and response to tx is assessed.
Alcohol Misuse Monitoring (3-month follow-up module)

- Follow-up at 3-months by a health tech to track the progress of complex patients who are unlikely to become or remain engaged in tx.

- The interview focuses on current alcohol use, depressive symptoms, motivation for treatment, and adherence.

- In the BHL, patients meeting criteria for alcohol dependence are enrolled in this module, though the criteria for enrollment can be tailored by site.
Depression and Anxiety Disease Management Module

- Modules are designed for the management of patients diagnosed with depressive or anxiety disorders who are actively enrolled in primary care.

- Treatment options are delivered by behavioral health specialists (nurses) who are trained to facilitate care and provide informal psychosocial therapy.
Alcohol Misuse Disease Management (Brief Alcohol Interventions Module)

- **Definition**
  - Targets excessive drinking in 1-3 brief sessions that are time-limited, workbook-based, structured, and founded in motivational interviewing.

- **Goals**
  - Facilitate treatment entry
  - Change in behavior
**Referral Management Module**

Problem: Low rates of MH/SA treatment engagement (30 - 40%)

<table>
<thead>
<tr>
<th>Motivational Session</th>
<th>Attended 1st Appointment</th>
<th>Control Group</th>
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<tr>
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<td>70%</td>
<td>32%</td>
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The Detroit VAMC Behavioral Health Clinic – Getting Started

- Practical considerations – physical space
  - BHC is both integrated and co-located with PC.
  - We currently have 5 offices located directly between the two primary care clinics (18-20 providers serving 29,000 veterans)

- Introductions and marketing to the PCPs

- Modifying the way services are delivered within the BHL software to meet the staffing constraints of the BHC.
BHC Clinical Process

Patient Identification
Screening / Clinical Assessment

BHC Initial Core Assessment

Treatment Options

Referral to MHC/CD Care

Monitor Response

Disease Manage as Appropriate

Watchful Waiting/Brief Interventions

No treatment / “False Positive” Screen

Patient Education and Promotion of Self-Care

Chart adapted from BHL materials dated 8/07
BHC Outcomes

- Access
- Screening
- Follow-up of positive clinical reminders
- Monitoring of newly initiated treatment
- Follow-up to missed appointments
- A decrease in consults to the Mental Health Clinic
How is Business?

Mental Health Clinic vs. Behavioral Health Clinic Consults

- MHC Consults (Total = 792)
- BHC Consults (Total = 849)
Where is the BHC going?

- Currently, positive PTSD screens generate a consult to the PTSD Clinic. Because 40% of veterans with PTSD have comorbid depression, it makes sense to evaluate for PTSD in the BHC.
  - The BHC will be expanding to include 2 additional nurses to manage f/u of positive PTSD screens.

- Efforts will be focused on improving program evaluation and gathering outcome data in the BHC.