Author's response to reviews

Title: Behavioral Health Providers' Perspectives of Delivering Behavioral Health Services in Primary Care: A Qualitative Analysis

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Author's response to reviews: see over
Dear Executive Editor,

Please find the attached revised manuscript entitled “Behavioral Health Providers' Perspectives of Delivering Behavioral Health Services in Primary Care: A Qualitative Analysis” submitted to you for publication as a Research Article in BMC Health Services Research.

We would like to express our appreciation to the reviewers for their kind comments and thoughtful critique of our manuscript. We have modified our paper to address several of their suggestions and feel that the manuscript has been strengthened accordingly. We edited our manuscript to address the RATS guidelines more accurately and clearly present our qualitative methods and findings. We additionally edited the text in total to improve clarity and readability. All revisions of the text have been made with track changes.

Below we have addressed the discretionary reviewer comments from Dr. Brawer:

1) There is not a reference in which the 4-major areas of PCMH are noted which included a) depression b) anxiety c) PTSD d) alcohol misuse. It may be beneficial to readers to know this is the mandated portion of the program.

   Response: We have added a line to the first paragraph of the introduction (p.3) specifying PC-MHI’s emphasis on these four disorders.

2) On page 5 while describing the “participants” it may be beneficial to describe how many pts were served, how many PCPs were involved or how many “clinics” were involved. May help the reader further comprehend the scope of the program.

   Response: We have added a line on page 6 noting that 15 primary care clinics were represented. Although we agree that additional information of this sort would be very useful, we are unable to indicate the number of PCPs or veterans served by the BHPs in 2008 as this information was not documented at the time of data collection. PCP staffing has changed considerably across sites making it difficult to generate accurate estimates retrospectively.

3) There is a reference/quotation to “supportive counseling” (p.9) which may not be fully aligned with PCMH reasoning.
Response: We agree that supportive counseling technically has a limited role within PC-MHI which heavily emphasizes the use of empirically supported treatments (or empirically supported treatments adapted to the primary care setting.) In this study, there are numerous instances in which BHPs did not necessarily show high levels of fidelity to PC-MHI principles (see Developing a Local Integrated Model). However, our emphasis in this analysis was on conceptualizing practices as they occurred at the time of data collection without evaluating these behaviors in relation to protocol adherence. Therefore, while this particular BHP self-reported engaging in supportive counseling frequently, we have chosen to include this quotation because it illustrates well the process of managing access to care.

4) There are a few references to “supporting the PCP”. This wording may detract from the concept of a total shared responsibility of the patient and a true team approach.

Response: We appreciate that subsequent to the time of data collection, there has been increased emphasis on shared responsibility across providers in newly formulated VA Patient Aligned Care Teams (PACT). However, we believe the notion of supporting the PCP remains an accurate depiction of the CCC model in place at the time of study. This particular phrasing is derived from the foundational model of CCC used in VISN 2 at the time (i.e., Strosahl et al, 1997).

5) Page 10 – I think it would be beneficial to detail some more of the difficulties with working with specialty mental health, as I think this is a major stumbling block.

Response: We agree that coordinating with SMH is critical and often perceived as a barrier to implementing CCC. We have elaborated to the best of our ability on this topic on page 10, noting that participants who saw referral and coordination with SMH as problematic tended to rely on workarounds rather than engaging in system-wide changes or advocacy for more PCMHI support. The response to referral barriers among BHPs we interviewed was relatively narrow (i.e., finding workarounds or providing interim care). We also wish to be cautious and not overstate issues regarding barriers to SMH given the many systemic and site-specific factors likely impacting access not explored in this study.

6) Assessing Care Trajectory: I actually believe this is the most important part of the study and could be emphasized more.

Response: We agree with the reviewer that Assessing a Care Trajectory is a novel finding of the study that has not been identified previously. We added to our discussion of this theme on page 18.

7) Recently there have been some discussions regarding MOU’s between service lines, and having an agreement in place to have pts return from SMH to PMCHI...Although this discussion was not present in 2008 it may be worth mentioning later in the article.

Response: We agree with these suggestions and have added a line on page 19 adding to our recommendation regarding treatment algorithms: “Furthermore, clearly articulated service agreements across CCC, primary care, and specialty mental health clinics could address a range of clinical issues that are especially challenging to BHPs, such as standardizing procedures for managing crisis interventions and transitioning patients to and from more intensive specialty mental health services.”
Thank you again for your further consideration of this manuscript. Please do not hesitate to contact me with any questions regarding this submission.

Sincerely,

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