AETC AIDS Education & Training Center Program Southeast

Innovative Solutions: Integrated Behavioral Health in HIV Primary Care

Disclosures

- Treatment team is funded in part by Ryan White Part C and Part D.
- Off-label or investigational medications may be discussed.
- Case presentations are based on real clinical scenarios with de-identified information.
- Treatment considerations and suggestions are based on specific clinical scenarios. All recommendations should be implemented with consideration of the patient's relevant history and clinical status.
- We are mental health professionals – we like to tell stories.

VCCC Behavioral Health

- Dr. David Steadman, MD
- Dr. Brent Necaise, MD
- Dr. Elizabeth Shultz, DO
- Dr. Katie White, MD, PhD
- Schuyler Matthew, CPRS
- Gail Beller, LPN
- Chris James, LCSW
- Allie Harvick, PMHNP-BC
- Scott Adams, PMHNP-BC

Integrated Behavioral Health at VCCC

- Clinic Nurse
  - LPN (full-time, Monday-Friday)
- Behavioral Health Consultant (BHC)
  - LCSW (two full-time positions, Monday-Friday)
  - 50/50 role division (psychotherapy and behavioral health consultation)
- Psychiatric Evaluation & Management
  - PMHNP (two full-time positions, Monday-Friday)
  - Resident clinic (one half-day, Wednesday PM)
- Substance Use Disorder Evaluation & Management
  - MD (one half-day, Tuesday AM)
  - Recovery Coach (one half-day, Tuesday AM, and telephone-based Peer Support Monday-Friday 8:00 AM – 4:00 PM.)

Case 1: Trust and Time

- GB is a 62-year-old Caucasian female who has received psychiatric services at VCCC since 2017 and carries historical diagnoses of Major Depressive Disorder (MDD) and Alcohol Use Disorder (AUD.) Client missed her last appointment with psychiatric provider and contacted clinic by phone stating “I need to speak with Scott. It’s an emergency.” Multiple attempts to return call by clinic staff were left unanswered including a MHAV message which remained unread.

Case 2: New HIV Diagnosis & Depression

- JJ is a 24-year-old AAM who was recently diagnosed with HIV at a PRIDE event. At the VCCC intake, JJ reports a prior psychiatric treatment history of depression with two SSRIs and one SNRI, but stopped all due to sexual side effects. During the initial medical appointment, JJ completes a PHQ-9 with a score of 15/27 with pertinent positives of depressed mood, anhedonia/amotivation, hypersomnia, anergia, and excessive guilt. Patient has experienced hopelessness intermittently but denied active SI. He is future and forward thinking. Denies substance use. He has disclosed his status to close family and friends and has positive social support. Insurance: Ryan White.
- BHC is asked to perform a brief assessment and facilitate a medication consult for PCP to implement.

Case 3: Cognitive Impairment

- RW is a 50-year-old Caucasian male with HIV/AIDS Dx 1964, nadir CD4 <200, ART: Biktarvy + Prezcobix with UD VL. PPH: Depression and anxiety currently treated with SSRI. PMH: DM, HLD, HTN, and peripheral neuropathy.
- CC: “I can’t seem to play the piano like I use to. I can read the music, but it’s like my hands and brain aren’t connecting.”

Case 4

- JP is a 42-year-old female who has been lost to HIV and psychiatric care for the past year. At her medical appointment, she reports being off ART and upon further discussion reports she has been drinking a pint of alcohol (vodka) near daily. She has tried AA but did not feel it was inclusive and affirming. She is motivated by her detectable VL to present to treatment but is worried about transportation and stigma.

Case 5

- JP is a 45-year-old CM who has been followed by VCCC psychiatry for Bipolar I Disorder. His ART regimen consists of Truvada 200/300 mg daily, Prezista 800 mg daily, and Norvir 100 mg daily. His previous psychiatric regimen included Citalopram (Celexa) 40 mg daily, Lamotrigine (Lamictal) 200 mg daily, and Quetiapine (Seroquel) 600 mg at bedtime. He had later been switched to Risperidone (Risperdal) 1 mg at bedtime. He had called VCCC Psychiatry on call 2 months later with c/o suicidal ideations and was instructed to go to the ER where he was taken by his mother. He was evaluated and admitted to an outside psychiatric hospital for 5 days with suicidal ideations and auditory hallucinations. He was discharged on the following psychotropic regimen: Venlafaxine XR (Effexor XR) 75 mg each AM, Lurasidone (Latuda) 60 mg each evening and Chlorpromazine (Thorazine) 25 mg at bedtime.

Live Q&A

- Allie Harvick, PMHNP-BC – alexandria.d.harvick@vumc.org
- Scott Adams, PMHNP-BC – rodney.s.adams@vumc.org
- Chris James, LCSW – christopher.a.james@vumc.org