



*A decade of bridging
the gap between research
and clinical care*

Communiqué

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Research, Education, and Clinical Center's Education Core*

“Improving access to mental health care for rural and other underserved veterans”

Mental Health Disaster Team Training II

John Tasse, PhD

Director, Health Psychology Clinic

Oklahoma City Veterans Affairs Medical Center

In preparation for the upcoming hurricane season, Mental Health Disaster Teams (MHDT) from all 10 VISN 16 medical centers met for training at the Wyndham Riverfront Hotel in North Little Rock, Arkansas May 20 – 21. This was the second VISN-wide training since the inception of the MHDTs following Hurricanes Katrina and Rita in the late summer 2005. Advanced nurse practitioners, chaplains, counselors, psychiatric nurses, psychiatrists, psychologists and social workers composed the four-person multidisciplinary teams from each medical center. The topics of the training ranged from lessons learned from the VISN 16 response to Hurricanes Katrina and Rita to preparing for future disaster mental health deployments.

Tuesday, May 21st was reserved for new members of the MHDTs. On that first morning the participants were introduced to the genesis behind the MHDT concept. Susan Moore, MSE, Craig Rookie, PhD and Don Deaton, MSSW, LCSW from the Little Rock VAMC described their personal stories of the initial mental health response to the devastation of Hurricane Katrina. In the early afternoon, John Tasse reviewed longitudinal data from the 1995 Oklahoma City federal building bombing to illuminate the long-term psychological impact of large, mass casualty disasters. Susan Moore then offered an essential presentation emphasizing the need for personal safety and awareness when deploying. The afternoon finished with Richard Smith, Area Emergency Manager from the Emergency Management Strategic Health Care Group, describing the newly published Federal Response Framework and the VA authority under which the VISN 16 MHDTs could be activated.

The second day of training was open to all members of VISN 16 MHDTs. Kathy Henderson, MD, VISN 16 MHPL manager, described the VISN 16 medical and mental health response immediately following Hurricane Katrina and the lessons learned. Rob Harrell from Little Rock, Kim Pearson from Fayetteville, and Steve Scruggs from Oklahoma City recounted their experiences responding in the aftermath of Hurricane Katrina. Karen Wyche, PhD, Professor of Psychiatry at the Oklahoma University Health Sciences Center reviewed her study of first responders at the Hurricane Katrina evacuee site at Camp Gruber, Oklahoma. Dr. Wyche also led the group in a discussion of cultural diversity and sensitivity when responding to the emotional needs of diverse populations. Susan Moore finished the morning with her presentation emphasizing the important need for self care while on disaster assignment. In the

afternoon, Richard Smith walked us through a table-top exercise incorporating VA policies and the federal response framework. The training concluded with a hands-on activity with the MHDT disaster response equipment cache. Leigh Bishop, MD, from Houston, explained the development of the equipment cache and led volunteers in the erection of a 12' x 9' tent. The VISN 16 MHDT members stand ready to respond to help our medical centers and the impacted communities when called.

We would like to thank the conference planners Dawn Clark, Susan Derivas, Kathy Henderson, Donna Lipin, Ruan Mitchell, Susan Moore and John Tassey.



Resources for Rural Researchers

New AHRQ funding opportunity/program announcement: Researching Implementation and Change While Improving Quality

See full details at <http://grants.nih.gov/grants/guide/pa-files/PAR-08-136.html>

Purpose: The Agency for Healthcare Research and Quality (AHRQ) announces the Agency's interest in supporting grants to rigorously study the implementation of quality improvement strategies and provide generalizable scientific findings about the implementation of the quality improvement strategy, related organizational changes, and their impact.

Funds Available and Anticipated Number of Awards: Because the nature and scope of the proposed research will vary from application to application, it is anticipated that the size and duration of each award will also vary. The total amount and number of awards will depend upon the quality, duration, and costs of applications received as determined by the peer review process, available funds, Agency research objectives and program priorities.

Budget and Project Period: The total costs (direct plus associated facilities and administrative costs) awarded under this FOA will not exceed \$300,000 annually for the entire project period. An application with a budget that exceeds \$300,000 total costs per year will be returned without review. The project period may be one to three years in duration. Funding beyond the first year will be contingent upon a review by Agency staff of the non-competing continuation report.

Key Dates

Opening Date: April 25, 2008 (Earliest date an application may be submitted to Grants.gov)

NOTE: On time submission requires that applications be successfully submitted to Grants.gov no later than 5:00 p.m. local time (of the applicant institution/organization).

Application Submission/Receipt Date(s): <http://grants.nih.gov/grants/funding/submissionschedule.htm>

Peer Review Date(s): Generally four months after receipt date

Earliest Anticipated Start Date(s): Generally three months after peer review date

Expiration Date: May 8, 2011

THE CONSUMER ADVISORY BOARD

Taking Initiative to Guide the Mission Transformation in the South Central MIRECC

LaKiesha Mitchell

This year's annual Mental Illness Research, Education, and Clinical Center (MIRECC) Retreat, held on April 16-18 at the Peabody Hotel in Little Rock, AR, marked the tenth anniversary of the South Central MIRECC—a decade for bridging the gap between research and clinical care. In addition, it was an opportunity for the Consumer Advisory Board (CAB) members and representatives to meet face-to-face to strategize on a recent call to action from Central Office to redirect the MIRECC's mission to focus more on rural issues.

While priorities as a board will always lie in addressing veteran, consumer, and family needs, the retreat's theme: "Caring for Rural and Underserved Veterans: Our New Mission" ignited a recommitment among board members present, to bolster its efforts as a rural network to focus more on access to care for rural and underserved veterans.

The board met as a separate entity on Wednesday evening, April 16, after participating in agenda discussions that helped to provide a more vivid perspective on their role as an intricate piece to the puzzle in solving the dilemmas in veteran care. This collaboration led to the board's establishing a focused mission transformation in the following areas for 2008: (1) form an alliance with community partners; (2) increase awareness by educating at the local, state, and federal levels; (3) and expand the definition of "soldier" to apply this concept to encompass the families, who are also impacted. In an effort to obtain these goals and effect change, the board has also realigned its membership infrastructure to include a spouse (male or female) with or without a child—in which case, a child of a veteran will also be recruited to help close the gap in understanding how these families are affected and what needs they require. Ideally, the board felt compelled to include a military service chaplain or representation from a Chaplain's Corp to link the board with the pillar of the community—the church or religious foundations, which play a large role in the community, the rural community in particular. Among this new membership design, the board agreed this it is critical to include an OIF/OEF veteran member from one of the ten active Consumer Advisory Councils (CACs) within the VISN to provide a direct perspective. Recruitment is currently in progress to identify and secure these classes of individuals among the board.

The Consumer Advisory Board feels confident in moving forward in this effort because of the diversity and experiences that its members have brought to perspective from real life issues that have existed among them as a group of collaborators; and strongly believes that the new order of membership will only add to the effectiveness of the CAB and it's ability to produce practical outcomes among the community of rural and underserved veterans and abroad. At present, the CAB will continue to meet quarterly via teleconference; conduct one annual face-to-face meeting during the retreat; and the Project Coordinator, Chair, Associate Directors for MIRECC, and the Manager for Mental Health Product Line (MHPL) will continue to meet frequently and collaborate to guide CAB business according to the board's consensus. CAB plans are also underway to host a network-wide CAC Video-Teleconference meeting in October, during Mental Health Awareness Week. Board member and Houston CAC member, Ray Wodynski, and Cristy Gamez-Galka, PhD are points of contact for this event.

Since the 2007 MIRECC Retreat, several newcomers have migrated into the fold of the CAB. They are the following individuals: Kelly Moak, MSW—Consumer Representative (Oklahoma City, OK); Lola West, LCSW—Social Work Group Leader for Community Based Outreach Clinics (CBOCs) & Mental Health Clinic at Little Rock Representative (North Little Rock, AR); Mark Worley, MD—Chief of Staff Representative (North Little Rock, AR); and LaKiesha Mitchell—Project Coordinator (North Little Rock, AR). During this past retreat, the board was privileged to have established members, Jesse Martin and Ed Schmidt agree to serve another two-year term; while, Estella Morris, LCSW, PhD agreed to Chair. It goes without saying that the CAB would cease to exist without the hard work and dedication of all of its board members, and their efforts are always greatly appreciated.

Meet the MIRECC Researchers: Teresa Hudson, PharmD

Interview with
Teresa Hudson, PharmD
 Research Health Scientist
 Co-PI VA Center for Mental Healthcare and Outcomes Research
 SCMIRECC Core Investigator
 Assistant Professor UAMS College of Medicine

What is your area of research?

Pharmacoepidemiology (the study of the utilization and effects of drugs in large numbers of people), schizophrenia and serious mental illness, rural/urban differences in care, and physical health effects of psychotropic medications.

What active studies do you have going?

I am PI on the following projects:

- 1) Rural/Urban Differences in Mental Health Service Utilization Among OEF/OIF veterans in VISN 16.
- 2) Cost-effectiveness of Antipsychotic Monitoring: this study uses data from the VISN 16 data warehouse to evaluate the costs associated with physical health monitoring of individuals receiving newer, 2nd generation antipsychotic medications such as olanzapine, risperidone etc.

I also work on Dr. Rick Owen's ASSIST project that compares strategies for implementation of physical health monitoring programs and Dr. John Fortney's OUTREACH project that uses telemedicine technology to provide evidence-based care for depression for individuals receiving care in Arkansas Community Health Centers.

In June, I submitted an IIR to VA HSR&D looking at use of opioid medications among OEF/OIF veterans nationwide to determine what factors predict chronic opioid use, possible opioid misuse and opioid abuse or dependence. Pain is one of the most common problems among OEF/OIF veterans. Depression and substance abuse disorders are risk factors for developing opioid misuse/abuse and these problems are common in OEF/OIF veterans. However, most studies were done in older populations that the OEF/OIF veterans so I am hopeful this will be funded.

What are the implications or potential benefits of your research?

I am especially excited about the project on Rural/Urban Differences. This project looks at OEF/OIF veterans who are eligible for care in VISN 16 and examines factors that influence likelihood of using VA services and of being screened for depression, PTSD, and alcohol use disorders. VISN 16 covers a large geographical area and roughly 40% of veterans in this VISN live in rural areas. If there are differences in service utilization among veterans living in rural areas compared with those in urban areas, it will provide information that can be used to develop strategies to reach out to veterans who are not using VA services.

How did you get started in this area of research?

My interest in rural/urban differences grew from previous interest in demographic differences that predict receipt of medications for mental health disorders and from statistics that indicate only about 37% of OEF/OIF veterans who are eligible for VA care actually use that care. In early 2008, the HSR&D published a call for small research proposals which was not long after the SCMIRECC began its new focus on services to rural veterans. This all seemed to come together and provide an opportunity to conduct some important analyses in this area.

What person or experience had the most influence on your research career?

Many people in CeMHOR and the UAMS Division of Health Services Research helped me develop a research career, but I probably would not have embarked on a research career at all without the mentoring of Dr. JoAnn Kirchner and Dr. Rick Owen. Dr. Rick Smith allowed me to join the UAMS CORE Scholars program which

introduced me to health services research, and I realized I wanted to work in this area full time, but was somewhat unclear about how to begin. I met JoAnn during the Scholars program and she was so approachable so I asked her advice. She introduced me to Dr. Rick Owen who had just received funding for his Schizophrenia Guidelines Project. Since then, Dr. Rick Owen has been my primary mentor. He hired me to work on his schizophrenia guidelines study in 1997 and has helped me “learn the ropes”. He has been very supportive and has helped me write manuscripts as well as grants. JoAnn has continued to be my “go to” mentor when I am utterly stumped and need a fresh perspective. Dr. Greer Sullivan and the various individuals in the SCMIRECC have also provided support and guidance. Recently, Dr. John Fortney has helped me branch out to a relatively new area of research in rural/urban differences in care and PTSD. I am very grateful to all my mentors but especially for Rick and JoAnn for helping me to get started. I am also grateful to Rick for his support for my involvement in the American society of Health-system Pharmacy (ASHP). This is a large, national organization with approximately 40,000 members who are pharmacists in hospitals and health-systems. I was elected as the chair of the

House of Delegates and a member of the board of directors. Rick has been very supportive of the time I need to spend to participate in ASHP.

What advice would you give to junior investigators and to people who are new to research?

Find a good mentor or mentors and a topic on which you are passionate. As I noted above, I have been fortunate enough to have many mentors over the last ten years. It would not be possible for me to work in research if I had not had their guidance. Research is a time consuming process that is filled with rejection...rejection of papers and grants...and much time is spent rewriting your work so it's important to be passionate about the topic you are researching. Since coming to the VA, I have found that working to improve the mental health and healthcare for veterans is a topic important to me and gives me the energy to spend necessary hours writing and rewriting grants and manuscripts.

How can people get in touch with you if they have questions about your work?

Teresa.hudson@va.gov

501-257-1716

Continuing the Transformation of VHA Mental Health Care Conference July 22- 24, 2008 Hyatt Regency Crystal City, Washington DC

We hope to see many of you at this year's national VA Mental Health conference. Mental health professionals, Vet Center counselors, mental health administrators, and readjustment counseling program officials can share information on the Mental Health Strategic Plan, the utilization of funding, research-informed practices, and best practices identified by clinicians in the field. The SCMIRECC and VISN 16 will be well represented as contributors to the conference.

The following people will make oral presentations at the conference:

Greer Sullivan, MD and Joe Constans, PhD: Impact of Hurricane Katrina on Gulf Coast Veterans with and without Preexisting Mental Illness.

Michael Kauth, PhD: Employing Performance Monitoring and Facilitation to Promote Consumer Councils and Recovery Plan Adoption in VISN 16

Richard Owen, MD: Comparison of Strategies to Improve Antipsychotic Monitoring and management for Schizophrenia

JoAnn Kirchner, MD, Kathy Henderson, MD, Lawrence Daily, LSSW, Kim Kalupa, PhD: Blended facilitation Model: Outcomes in Implementing the PCMH Initiative

Jay Otero, MD and John Fortney, PhD: Implementation of Telemedicine-Based Depression Care Management in Contract CBOCs

Continuing the Transformation of VHA Mental Health Care Conference
July 22- 24, 2008
Hyatt Regency Crystal City, Washington DC

The following people will make poster presentations at the conference:

- Roca, J. Vincent, PhD: A Community-Based Intervention for Returning Veterans and Their Families: VISN 16
- Gabriel Tan, PhD, ABPP; John Thornby, PhD; Quang Nguyen, PhD; Tam Dao, PhD: Heart Rate Variability (HRV) and Posttraumatic Stress Disorder (PTSD): VISN 16
- Andra L. Teten, Ph.D: Intimate Partner Abuse among Iraq, Afghanistan, and Vietnam Veterans with and without Posttraumatic Stress Disorder:
- Greer Sullivan, MD, MSPH; Mary Sue Farmer, MS; Dean Blevins, PhD: The Status of Veterans with Mental Illness and Substance Use Disorders Two Years after Hurricane Katrina: VISN 16



Recovery Corner

Improving the Quality of Care for Veterans with Serious Mental Illness

Cristina Gamez-Galka, PhD

Psychologist/Local Recovery Coordinator

Michael E. DeBakey VA Medical Center

The transformation of the VA mental healthcare system to one that is recovery-oriented provides an exciting opportunity to unite research, practice, and people. In this edition of the Recovery Corner, we will look at how evidence-based practice and evidence-based quality improvement can be brought together by the recovery philosophy to assist veterans whose quality of life and involvement in the community have been largely ignored in the quest for symptom reduction.

Evidence-based practice, an outgrowth of the Decade of the Brain, has offered individuals with a diagnosis of schizophrenia choices in their care. But has it, really? The answer is no, unfortunately. That is because evidence-based practices (EBPs) have not been readily available or used. On one hand, the call for implementation of evidence-based practice and recovery-oriented care has a great deal of support from the President's New Freedom Commission (2003) through the Uniform Services Package (2008). On the other hand, it can be a daunting task to determine how to bring together the science and the practice. As Frese, Stanley, Kress, & Vogel-Scibilia (2001) pointed out there is a way to blend "the scientific, objective, evidence-based approach" with the focus on the "phenomenological, subjective experiences" that are important in recovery. They suggest that individuals experiencing a mental health concern "appear to desire more control and influence but also seem to realize that they need more and better treatment" (p. 1468). The promotion and support for the adoption of EBPs has been felt throughout the VA system, but process problems can impair the involvement of veterans in these services. What can we do?

Evidence-based quality improvement like evidence-based medicine is the "explicit use of the best available evidence to inform decisions about the care of individual patients" (Shojania & Grimshaw, 2005.) The Enhancing Quality of care In Psychosis (EQUIP) study provided a look at the multiple quality gaps which exist and interventions to target these areas. They found quality varied by treatment (family services versus weight management), clinician competencies, and difficulty in changing psychiatric treatments (Brown, Cohen, Chinman, Kessler, & Young, 2008). Hence, the recommendation was that "improving care required creating resources to support clinicians and reorganizing care to help them easily implement changes in their clinical practices". How do we do that?

EQUIP-2 has taken the findings from the earlier study and paired these with planning and change models to guide how to close the quality gaps in care for those experiencing symptoms of schizophrenia. Brown et al. (2008) summarized the six areas that can be targeted to help close the gaps in quality by maximizing implementation efforts. Implementation should . . .

- ▶ Be based on assessments of needs, barriers, and incentives of veterans
- ▶ Be based on an understanding of the local setting
- ▶ Involve diverse stakeholders in planning process
- ▶ Involve experts in planning
- ▶ Employ marketing ideas to develop and disseminate intervention
- ▶ Secure leadership and product champion support and involvement

But what does that mean for my site? *It's all about the people.*

Quality Improvement and its cousin Performance Improvement have been around for some time, but now with the scientific evidence we can bring together the people to determine the problem, generate the solutions, implement and monitor effectiveness, and lastly, plan how to sustain the change or modify the process to produce the desired change. This is where recovery ideology comes in. Recovery is an approach fostering collaboration, individualized care, responsibility, and hope. You might have already noticed the parallels with maximizing implementation efforts. Recovery encourages providers to ask about the desires and goals of the veterans with whom they interact, so both can partner to facilitate the veteran's journey toward living his or her desired life in a chosen community. But wait - we have been talking about research and quality. Pairing the best interventions based on the research evidence with the goals and desires of individual veterans is something every provider can do. Yet, there are process barriers which hinder bringing the right people together with the right evidence-based practice. So, what do we do?

One option is to take the findings from EQUIP and form teams whose focus is on improving the quality of care for those with schizophrenia. Now you might say, "We already do performance improvement, isn't that enough?" I don't know, is it at your site? To answer this question, examine what veterans, staff, and other stakeholders say about the need for change in mental health. The evidence we have to date points to the idea that the voice of veterans and their family members has to be brought together in a collaborative manner with providers to determine the areas in need of change or improvement. Recovery's support for evidence-based practices and evidence-based quality improvement can help us improve the care for those with serious mental illness.

Partner with your Local Recovery Coordinator to determine how your site can best use the evidence to approach improving mental health care for those individuals with serious mental illness. For more information regarding evidence-based quality improvement contact the author at Cristina.Gamez-Galka@va.gov or Alison Hamilton, lead author of the first article in the reference section, at alisonh@ucla.edu.

References

Brown, A., Cohen, A., Chinman, M.J., Kessler, C., & Young, A. (2008). EQUIP: Implementing chronic care principles and applying formative evaluation methods to improve care for schizophrenia: QUERI Series. *Implementation Science*, 3:9.

Frese F., Stanley J., Kress K., & Vogel-Scibilia S. (2001, Nov). Integrating Evidence-Based Practices and the Recovery Model. *Psychiatric Services*, 52, 1462-1468.

President's New Freedom Commission on Mental Health (2003). www.mentalhealthcommission.gov

Shojania, K. & Grimshaw, J. (2005). Evidence-based Quality Improvement: The state of the science. *Health Affairs*, 24(1), 138-150.



July Conference Calls
1-800-767-1750

- 8—MIRECC Leadership Council, 3:30 PM CT, access code 19356#
- 15—VISN 16 Mental Disaster Team, 11AM CT, access code 76670#
- 16—MIRECC Program Assistants,
- 22—MIRECC Leadership Council, *cancelled*
- 24—National MIRECC & COE Education Recovery Interest Group, *cancelled for July*
- 24—National MIRECC & COE Education Implementation Science Group, *cancelled for July*
- 28—MIRECC Education Core, 3:00 PM CT, access code 28791#

The next issue of the *South Central MIRECC Communiqué* will be published August 4, 2008. Deadline for submission of items to the August newsletter is July 25. Urgent items may be submitted for publication in the *Communiqué Newsflash* at any time. Email items to the Editor, Mary Sue Farmer, at Mary.Farmer2@va.gov

South Central MIRECC Internet site: www.va.gov/scmirecc

National MIRECC Internet site: www.mirecc.va.gov