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The next issue of the *South Central MIRECC Communiqué* will be published July 5, 2011. Deadline for submission of items to the June newsletter is June 27, 2011. Urgent items may be submitted for publication in the *Communiqué Newsflash* at any time. Email items to the Editor, Ashley McDaniel, at [Ashley.McDaniel@va.gov](mailto:Ashley.McDaniel@va.gov)

South Central MIRECC Internet site: [www.mirecc.va.gov/visn16](http://www.mirecc.va.gov/visn16)

National MIRECC Internet site: [www.mirecc.va.gov](http://www.mirecc.va.gov)

## IMPROVING ACCESS TO VA CARE: REFLECTIONS ON THE VA HSR&D STATE OF THE ART CONFERENCE

By John Fortney, Ph.D.

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HSR&D Center for Mental Healthcare and Outcomes Research  
Director, Division of Health Services Research,  
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In the fall of 2010, the VA's Health Services Research and Development Service (HSR&D) held a State-of-the-Art Conference (SOTA) on the topic of "Improving Access to VA Care." HSR&D has hosted eight previous SOTA conferences that focused on such topics as Traumatic Brain Injury, Managing Complexity in Chronic Care, Long-term Care and Organizational Transformation (<http://www.hsr.d.research.va.gov/meetings/sota/>).

The objective of the 2010 SOTA was to identify what we know and what we need to know about the relationship of access to individual patient needs and characteristics, community networks and characteristics, healthcare services utilization (VA and non-VA), and patient outcomes.

I co-chaired the 2010 SOTA conference along with Peter Kaboli, M.D., M.S., from the Veterans Rural



Pictured: John Fortney, PhD

Health Resource Center, Central Region and the HSR&D Center for Comprehensive Access and Delivery Research and Evaluation. The SOTA was facilitated by Geraldine McGlynn, M.Ed. and her staff from the HSR&D Center for Information Dissemination and Education Resources.

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## *VA HSR&D State of the Art Conference continued...*

Prior to the SOTA conference, a planning committee was assembled in Washington, D.C. and included both VA and non-VA experts in access to healthcare, including such disciplines as telehealth, women's health, disparities, health services research, clinical leadership, and VA operations. The planning committee identified issues for special focus at the SOTA and developed five topics that would be addressed by invited experts in workgroups at the SOTA conference. The five workgroup topics were:

1. Defining Access and Constructs
2. Identifying Access Issues for Special Populations
3. Impact of Access on Utilization, Quality, Outcomes, and Satisfaction
4. Impact of Policy and Organization of Care on Access
5. Adoption and Implementation of IT

Additionally, the planning committee created a list of stakeholders to invite to the SOTA conference. An effort was made to include representatives from all appropriate offices and expertise. As a result, an interdisciplinary group of 75 experts was invited. South Central MIRECC invitees included John Crilly, Ph.D., M.P.H., M.S.W., Maurilio Garcia-Maldonado, M.D., M.M.M., FACHE and Greer Sullivan, M.D., MSPH. The former Chief Medical Officer of VISN 16, Mark Enderle, M.D. (now Senior Medical Officer of the VA Office of Quality and Performance) was also in attendance. The planning committee also commissioned several white papers from VA and non-VA investigators on specific access issues relevant to VA for distribution prior to the SOTA conference.

Seth Eisen, M.D., M.Sc. (HSR&D Director) opened the conference with a welcome to attendees, followed by introductory remarks by Robert Jesse, M.D., Ph.D., the Principal Deputy Under Secretary for Health. The keynote speech was delivered by Joseph C. Kvedar, M.D., the Founder and Director of the Center for Connected Health (<http://www.connected-health.org/>). Dr. Kvedar talked about the work at the Center for Connected Health, where they are developing innovative strategies to move care from the doctor's office into the

day-to-day lives of patients. Dr. Kvedar described how information technologies, including cell phones, computers, networked devices and simple remote health monitoring tools, are being leveraged to help providers and patients manage chronic conditions, maintain health and wellness and improve adherence, engagement and clinical outcomes.

In the afternoon, the experts broke into the five workgroups and were given two primary aims: 1) develop recommendations for policy that would assist VA and the larger healthcare community to improve access, and 2) outline a research agenda to address knowledge gaps in access to quality care. The groups then summarized the findings from their group discussions to present to the entire SOTA conference on the second day. The recommendations were discussed by a panel of VA leaders including: Joel Kupersmith, M.D. (Office of Research and Development), Adam Darkins, M.D., MPH (Office of Telehealth Services), Mark Enderle, M.D., and David Atkins, M.D., M.P.H. (HSR&D QUERI Director).

After the conference, the recommendations from each group were coalesced into three Policy Recommendation categories (Measurement, Improving Access, and VA/Non-VA Partnering and Contracting) and five Research Recommendation categories (Define Access and Constructs; Identify Access Issues across VA and for Special Populations; Impact of Access on Utilization, Quality, Outcomes, and Satisfaction; Impact of Policy and Organization of Care on Access; Analysis and Implementation of Information Technology) by the SOTA chairs with input from the facilitators of each of the five workgroups. The objective of the Policy and Research Recommendations was to distill the findings of the expert panel convened at the SOTA into recommendations for VA leadership. Those recommendations are currently under review by VA leadership.

Additionally, a supplement to the *Journal of General Internal Medicine* was developed from commissioned papers that synthesize the current state of access to healthcare, as well as other original research and review articles related to access. This special supplement on access to care is scheduled to be published in the Fall of 2011. ■

## Recent SC MIRECC Publications

### **A CASE STUDY OF EARLY EXPERIENCE WITH IMPLEMENTATION OF COLLABORATIVE CARE IN THE VETERANS HEALTH ADMINISTRATION**

Tai-Seale M, **Kunik ME**, Shepherd A, **Kirchner J**, **Gottumukkala A**

*Popul Health Manag.* 2010;13(6):331-7

Primary care remains critically important for those who suffer from mental disorders. Although collaborative care, which integrates mental health services into primary care, has been shown to be more effective than usual care, its implementation has been slow and the experience of providers and patients with collaborative care is less well known. The objective of this case study was to examine the effects of collaborative care on patient and primary care provider (PCP) experiences and communication during clinical encounters. Participating physicians completed a self-administered visit reconstruction questionnaire in which they logged details of patient visits and described their perceptions of the visits and the influence of collaborative care. Audio recordings of visits were analyzed to assess the extent of discussion about co-located mental health services and visit time devoted to mental health topics.

The main outcome measures were the extent of discussion and recommendation for collaborative care during clinical visits and providers' experiences based on their responses to the visit reconstruction questionnaire. Providers surveyed expressed enthusiasm about collaborative care and cited the time constraint of office visits and lack of specialty support as the main reasons for limiting their discussion of mental health topics with patients. Despite the availability of mental health providers at the same clinic, PCPs missed many opportunities to address mental health issues with their patients. Ongoing education for PCPs regarding how to conduct a "warm handoff" to co-located providers will

need to be an integral part of the implementation of collaborative care.

### **UNRECOGNIZED PHYSICAL ILLNESS PROMPTING PSYCHIATRIC ADMISSION**

**Reeves RR, Parker JD**, Loveless P, **Burke RS**, Hart RH

*Ann Clin Psychiatry.* 2010;22(3):180-5.

The objective of this study was to assess the factors that might contribute to clinicians erroneously attributing medically-based changes in a patient's mental status to psychiatric illness. We reviewed the records of 1340 patients admitted to a VA hospital psychiatric unit and 613 to a public hospital psychiatric unit from 2001 to 2007. Cases admitted because of an unrecognized medical disorder underwent further analysis of the preadmission assessment and documented history of mental illness.

Of 1340 patients whose records were reviewed, 55 (2.8%) had a medical disorder that caused their symptoms. Compared with patients admitted to medical units, patients inappropriately admitted to psychiatric units had lower rates of completion of medical histories, physical examinations, cognitive assessments, indicated laboratory and/or radiologic studies, and treatment of abnormal vital signs ( $P < .001$  in each case). Among patients admitted to psychiatric units, 85.5% had a history of mental illness vs. 30.9% of comparable admissions to medical units ( $\text{Chi}^2(1) = 35.85$ ;  $P < .001$ ).

Our study found that key assessment procedures are less likely to be performed in patients with mental status changes who are admitted to psychiatric units than in comparable patients admitted to medical units. Symptoms of patients with a history of mental illness are more likely to be attributed to psychiatric illness than are those of patients without such a history. ■

## SC MIRECC CLINICAL EDUCATOR PRODUCT UPDATE

### SECOND EDITION OF OPERATION ENDURING FAMILIES IS NOW AVAILABLE

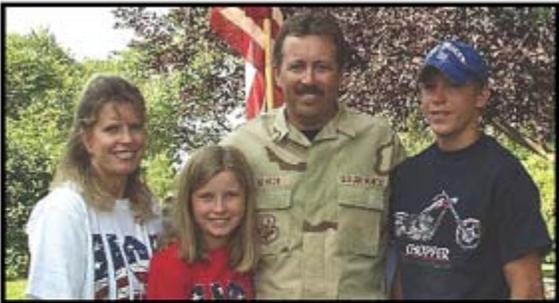
Michelle Sherman, Ph.D., Ursula Bowling Psy.D., Alan “Dutch” Doerman, Psy.D., ABPP

The Oklahoma City VAMC’s Family Mental Health Program (Drs. Ursula Bowling, Dutch Doerman, and Michelle Sherman) has recently updated their family education curriculum, Operation Enduring Families. This is a 5-session program for OEF/OIF/OND Veterans and/or family members, addressing issues of Family Relationships; Communication & Intimacy; Anger; Post-Traumatic Stress Disorder; and Depression.

Because the original curriculum was written in 2006, substantial updates have been made, and an optional 6th module has been added focusing on Traumatic Brain Injury. The University of Oklahoma Health Sciences Center Information Technology Department kindly continues to host the website for our curriculum at [www.ouhsc.edu/oef](http://www.ouhsc.edu/oef).

The Oklahoma City Family Team is also honored that Operation Enduring Families was selected as a “model program” by the VA/Department of Defense Integrated Mental Health Strategy. The curriculum will be distributed in both the VA and DoD as an approved and supported family education program. The VA/DoD Integrated Mental Health Strategy is a joint effort to engage and include families across the DoD/VA continuum of care. ■

**Operation Enduring Families**  
Information and Support for Iraq & Afghanistan Veterans and Their Families



A 5-session family education and support program for service members and veterans who have recently returned from a combat theater and their family members

Ursula Bowling, Psy.D.  
Alan Doerman, Psy.D., ABPP  
Michelle Sherman, Ph.D.

**Second Edition, May 2011**

Based on the SAFE Program Manual by Michalis D. Sherman, Ph.D.



Caring for...AMERICA'S HEROES  
www.ouhsc.edu/oef

## RURAL HEALTH RESOURCES UPDATE

### Informing Rural Primary Care Workforce Policy: What Does the Evidence Tell Us? A Review of Rural Health Research Center Literature, 2000-2010

This literature review profiles 51 publications constituting the body of evidence-based research produced by the federally-funded Rural Health Research Centers from 2000 to 2010 that are relevant to the rural primary care workforce. The review sub-divides this body of literature according to subject:

- Supply & Demand
- Recruitment & Retention
- Training Pipeline & Education
- Lifestyle & Compensation
- Nurse Practitioners, Physician Assistants, & International Medical Graduates
- New Directions for Primary Care

For more information, contact: Alex McEllistrem-Evenson, MA, Rural Health Research Gateway, Phone: 701-777-6026, [alex.evenson@med.und.edu](mailto:alex.evenson@med.und.edu). For download a copy of the review, visit: [http://www.ruralhealthresearch.org/pdf/primary\\_care\\_lit\\_review.pdf](http://www.ruralhealthresearch.org/pdf/primary_care_lit_review.pdf). ■

## Recovery Corner

### OUTREACH AND RE- ENGAGEMENT OF VETERANS WITH SERIOUS MENTAL ILLNESS

Michael Roach, M.S.W., LCSW, BACS

Local Recovery Coordinator  
Alexandria VA Medical Center

Veterans with a diagnosis of schizophrenia who have not accessed care in a year to two years are at higher risk of death (Quality, 2010). This is especially important when the Veteran lacks the capacity to provide for his or her own care or to work with a provider concerning mental health or medical issues. Veterans diagnosed with bipolar disorder are particularly vulnerable when they are not connected with medical or mental health care.

A quality improvement project by the VHA Office of the Medical Inspector showed that re-engaging Veterans with serious mental illness in treatment can significantly impact their mortality rate (Quality, 2010). Additionally, outreach gives Veterans an opportunity to connect with recovery-oriented programs that may not have been available in the past.

The VHA Office of Mental Health Services and the VHA Serious Mental Illness Treatment Resources and Evaluation Centers have developed a project that addresses outreach to and re-engagement of Veterans with serious mental illness. The project focuses on reaching out to Veterans diagnosed with schizophrenia or bipolar disorder who previously accessed mental health care at the VA but have been lost to follow-up care over the past 12 to 24 months.

Currently, there are seven sites involved in this project. The Local Recovery Coordinators at each site are leading the charge to locate these Veterans and attempt to re-engage them in treatment. These Veterans are identified by the Serious Mental Illness Treatment Resources and Evaluation Center and the names are provided to each facility. Though the numbers are relatively low (Alexandria, LA = 32; Ann Arbor, MI = 27; Augusta, GA = 18; Durham, NC = 26; Mountain Home, TN = 24; Oklahoma City, OK = 35; Temple, TX = 38), the impact on these Veterans is undeniably significant. These outreach efforts include determining if the Veteran is in need of medical, mental health, or psychosocial services available in primary care clinics, substance abuse clinics, and dental clinics; or homeless

services and community resources. The contact for these Veterans is made by telephone or face-to-face and the Local Recovery Coordinator facilitates appointments as needed, which are scheduled within five working days of the request (requests for later appointment dates are also accommodated). This effort requires cooperation from all departments of the medical center including mental health, primary care and specialty clinics.

The benefits of this program include reduced utilization of emergency services, reduced incarceration rates in homeless Veterans, and reduced premature mortality exacerbated by untreated medical and mental health morbidity. Also, it affords the facility the opportunity to promote recovery- oriented, Veteran-centered care and potentially connect homeless Veterans with the care they need and thus impact the VA's goal of eliminating homelessness among Veterans.

This outreach project is an ongoing effort. All VA Medical Centers will receive names periodically from the Serious Mental Illness Treatment Resources and Evaluation Center. The Local Recovery Coordinators will continue to coordinate the outreach and re-engagement efforts. Future plans include expanding the outreach to those diagnosed with PTSD and depression.

This program requires a coordinated effort with all departments in the medical center including administration, clinical staff, and support staff. There are challenges related to locating these Veterans and each facility will develop creative ways to overcome these. Facilities will also be responsible for developing ways to accommodate the needs of these Veterans. Timely appointments, compassionate care, and flexible scheduling will be the key to successfully integrating these Veterans back into VA care.

#### References

1. Quality Improvement Assessment: Outreach Service to Schizophrenic and Bipolar Patients Lost to Follow-up Care (2010-D-252), December 7, 2010.
2. VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics, September 11, 2008. ■

## MENTAL HEALTH RESOURCES UPDATE

### Children of Military Service Members Resource Guide

The Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE) is committed to building resilience, maximizing recovery and promoting reintegration for our nation's warriors and their families in all areas related to psychological health and traumatic brain injury. As part of that vision, DCoE recognizes that children of military service members may demonstrate mental and emotional health needs associated with their parents' deployment, rehabilitation or reintegration. DCoE is pleased to provide the Children of Military Service Members Resource Guide to assist parents, other family members and health care providers in addressing the mental and emotional health needs of military children through topic-specific, age-related, public-domain literature.

The resources listed in the guide, compiled from DCoE's internet-based literature review and scan of public domain materials, include books, films, websites and social media and support groups.

To download a copy of the guide, visit

<http://www.dcoe.health.mil/Content/Navigation/Documents/DCoE%20Children%20of%20Military%20Service%20Members%20Resource%20Guide.pdf>. ■

