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The next issue of the *South Central MIRECC Communiqué* will be published May 3, 2010. Deadline for submission of items to the April newsletter is April 26, 2010. 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](mailto:Mary.Farmer2@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)

## SAVING LIVES:

### DIANNE TURNEY TACKLES SUICIDE PREVENTION IN VISN 16

Interviewed by Ashley McDaniel

*Share a little about your role here in VISN 16.*

I feel very fortunate to be part of the VISN 16 Mental Health Product Line (MHPL) team. Our network was one of the first in the nation to recognize a need to have a VISN-level Suicide Prevention Coordinator. The majority of my 23-year VA nursing career has been within the mental health arena, which has provided me with numerous experiences that laid the foundation for my work in this position. As the Network Suicide Prevention Coordinator, I provide coordination and oversight of VISN-wide suicide prevention programs. I am excited to have an opportunity to provide consultation to the many wonderful Suicide Prevention Coordinators in our network. They are a very dedicated group of individuals working hard to increase awareness about suicide and suicide prevention. We work together to identify trends and opportunities for improvement for all the suicide prevention programs in the network. By providing facility-level program assessments and recommendations, I help to ensure success for the operations of the VISN Suicide Prevention Program. I find this position to be rewarding and challenging as we implement VISN guidelines related to suicide

prevention. In collaboration with facility Suicide Prevention Coordinators, the MHPL Advisory Council and VISN leadership, I hope to have VISN guidelines for completing a suicide risk assessment in place by late June 2010.

*What strategies will be implemented in 2010 to prevent suicide?*

Increasing suicide and suicide prevention awareness will continue to be a priority in 2010. Several memoranda have been published to assist providers in the recognition of suicide risk among the Veteran population. For example, recent memoranda provided additional guidance to clinicians regarding the suicide risk among VHA patients with a diagnosis of traumatic brain injury and chronic pain. The Suicide Prevention Coordinators are increasing the number of outreach activities they provide from 2-3 a month to 5 a month.

These outreach efforts increase our ability to get help to Veterans in need and play a critical role in the public awareness of suicide prevention strategies.

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## *Saving Lives continued...*

We are making great strides in safety planning. A safety plan is a prioritized list of coping strategies and resources a Veteran can use during a suicidal crisis. It is a collaborative effort between the provider and the Veteran and is written in the Veteran's own words. A safety plan can immediately enhance Veterans' sense of control over a suicidal crisis and convey a feeling that they can "survive" the crisis. It provides organization to the Veteran during a time of disorganization.

You will see expanded suicide prevention efforts within our Community Based Outreach Clinics (CBOCs). The SC MIRECC conducted a needs assessment of VISN 16 CBOCs, and suicide risk reduction was listed as one of the top five education priorities for CBOC clinicians this year. It is our goal to develop a strategic plan during the VISN Suicide Prevention Training Conference in April to meet the needs of these providers.

I hope everyone has heard about the Family Firearm Safety Program. Project ChildSafe is the nation's largest and most comprehensive firearm safety education program. Project ChildSafe reminds gun owners to: properly store firearms in the home, practice safe firearm storage options in the home, and to make certain that firearms in the home are not casually accessible to anyone, especially a child. Project ChildSafe makes these recommendations possible by providing safety kits that include a cable-style gun-locking device, lock installation instructions, and a safety booklet. The Under Secretary for Health endorsed Project ChildSafe and has required that the project be implemented in each VA Medical Center. This is a great program for all our Veterans, especially those with children. It is an excellent child safety program and serves as a suicide prevention effort.

To learn more about any of these suicide prevention strategies, please contact your local Suicide Prevention Coordinator or me.

### *The VA also has suicide prevention performance measures. What are they?*

The Outpatient Screen Positive with Timely Suicide Risk/Behavioral Evaluation (C1a3) performance measure looks at Veterans who have had a positive depression or PTSD screen. Veterans who screen positive should be interviewed to determine the presence of risk factors indicating a need for urgent intervention. After an

evaluation and discussion with the Veteran, the provider can decide if the Veteran may benefit from urgent intervention and/or specialized mental health evaluations.

The Health Systems Indicator (HSI9q) monitors documentation of timely disposition following a positive score on the PHQ-2, PHQ-9, or an affirmative response to question 9 on the PHQ-9 for depression.

There is also a monitor that looks at the follow up care provided to high-risk Veterans post-discharge. Veterans who have been identified as a high risk for suicide should have weekly follow-up (phone calls) for 30 days after discharge.

### *How can SC MIRECC stakeholders aid in the VISN's suicide prevention efforts?*

One of the first suicide prevention campaigns in the VA, "Suicide Prevention is Everybody's Business," emphasized that not only is it crucial that we remember suicide prevention is everybody's business, but that when it comes to suicide prevention we should remember everyone. Operation SAVE training helps you act with care and compassion when encountering a person who is suicidal. The acronym SAVE summarizes the steps needed to play a major role in suicide prevention: **S**igns of suicidal thinking, **A**sk questions, **V**alidate the person's experience, **E**ncourage treatment and expedite getting help. SC MIRECC stakeholders can aid our suicide prevention efforts by sharing the principles of Operation Save with their family, friends, and neighbors. Remember your coworkers, recognize the warning signs and ask the questions. Get to know your suicide prevention team; they are a wonderful resource for learning more about safety plans, suicide risk assessments, identifying Veterans at high risk for suicide, and other suicide prevention efforts. Be proactive and attend suicide prevention trainings. If you need a specific training such as safety planning and it is not being offered, ask your suicide prevention team for assistance. It is important to remember that together we can make a difference.

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

The easiest way to contact me is by sending an email to [virginia.turney@va.gov](mailto:virginia.turney@va.gov) or by calling the Mental Health Product Line office at 501-257-1722.

## RECENT SC MIRECC PUBLICATIONS

### STEPS FOR IMPLEMENTING COLLABORATIVE CARE PROGRAMS FOR DEPRESSION

**Fortney JC, Pyne JM, Smith JL, Curran GM, Otero JM, Enderle MA, McDougall S.**

*Popul Health Manag, 2009;12:69-79*

Numerous studies have demonstrated that collaborative care (care management) for depression improves outcomes, yet few clinics have implemented this evidence-based practice. To promote adoption of this best practice, our objective was to describe the steps needed to tailor collaborative care models for local needs, resources, and priorities while maintaining fidelity to the evidence base.

Based on lessons learned from two multi-site VA implementation studies conducted in two different clinical, organizational, and geographic contexts, we describe in detail the steps needed to adapt an evidence-based collaborative care program for depression for local context while maintaining high fidelity to the research evidence. These steps represent a detailed checklist of decisions and action items that can be used as a tool to plan the implementation of a collaborative care model for depression. We also identify other tools (e.g., decision support systems, suicide risk assessment) and resources (e.g., training materials) that will support implementation efforts. These implementation tools should help clinicians and administrators

develop informed strategies for rolling out collaborative care models for depression.

### PHYSICAL ACTIVITY AND SUBCLINICAL MRI CEREBRAL INFARCTS: THE ARIC STUDY

**Dubbert PM, Penman AD, Evenson KR, Reeves RR, Mosley TH Jr.**

*J Neurol Sci, 2009;284(1-2):135-9.*

We hypothesized that physical activity (PA), which is often associated with reduced risk of ischemic stroke, may also be associated with reduced risk of subclinical cerebral infarcts. We studied the cross-sectional association between PA and subclinical cerebral infarcts among African Americans in the Atherosclerosis Risk in Communities (ARIC) Study. PA self-reported at baseline and images from cerebral MRI examination obtained 6 years later were evaluated for presence and location of subclinical infarcts  $\geq$  or = 3 mm in size. After exclusions, 944 participants were eligible for study.

The results suggested an inverse relationship between odds of having a subclinical cerebral infarct and level of PA on several measures, although the multivariable adjusted odds ratios (OR) were statistically significant only for the sport score. A 1-unit increase in the sport score, indicating more leisure PA, was associated with an adjusted OR for having a subclinical cerebral infarct of 0.62 (0.44-0.87), with a statistically significant monotonic trend across quartiles of the score ( $P =$

0.01). There was no association of work scores with subclinical infarcts. In African Americans, sport PA was inversely related to subclinical MRI-detected cerebral infarcts assessed six years later.

### THE UTILITY OF THE GENERALIZED ANXIETY DISORDER SEVERITY SCALE (GADSS) WITH OLDER ADULTS IN PRIMARY CARE

**Weiss BJ, Calleo J, Rhoades HM, Novy DM, Kunik ME, Lenze EJ, Stanley MA.**

*Depress Anxiety, 2009;26(1):E10-5.*

The Generalized Anxiety Disorder Severity Scale (GADSS) is an interview rating scale designed specifically for assessing symptom severity of generalized anxiety disorder (GAD), which has demonstrated positive psychometric data in a sample of adult primary care patients with GAD and panic disorder. However, the psychometric properties of the GADSS have not been evaluated for older adults. This study evaluated the psychometric properties of the GADSS, administered via telephone, with a sample of older primary care patients ( $n=223$ ) referred for treatment of worry and/or anxiety. The GADSS demonstrated adequate internal consistency, strong inter-rater reliability, adequate convergent validity, poor diagnostic accuracy, and mixed discriminant validity. Results provide mixed preliminary support for use of the GADSS with older adults.

## RECOVERY CORNER

### EXPANDING THE REACH OF RECOVERY

Michael W. Roach, MSW, LCSW-BACS  
Local Recovery Coordinator  
VA Medical Center  
Alexandria, Louisiana

A treatment program that includes the Veteran and his or her family and friends as part of the treatment team is considered "Veteran-centric" (McClafferty, 2007). That treatment team collaborates to make decisions about the Veteran's healthcare and ensures communication flow and sharing of ideas and resources among the Veteran, family members, providers, departments, and health care settings in an efficient and flexible manner.

Although the notion of Veteran-centric care is not new, VA Medical Centers formally embraced this idea with the hiring of Local Recovery Coordinators (LRCs) starting in early 2007. The formal implementation of Veteran-centric care has in many ways revolutionized and revitalized the delivery of healthcare at VA Medical Centers across the country, particularly in the area of mental health recovery. LRCs have played various roles as purveyors of Veteran-centric care and mental health recovery. Many of us have concentrated our efforts on mental health programs and inpatient wards. We have imbedded ourselves in various programs and settings in an attempt to ensure that recovery-oriented practices permeate mental health settings. Much progress has been made. LRCs have worked tirelessly in VISN 16 and across the nation spreading the news that recovery is possible through education of staff, Veterans, Veterans' families, and communities. LRCs have connected with community agencies such as the National Alliance on Mental Illness to offer programming that allows Veterans the chance to be heard and reduce mental health stigma as part of these educational efforts.

Though progress has been made, unfortunately mental health stigma remains present. This stigma is not just confined to programs identified as "mental health." It is important to realize the Veterans who access mental health services at the VA also receive care in other settings such as outpatient and inpatient primary care, specialty clinics, Community Living Centers, and other programs that do not necessarily have a mental health focus. It is time to spread the news of recovery to these settings.

Recovery is about self-determination, encouraging Veterans to choose their own paths, instilling hope that recovery is possible, and so much more. An example of the

implementation of Veteran-centric care and mental health recovery principles in an area not primarily identified as mental health occurs in polytrauma-TBI programs. According to VHA Directive 2009-028 Polytrauma-Traumatic Brain Injury (TBI) System of Care, "Blast injuries resulting in polytrauma and TBI are among the most frequent combat-related injuries from Operation Enduring Freedom and Operation Iraqi Freedom." Because of the number of Veterans presenting with these injuries, polytrauma teams have been developed at facilities across the nation offering multiple opportunities to advocate for these Veterans. Facilities in VISN 16 have interdisciplinary teams comprised of key clinical staff that include speech language pathology, social work, psychology, nursing, occupational therapy, physical therapy, rehabilitation physicians, and others who are dedicated to caring for Veterans with TBI. This is an excellent avenue for mental health recovery principles to be promoted in an area that is not identified as mental health but certainly addresses the needs of many Veterans who may also have mental health diagnoses. Polytrauma teams address all aspects of the Veteran's life, including assisting the Veteran with setting and achieving goals. These teams are able to instill hope, offer Veterans an environment of healing and help, and address the unique needs of these Veterans' family members. In other words, these teams are promoting recovery principles.

Another example of the implementation of Veteran-centric care and mental health recovery principles exists in the Primary Care Medical Home Model. This model promotes a partnership among the Veteran, his or her family, and the healthcare team, thus creating an environment that promotes healing and improves the Veteran's quality of life. The April 2009 report from the Universal Services Task Force identifies twelve principles that define the Primary Care Medical Home model. They are: Honor the Veteran's expectations of safe, high quality, accessible care; Enhance the quality of human interactions and therapeutic alliances; Solicit and respect the Veteran's values, preferences, and needs; Systematize the coordination, continuity, and integration of care; Empower Veterans through information and education; Incorporate the nutritional, cultural and nurturing aspects of food;

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Provide for physical comfort and pain management; Ensure emotional and spiritual support; Encourage involvement of family and friends; Ensure that architectural layout and design are conducive to health and healing; Introduce creative arts into the healing environment; and Support and sustain an engaged work force as key to providing Veteran centered care (VHA National Center for Health Promotion & Disease Prevention (NCP), Winter 2009). Veterans with mental health diagnoses will benefit from these teams. Therefore, facilities in VISN 16 have welcomed mental health staff who embrace recovery principles as part of the planning teams.

The aforementioned programs illustrate how Veteran-centric care and the application of mental health recovery principles work in non-traditional mental health settings. A common theme of these programs is hope. Instilling hope in

Veterans is the responsibility of all staff, in all settings. "Perhaps hope is like other theological virtues such as faith, love, or forgiveness: exceedingly difficult to measure or define, but known when experienced, or lamented when absent" (Whitley, 2010).

References

1. McClafferty, S. (2007, May 18). *Healthcare IT & Transformation*. Retrieved March 23, 2010, from [www.ithealthcareblog.com/archives/11](http://www.ithealthcareblog.com/archives/11)
2. VHA Handbook 2009-028 (2009). Polytrauma-Traumatic Brain Injury (TBI) System of Care.
3. *VHA National Center for Health Promotion & Disease Prevention (NCP)*. (Winter 2009). Retrieved March 23, 2010, from HealthPower! Prevention News - Honoring Veterans: [www.prevention.va.gov/HealthPOWER\\_Prevention\\_News\\_Winter\\_2009\\_Feature\\_Article.asp](http://www.prevention.va.gov/HealthPOWER_Prevention_News_Winter_2009_Feature_Article.asp)
4. Whitley, R. (2010). Rediscovering Hope. *Psychiatric Rehabilitation Journal*, 239 - 241.

## MEET YOUR CBOC: HARTSHORNE, OK

PARENT FACILITY: MUSKOGEE VAMC

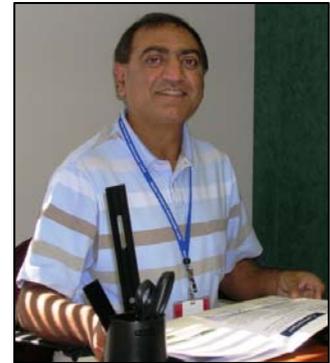
By Ashley McDaniel

In the fall of 2008, the CBOC Partnership Project team had the opportunity to visit the Hartshorne, Oklahoma CBOC.

Incorporated in the late 1890s, Hartshorne is known for its abundance of natural resources including limestone, coal, gas, oil, and timber. Local attractions include Kiamichi and Jack Fork Mountains, Robber's Cave, and Talimena Drive.

During our visit, we met with social worker Scott Henderson and psychiatrist Masood Ahmad, MD at the Hartshorne CBOC. The clinic provides primary care, mental health, social work and lab onsite to Veterans who live in the six-county surrounding area of Atoka, Coal, Hughes, Latimer, Pittsburg, and Pushmataha counties.

We thank the Hartshorne CBOC for welcoming us during our visit.



*Pictured: Masood Ahmad, MD, previously of the Hartshorne CBOC.*

### APRIL CONFERENCE CALLS

CALL-IN NUMBER: 1-800-767-1750

		ACCESS CODE
8	National MIRECC & COE Education Group, 1:00 PM CT	28791#
13	MIRECC Site Leaders, 11:00 AM CT <b>CANCELED</b>	27761#
14	MIRECC Leadership Council, 3:30 PM CT	19356#
16	VISN 16 Mental Disaster Team, 11AM CT	76670#
21	MIRECC Program Assistants, 2PM Central	43593#
22	National MIRECC & COE Implementation Science discussion, 2:00 PM CT	59066#
26	MIRECC Education Core, 3:00 PM CT	16821#
27	MIRECC Leadership Council, 3:30 PM CT	19356#

## RURAL HEALTH RESOURCES UPDATE



### National Rural Health Association

#### Learn how the new health reform law will impact you.

NRHA's [Annual Rural Health Conference](#) will offer numerous educational sessions on providing care in the new climate May 19-21. Arrive early in Savannah, Georgia to hear expert analysis of the historic health reform legislation. Gain insight from the nation's top rural health lobbyists on how providers, employers, physicians, hospitals, clinics, state agencies and health centers will be affected, and learn how health reform will provide funding and help you advance HIT efforts.

#### Health Reform Workshop

Tuesday, May 18

10 a.m. to 4 p.m.

\$69, lunch included

**Space is limited**

The workshop will also cover:

- Medicare/Medicaid provider bonus payments
- Grants available to improve workforce
- Primary care training options
- 340B
- Extenders
- Value-based purchasing
- Frontier regions
- Emergency care
- Mental health services
- General disparities

Please register online by clicking [here](#) (workshop registration is within the same link as Annual Conference registration). However, if you have already registered for the Annual Conference, please click [here](#) to download and submit the attached form.

## NEW WEB COURSE FOR PROVIDERS

### TREATING THE INVISIBLE WOUNDS OF WAR: B. TRAUMATIC BRAIN INJURY



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This course is designed to help primary care physicians, case workers, mental health providers - who may see a Veteran or family member on an unrelated issue - develop a better understanding of the culture in which Veterans and their families live and work, and provide best practices for identifying, assessing and treating mental health problems that result from the trauma of war. At the conclusion of this course, you should be able to:

- Identify strategies for establishing and maintaining a therapeutic alliance with combat Veterans and their families by examining military structure and culture and the combat experience;
- Identify functional anatomy of emotion, memory and behavior circuits;
- Recognize symptoms of TBI and the impact TBI has on daily life of service members and families;
- Identify TBI screening tools and treatment recommendations;
- Identify frames of mental health assessment and treatment options for military personnel;
- Identify how family relationships are impacted by mobilization, deployment and redeployment;
- Identify services available for Veterans and their families, including those provided by the U.S. Department of Veterans Affairs and TRICARE.

To register for this training, visit <http://www.aheconnect.com/citizensoldier/> and click on **New Users**. Access the presentation by clicking on **Courses**.