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The next issue of the *South Central MIRECC Communiqué* will be published July 2, 2010. Deadline for submission of items to the June newsletter is June 25, 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

South Central MIRECC Internet site: www.mirecc.va.gov/visn16

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

DR. MARK KUNIK PRESENTS PARTNERS IN DEMENTIA CARE PROJECT AT 2010 NATIONAL VA RESEARCH WEEK

By: Mark Kunik, M.D., M.P.H.

South Central MIRECC Associate Director of Research Training, Dr. Mark E. Kunik, located at the Michael E. DeBakey VA Medical Center (MEDVAMC) in Houston, gave a presentation on his Partners in Dementia Care (PDC) study (a VA-funded IIR study) at National VA 2010 Research Week April 19- 23. This year's theme was "85 Years of Discovery, Innovation and Advancement for Veterans," and activities were hosted by the Richmond VAMC in Virginia.



Mark Kunik, MD

PDC is a care coordination intervention with a focus on partnership between the VA and Alzheimer Association local chapters to coordinate services for Veterans diagnosed with dementia. In addition to assisting Veterans, the project also provides caregivers for the Veterans with information about resources and referrals to assist with their loved ones' care. The VA, in recognizing the importance of caregivers and their contributions to the care of their Veteran loved ones, is providing the resources for clinical care and research. In addition to VA funding, the PDC project is also partly funded by the South Central MIRECC, as well

as the Robert Wood Johnson Foundation and the Alzheimer's Association (AA) Foundation. The nationwide rollout for implementation of this project is planned for 2012.

PDC, an ongoing randomized controlled study, examines the impact of "care as usual" compared with the intervention (coordination of care services between a VA and AA care coordinator) and the Veteran's and/or caregiver's experiences.

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Partners in Dementia Care Presentation continued...

The PDC project is a multi-site study spanning five VA facilities, including Houston, Boston, Providence, Oklahoma City, and Beaumont. As the research team completes the analyses, team members at the VA sites, along with those at AA local chapters, will work together to create an implementation manual to guide future partnership development.

At National VA 2010 Research Week, Dr. Kunik and Katie Maslow, MSW, with the AA in Washington, DC, along with a Veteran with dementia and his caregiver, talked about the PDC project, the partnership and one caregiver's experience with the support she received as a result of participating.

The participating Veteran represented his native state by donning traditional Texas wear -- a cowboy hat -- while his

caregiver gave a brief history of before and after his dementia diagnosis. She expressed that, initially, she thought she was strong enough to handle being a caregiver for her newly diagnosed father but that she came to realize she was not adjusting or keeping up with the changes. She asked, "How do I get help for both our needs?" She returned to her father's primary care provider and was referred to PDC.

"This program has been so helpful to my dad and me by providing a specific action plan to help with my issues and problems, and I received support in so many areas," she said. "I was connected to the right people, informative resources and services." She added that what amazed her most about the PDC program was the ongoing inquiring and supportive phone calls.

"They were not only concerned about my father, but me, too," she said.

"While Katie Maslow and I presented the purpose, design, plan and preliminary impressions of the study; it was the caregiver who enthusiastically shared the impact of participating in the project on her life and demonstrated the ongoing need for such a project and partnership," said Kunik. "She is a great spokesperson about caregiver needs and the importance of partnerships for coordinating care for the Veteran and his or her caregiver."

The caregiver's well-received take-home message was, "You never know how strong you are until being strong is your only choice." She gave heartfelt thanks for not having to go it alone -- thanks to PDC.

MEET YOUR CBOC: BEAUMONT CBOC

PARENT FACILITY: HOUSTON VAMC

By Ashley McDaniel

In 2009, the CBOC Partnership Project team visited the Beaumont, Texas Community Based Outpatient Clinic. Beaumont, the first major oil-producing city in the country, was incorporated in 1838. Within 65 years, Beaumont's population exploded from 9,000 to 30,000 residents due to the abundance of the natural resource. Today, Beaumont has over 109,000 residents and is host to a plethora of historic and scenic sites including the Texas Energy Museum, the Shangri-La Botanical Gardens, the Babe Didrikson Zaharias Museum and Visitors Center, and the Adventure Kingdom amusement park.



The Beaumont CBOC, a Michael E. DeBakey VA Medical Center clinic, provides general and mental health care. The mental health treatment team includes psychiatrist Robert Robinson, nurse practitioner Penny Hashop, physician's assistant Denise Prejean, and social worker Evonne Mondy.

RECENT SC MIRECC PUBLICATIONS

PERCEPTION OF OSTEOPATHIC MEDICINE AMONG ALLOPATHIC PHYSICIANS IN THE DEEP CENTRAL SOUTHERN UNITED STATES

Reeves RR, Burke RS.

J Am Osteopath Assoc. 2009 Jun;
109(6):318-23

Relatively few osteopathic physicians (DOs) practice in the deep central southern geographic region as compared to other parts of the United States. The objective of this study was to assess the potential effects of underrepresentation on the perception of osteopathic medicine among allopathic physicians (MDs) in this geographic region. A 20-item, Likert scale survey was designed to evaluate participant perceptions of the osteopathic medical profession. The instrument was mailed to 468 MDs who reside and practice in the deep central southern region of the United States.

One hundred seven individuals completed the survey for a response rate of 22.9%. Although the majority of respondents (71 [66.3%]) recognized the distinctiveness of the osteopathic medical profession, they were not necessarily able to articulate these differences clearly through their responses to other survey items. In addition, survey participants expressed a belief that residency training programs accredited by the Accreditation Council for Graduate Medical Education were more beneficial to osteopathic medical graduates than those approved by the American Osteopathic Association (94 [87.8%]). Finally, there was a perception that research efforts

supporting "the scientific basis of osteopathic medicine" were inadequate (53 [49.5%]). The one demographic factor that had a statistically significant ($P < .001$) positive impact on perceptions of osteopathic medicine among these MDs was previous contact with DOs. Underrepresentation of DOs in the deep central southern region of the United States appears to have an impact on the perception of osteopathic medicine among MDs insofar as direct or indirect contact with osteopathic physicians led to improved perceptions among this cohort.

VALIDATION OF THE JACKSON HEART STUDY PHYSICAL ACTIVITY SURVEY IN AFRICAN AMERICANS

Smitherman TA, Dubbert PM, Grothe KB, Sung JH, Kendzor DE, Reis JP, Ainsworth BE, Newton RL Jr, Lesniak KT, Taylor HA Jr.

J Phys Act Health. 2009;6 Suppl
1:S124-32

Physical inactivity has been consistently linked to cardiovascular disease, yet few instruments have been validated for assessment of physical activity in African Americans, a group particularly vulnerable to heart disease. The current study aimed to establish the psychometric properties of the activity survey used in the Jackson Heart Study (JHS) among African Americans, the JHS Physical Activity Cohort survey (JPAC).

Test-retest reliability over 2 weeks was assessed using a convenience sample of 40 African Americans. Convergent validity with accelerometer and pedometer data were assessed in 2 samples from the

JHS (N = 404 and 294, respectively). Test-retest reliability was excellent, with intraclass correlations = .99 for the JPAC total and index scores. Higher JPAC total scores were significantly associated with higher raw accelerometer and pedometer counts. Spearman correlations between JPAC total scores and accelerometer ($\rho = .24$) and pedometer counts ($\rho = .32$) were consistent with these results. Most subscales were significantly correlated with the objective measures. The JPAC total score was most strongly associated with objectively measured activity. This study provides support for the reliability and validity of the JPAC as a tool for assessing physical activity among African Americans across a variety of domains.

COGNITIVE BEHAVIOR THERAPY FOR GENERALIZED ANXIETY DISORDER AMONG OLDER ADULTS IN PRIMARY CARE: A RANDOMIZED CLINICAL TRIAL

Stanley MA, Wilson NL, Novy DM, Rhoades HM, Wagener PD, Greisinger AJ, Cully JA, Kunik ME

JAMA. 2009 Apr 8;301(14):1460-7

Cognitive behavior therapy (CBT) can be effective for late-life generalized anxiety disorder (GAD), but only pilot studies have been conducted in primary care, where older adults most often seek treatment. The objective of this study was to examine effects of CBT relative to enhanced usual care (EUC) in older adults with GAD in primary care.

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The study was a randomized clinical trial recruiting 134 older adults (mean age, 66.9 years) from March 2004 to August 2006 in 2 primary care settings. Treatment was provided for 3 months; assessments were conducted at baseline, posttreatment (3 months), and over 12 months of follow-up, with assessments at 6, 9, 12, and 15 months. The intervention consisted of CBT (n = 70) conducted in the primary care clinics. Treatment included education and awareness, motivational interviewing, relaxation training, cognitive therapy, exposure, problem-solving skills training, and behavioral sleep management. Patients assigned to receive EUC (n = 64) received biweekly telephone calls to ensure patient safety and provide minimal support.

Primary outcomes included worry severity (Penn State Worry Questionnaire) and GAD severity (GAD Severity Scale). Secondary outcomes included anxiety ratings (Hamilton Anxiety Rating Scale, Beck Anxiety Inventory), coexistent depressive symptoms (Beck Depression Inventory II), and physical/mental health quality of life (12-Item Short Form Health Survey). Cognitive behavior therapy compared with EUC significantly improved worry severity (45.6 [95% confidence interval {CI}, 43.4-47.8] vs. 54.4

[95% CI, 51.4-57.3], respectively; $P < .001$), depressive symptoms (10.2 [95% CI, 8.5-11.9] vs. 12.8 [95% CI, 10.5-15.1], $P = .02$), and general mental health (49.6 [95% CI, 47.4-51.8] vs. 45.3 [95% CI, 42.6-47.9], $P = .008$). There was no difference in GAD severity in patients receiving CBT vs. those receiving EUC (8.6 [95% CI, 7.7-9.5] vs. 9.9 [95% CI, 8.7-11.1], $P = .19$). In intention-to-treat analyses, response rates defined according to worry severity were higher following CBT compared with EUC at 3 months (40.0% [28/70] vs. 21.9% [14/64], $P = .02$).

Compared with EUC, CBT resulted in greater improvement in worry severity, depressive symptoms, and general mental health for older patients with GAD in primary care. However, a measure of GAD severity did not indicate greater improvement with CBT.

**GOOD AND POOR
ADHERENCE: OPTIMAL CUT-
POINT FOR ADHERENCE
MEASURES USING
ADMINISTRATIVE CLAIMS
DATA**

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

Popul Health Manag. 2009 Mar 26

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 2 multisite Veterans Affairs implementation studies conducted in 2 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 highly 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.

SC MIRECC HONORABLE MENTIONS

Psychologist and SC MIRECC Researcher Jeffrey A. Cully, Ph.D. was honored with Fulbright & Jaworski L.L.P. Faculty Excellence Awards for outstanding teaching in a specialty area and developing enduring educational materials.

RECOVERY CORNER

SPOTLIGHT ON PEER SUPPORT SERVICES

Wanda Shull, Ph.D., CRC
Local Recovery Coordinator
Veteran's Healthcare System of the Ozarks

As the Veteran's Administration and South Central MIRECC continue in their focus on Recovery Oriented Mental Health Services, it is an appropriate time to highlight the value of Peer Support in the recovery process. Peer support is a distinct aspect of mental health recovery, and is listed as a key component of recovery by the Substance Abuse and Mental Health Services Administration (SAMHSA) and a psychiatric principle by the United States Psychiatric Rehabilitation Association (USPRA). Peers serve as active members of the treatment team, performing many roles in assisting Veterans to achieve recovery. For centers newly implementing peer support services, some of the ideas below may assist in developing tasks for peer support specialists.

Peer services have gained increasing momentum in both community and VA mental health services. A person with severe mental illness who has been successful in his or her own recovery can assist others in taking control of their recovery process. Those who have experienced similar difficulties and setbacks often can be of greater help to a person with a severe mental illness than a mental health provider can; in fact, such a one-way relationship can be de-valuing and reduce self-esteem (Repper & Perkins, 2003). Important outcomes such as reduced isolation, reduction in psychiatric symptoms, and increased self-esteem are seen when peer support services are available. Further, outcomes tend to be better when supportive peers are present on case management teams. Mental Health America has asserted that peer support services are a necessary component of "culturally competent, recovery-based mental health and substance abuse programs."

As the implementation of the Uniform Mental Health Services Handbook (2008) is ongoing in the VA, Peer Support Specialists have been hired in many facilities, while at the same time many facilities have developed volunteer peer support programs. Both programs involve training and certification of each peer provider, usually through the Depression and Bipolar Support Alliance (DBSA). Many facilities have implemented large volunteer peer programs. Examples include the San Francisco VA, which has recently trained 41 volunteer peers; and Marion IL, which has 17 trained at this time. While not all facilities across the nation have been able to implement peer support

services as yet, many, both within VISN 16 and nationwide have really taken the lead on this effort and use peer specialists in creative ways that advance recovery in mental health services,

In VISN 16, the Fayetteville, peer support specialists provide a variety of services. These services include co-facilitating Social Skills Training and process groups; coordinating community outings; working with individual Veterans on addiction issues; assisting with CARF accreditation; transportation; peer mentoring; and crisis intervention. There is a paid peer support specialist on staff in Shreveport, and the Local Recovery Coordinator reported that the peer support specialist "does it all" in terms of ongoing mentoring and support, transportation, orientation, and facilitating groups. In Little Rock, peer support specialists Eric Twombly and Eddie Smith also provide a number of services that go beyond mentoring. These peers additionally lead or co-lead groups, including "What's up Doc?", that allow Veterans the opportunity to increase communication with their providers. The group "Warriors Talking Circle" led by the peer support specialists gives Veterans an opportunity for problem solving and increasing coping skills with various topics and issues. In addition to facilitating groups, peers act as point persons for referrals to the PRRC and assist as valued members of the team in recovery treatment planning, mentoring, providing community integration services, and. Their unique perspective as former VA employees is also a great value to Veterans, since they both know the system well and can assist Veterans with navigating that system. They are both pursuing further education to become more skilled in working as peer specialists.

The Muskogee VA recently used peer volunteers in the Veterans Court system, and hopes to expand peer support in the medical center. At Houston's Michael E. DeBakey Medical Center, a volunteer peer support program called POST (Peer Outreach and Support Team) is being implemented. The POST team will be responsible for facilitating all mental health services provided by peers to peers. Further, part-time peers are available in the domiciliary, and they plan to have peers available on the inpatient unit this month.

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Likewise, in Oklahoma City, a volunteer peer program is being developed, and a medical center memorandum recently signed. This will incorporate volunteer peer support technicians in various mental health programs such as Mental Health Intensive Case Management (MHICM), Substance Abuse Treatment Program (SATP), OEF/OIF Outreach, Post Traumatic Stress Recovery Program, Military Sexual Trauma (MST), Family Mental Health, OEF/OIF Reintegration Program, Ambulatory Mental Health Clinic, and in the inpatient psychiatric unit.

Nationally, peer support efforts are also moving forward. Holly LaFrance (Puget Sound VA) facilitates or co-facilitates seven groups per week while providing assistance for orientation, job and school applications, and facility trainings. She also follows up on recovery goal progress; provides pre-discharge job search assistance; attends Veteran council meetings when asked; brings in guest speakers; charts; creates educational handouts; and shares her own story with Veterans to further aid in their recovery. Likewise, George Ellis (Tampa, Florida) co-facilitates the Social Skills I and Social Skills II training groups, and is able to

lead them alone if necessary. He is also responsible for teaching goal setting and budgeting classes, assisting with the Family Education and Support group, conducting PRRC orientations, and, most importantly, serving as an advocate for Veterans.

Note that the peer support specialists go well beyond one to one mentoring with Veterans, but serve as valuable team members to the PRRC and other mental health teams. Not only does their time include helping with outings and sharing stories and giving feedback to Veterans, but also doing everything from facilitating groups, to charting, to community integration. Most importantly, peers are visible to the Veterans we are all serving in mental health clinics at various medical centers, giving a much needed sense of hope.

References

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- US Dept of Health and Human Services and SAMHSA Center for Mental Health Services (2004) National Consensus Statement on Mental Health Recovery.



Proposals for FY11 MIRECC Clinical Educator Grants

The South Central MIRECC is **accepting** proposals for Clinical Educator grants. These small grants of up to \$7,000 are designed for mental health clinicians to develop unique, exportable clinical education tools to enhance the delivery of care. The MIRECC is especially interested in funding projects that focus on the delivery of care in rural settings and that involve collaborations between medical centers and community based clinics.

Examples of past projects include a CD-ROM compendium of pain management information and tools for clinicians who treat veterans with substance abuse, a manual to conduct psychoeducational workshops for returning Iraq and Afghanistan veterans and their families about readjustment issues, and a DVD of ex-POWs telling their story about internment and their struggle with PTSD symptoms and how they have managed to survive and thrive in their lives. The Clinical Educator grants program has resulted in more than 30 excellent clinical education products that the MIRECC makes available to clinicians at no cost.

If you have a great idea for an educational tool to improve care delivery, this may be the opportunity that you are looking for! The application is attached, along with two sample applications that can serve as a model. The deadline for submitting a proposal is August 16. For more information about the Clinical Educator grants, contact Dr. Randy Burke (Randy.burke@va.gov) or Dr. Michael Kauth (Michael.kauth@va.gov).

JUNE CONFERENCE CALLS

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

	ACCESS
	CODE
8 MIRECC Leadership Council, 3:30 PM CT	19356#
10 National MIRECC & COE Education Group, 1:00 PM CT	28791#
14 MIRECC Site Leaders, 11:00 AM CT	27761#
15 VISN 16 Mental Disaster Team, 11AM CT	76670#
16 MIRECC Program Assistants, 2PM Central	43593#
22 MIRECC Leadership Council, 3:30 PM CT	19356#
24 National MIRECC & COE Implementation Science discussion, 2:00 PM CT	59066#
28 MIRECC Education Core, 3:00 PM CT	16821#