South Central MIRECC

Reducing mental health disparities among rural veterans

Communiqué

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The next issue of the *South Central MIRECC Communiqué* will be published October 4, 2010. Deadline for submission of items to the October newsletter is September 28, 2010. 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

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

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

TELEHEALTH COMES OF AGE

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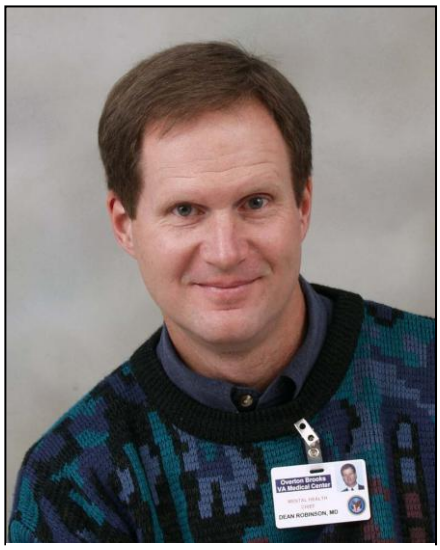
We all are well aware that we live in an increasingly wired world. Information technology has already vastly transformed many aspects of our commerce, entertainment, and social interactions. Medical care is also gradually adopting and adapting to this new paradigm, and the treatment of mental disorders is no longer an exception.

This article will highlight certain aspects of how clinical telemedicine is presently evolving in context of the VA health care system and familiarize readers with some of the main resources available for further research. This article will briefly describe one of the current investigations underway that seeks to understand and quantify the effectiveness and limitations of a specific mental health intervention employing this technology and will perhaps serve to stimulate interest in further studies of this transformation.

The VA has pioneered employment of informatics in the health care setting. Our computerized patient record



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system (CPRS) is probably the most extensive and comprehensive application of its type in existence anywhere at present. The VA also has laid much of the groundwork for the clinical use of videoconferencing in a mental health setting over the last 25 years. These two branches have now matured and intertwined in the context of the VA Office of Telehealth Services.

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Telehealth Comes of Age continued…

This agency collectively incorporates supports and promotes Care Coordination Home Telehealth, which provides home monitoring and disease management services, Store-and-Forward Telehealth, which provides remote interpretation of retinal and radiological imaging studies, and Clinical Video Telehealth, which provides clinical guidance and technical assistance to facilitate provision of mental health and other specialty services via real-time videoconferencing.

Each of these divisions also now has a dedicated training/resource facility. Clinical Video Telehealth is supported by the Rocky Mountain Telehealth Training Center (RMTTC), which can be accessed through the VA Care Coordination website (http://vaww.telehealth.va.gov/telehealth/cvt/tmh/index.asp). The RMTTC maintains an extensive collection of scientific articles related to telemental health (TMH) that can serve as the starting point for a literature review, and hosts a monthly Journal Club. It also contains numerous web-based instructional courses for telehealth staff training, as well as procedural and administrative protocols for establishing and successfully maintaining TMH Clinics.

TMH Clinics all employ video conferencing technology to conduct or facilitate mental health treatment for patients located at remote sites. The video information link permits enough interaction to enable therapists to perform the complex evaluations and obtain the feedback necessary for psychotherapy or medical management of mental disorders. SCVAHCN (VISN 16) presently offers dozens of TMH Clinics, staffed by over 125 telehealth credentialed clinicians, which have provided over 7000 therapeutic encounters to over 3500 Veterans thus far this Fiscal Year. This most likely will result in about a 10% increase in workload compared to the previous year, and substantial further growth is anticipated, since TMH appears to offer an effective and efficient means of extending mental health services to more rural areas in a manner consistent with the goals of the VA Mental Health Uniform Services Handbook. VISN 16 leadership has consistently and proactively supported TMH services during the last 8 years, and Dr. Kathy Henderson has also established a VISN TMH Workgroup that meets via teleconference on a monthly basis. Interested researchers are welcome to both listen in and submit questions or suggestions for our agenda.

Numerous but somewhat dated previous studies do indicate that TMH services appear to be as effective as face-to-face therapy for many emotional conditions. Patient satisfaction with and acceptance of TMH therapy generally is quite high, especially among younger Veterans. MIRECC affiliated researchers are presently conducting a multi site study that seeks to measure the effectiveness of telemed-administered Cognitive Processing Therapy for treatment of PTSD, as compared to treatment as usual (TOPS Study, Dr. John Fortney). More solid investigational work in this field is sorely needed, and the VA should remain supportive of such efforts, since further employment of this technology is being strongly encouraged at the highest levels.

Future trends in telehealth are likely to include expansion of the home-based disease management model to include additional mental disorders, increased Veteran access to their own health care information and communication of scheduling preferences through My Health*e*Vet. We are likely to see an expansion of the telemedicine provider and consulting networks to ultimately enable nation-wide sharing of professional expertise, accompanied by further extension of videoconferencing to locations even more accessible to Veterans, including all the way into their own homes. These advances will almost certainly alter many basic aspects of the health care delivery process, and although we are pretty sure that all of these initiatives are consistent with the desires of our Veterans and will ultimately have desirable consequences, we still need to be careful not to let our good intentions carry us too far beyond our evidence base.

Advances in implementation of telemedicine pioneered by the VA appear to have resolved or eliminated many of the technological constraints that have limited the reliability and acceptance of this tool in the past. The equipment works well, works consistently, and can now be used by clinicians to almost seamlessly intersperse remote site treatment with face-to face encounters. We have already acquired quite a bit of experience in the field and have developed the means to share this with our colleagues. But we still have a lot to learn about the potential advantages and constraints of telemedicine, and could really use additional research expertise to help guide us more adeptly through this strange new world.

MIRECC INVESTIGATORS BENEFIT FROM MIDAS CONSULTATION

Interviewed by Ashley McDaniel

The MIRECC Implementation, Design and Analysis Support team (MIDAS) is a service arm of the South Central MIRECC created to assist VISN 16 investigators who are seeking intramural or extramural funding or conducting pilot studies. The MIDAS team offers design, methods, and analytic support for all phases of project development, implementation, analysis, and/or dissemination. Team members have expertise in biostatistics, epidemiology, psychometrics, qualitative methods and project implementation and management.

This month we hear from three researchers who have used MIDAS services in the past year: Jeffrey Cully, Ph.D., Dinesh Mittal, M.D., and Salah Qureshi, M.D. We asked each of them to tell us a little about their projects, their experience working with MIDAS consultants, and the effect the MIDAS consultation had on achieving their goals.

Jeffrey Cully (Houston) – I was fortunate enough to work with the MIDAS program on two projects. For the first project, we wanted to use a dataset my team developed to examine the utilization of psychotherapy services by rural and urban Veterans. We were particularly interested in comparing rural Veterans to urban Veterans in terms of how often they received psychotherapy, how much psychotherapy they received (e.g., number of sessions), and how long the delay was between an initial mental health diagnosis and the receipt of psychotherapy. We used VA administrative databases to look at all patients in the VA system with a newly diagnosed depression, anxiety, or PTSD condition (from fiscal year 2004).

We had already published our results from a similar study and had developed explicit methods for what we wanted to accomplish for a study of rural psychotherapy. We requested programmer support from MIDAS. A Houston-based MIDAS programmer helped modify our database coding and ran our study analyses. The programmer, working with the study team, spent approximately 20-25 hours on this project. The resulting manuscript describing our findings would have not been possible without the MIDAS assistance.

The second project was a Health Services Research and Development Investigator Initiated Research grant proposal that Aanand Naik, M.D. and I resubmitted in June 2010. The project ("Behavioral Activation Therapy for Rural Veterans with Diabetes and Depression") proposes a 4-year randomized controlled trial to compare diabetes control and symptom outcomes for Veterans receiving a combined diabetes/depression behavioral coaching intervention plus usual care to outcomes for Veterans receiving usual care alone. Because the project presented a complex set of methodological challenges with which we had limited expertise, our team requested methodological assistance from MIDAS in revising the proposal.

MIDAS consultants provided informal grant review and feedback on ways we could improve our project. In particular, they provided invaluable assistance by helping the study team choose the best scientific methods to recruit and randomize patients for the proposed trial, given the variability of the CBOC practice patterns.

On both projects, MIDAS consultants were wonderful and exceeded my expectations. On the database project, the programmer not only carried out the general programming tasks but also provided valuable comments and suggestions that led to important changes in the data analysis plan and subsequently improved the manuscript. On the diabetes and depression project, we were truly impressed by the level of detail and thoughtfulness of the reviews and feedback. It was clear to us that the reviewer had not only methodological expertise but also expertise in grant writing as well as specific knowledge about what is important to VA HSR&D. We believe the feedback from MIDAS likely saved us a submission cycle by anticipating, and addressing, concerns that grant reviewers may have had with our original methodology. In my opinion, this feedback has significantly improved our chances of getting this project funded.

Dinesh Mittal (Little Rock) – Last year, I started developing a proposal to study self-stigma experienced by returning OEF/OIF Veterans with PTSD. The project involves qualitative and quantitative methods for instrument development. I had little background in qualitative methods and no direct exposure to the methods for instrument development. I needed a lot of guidance for both aspects of the proposal. I worked with Dean Blevins, Ph.D. on the initial submission of the proposal in December 2009, and requested MIDAS support for the resubmission.

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My mentor, Greer Sullivan, M.D., suggested I seek help from MIDAS consultants to prepare a thoughtful response to excellent critiques from the reviewers of the initial submission. Specifically, I received help with instrument development from two MIDAS consultants–Cathy Sherbourne, Ph.D. and Adam Kelly, Ph.D. I had weekly consultations with Dr. Kelly over a 6-week period to refine the quantitative methods. Dr. Cathy Sherbourne advised on development of the focus-group guide and helped refine the methods for instrument development. I can safely say that without the consultation I received from the group of MIDAS consultants, I would not have been able to submit the proposal in a timely manner or perhaps not even develop the proposal.

With all the help I received, I feel hopeful that our resubmission will receive a better and fundable score. However, beauty is in the eyes of the beholder! Regardless of the outcome, it was a huge learning experience for me; an experience I would not have had but for MIDAS consultants.

Salah Qureshi (Houston) – My team requested MIDAS support for a research project I started as a MIRECC fellow. Our request for MIDAS support encompassed a series of projects that use existing VISN16 data to examine the association between PTSD and physical comorbidities, including dementia, in older Veterans.

MIDAS has been extremely helpful in providing support for data analysis. Dr. Nancy Petersen and Mr. Hong-Jen Yu have been working with us as MIDAS consultants. Both of them have made important contributions to each project. Dr. Petersen has not only helped us decide which statistical models to use for analysis but she has also helped us in interpreting results and preparing a critical revision of manuscripts. Mr. Yu has helped us with running the analyses in a timely and efficient manner. We have biweekly telephone conference calls with them and the rest of the team along with one-on-one meetings, when needed. Without MIDAS support, we would have not been able to finish our projects on time.

With the help of Dr. Petersen and Mr. Yu we have already completed analyses for three manuscripts. Out of these three, one manuscript will be published next month while another one is already submitted and is under review. We hope to get analyses done for one more project by September.

Is there anything else you would like to share with readers about your MIDAS experience?

Cully – More folks should be using MIDAS. It is a strong program with dedicated and highly knowledgeable faculty. Many thanks to Dr. Fischer and the rest of the MIDAS program.

Mittal – It was a fun learning experience while at work! I was truly impressed by the availability and congeniality of all three consultants.

Qureshi – I would like to thank MIDAS and their consultants for providing this valuable resource to research fellows and early investigators like myself.

For all requests for assistance from MIDAS, please contact Dr. Ellen Fischer at FischerEllenP@uams.edu or Melonie Shelton at Melonie.Shelton@va.gov to fill out an application.

SEPTEMBER CONFERENCE CALLS

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

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

RECOVERY CORNER

COMBATING STIGMA: WORTH THE BATTLE

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Psychologist – Local Recovery Consultant
Team Leader – Primary Care Mental Health Integration
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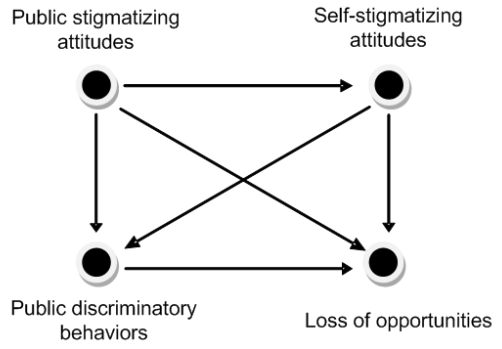
In early August, I had the opportunity to attend the annual VHA peer support conference entitled, Peer Support: Combating Stigma. The conference, primarily led by peers from within the VA system, included numerous outstanding keynote presenters as well as very informative breakout sessions. What follows is a small piece of what I gleaned. I will briefly discuss stigma regarding mental illness, illustrate two types of stigma and share how all of us can work together within the recovery framework to eliminate stigma.

Stigma is defined as a scar left by a hot iron; a mark of shame or discredit; an identifying mark or characteristic, (Merriam-Webster Dictionary, n.d.). Ancient Greeks would cut or burn marks onto the bodies of criminals, slaves, and traitors so all would know their status. Today the term stigma more commonly refers to something that is discredited by society, which causes others to classify people with that trait as somehow undesirable or as unaccepted. Erving Goffman (1963) used the term "spoiled identity" to convey that stigmatized persons are somehow "less than." In its basic form, think of stigma as devaluation based on group membership, (Boyd & Wilson, 2010). This then leads to self-stigmatizing attitudes, public discriminatory behaviors and a loss of opportunities (Corrigan et al., 2004). Figure 1 provides a graphical representation of this sequence of events (adapted from Corrigan et al., 2004).

Figure 1. Interaction of stigmatizing attitudes and outcomes



Stigma can be further broken down into two broad forms, external and internal stigma. External stigma originates from the world around us. The used car commercial stating, "I'd have to be crazy to let cars go this cheap!" exemplifies this form of stigma. The reduced opportunities for employment, housing and access to medical care (Link & Phelan, 2006) are consequences of external stigma towards people with mental illness. Fear of this stigma can cause individuals to not seek treatment or to forgo treatment for mental illness in an effort to avoid a stigmatizing label (Link & Phelan, 2006). One of the most powerful and detrimental effects of external stigma is the internal stigma one then applies to the self. Internal stigma includes stereotype endorsement, alienation and social withdrawal. Growing up, we are exposed to all the same stereotypes including those about groups to which we belong. This then makes individuals who are members of stigmatized groups (such as people with mental illness) prone to believing those stereotypes about themselves. This can lead to alienation and social withdrawal, making such individuals feel misunderstood, or "less than." What happens then? They distance themselves from others due to concerns over their status as a member of a stigmatized group. (Boyd & Wilson, 2010)

So, what part can VA health care providers, researchers, and educators play in combating stigma around mental illness? There are a number of actions that we can all take in order to reduce stigma. We can increase awareness of stigma in our communities, the VA system and within our programs. The National Alliance on Mental Illness (NAMI) has a group of volunteers called StigmaBusters. StigmaBusters receive email alerts concerning local or national stigmatizing events. VA health care providers, researchers, and educators can become informed and can learn how to educate others (e.g., businesses, individuals) about the (often unintended) harmful effects of their actions.

Use person first language when talking about mental illness. Do not refer to a Veteran as, "Mr. Jones the schizophrenic I'm treating." Instead, say, "Mr. Jones, the Veteran with a diagnosis of schizophrenia I'm working with." Veterans with mental health concerns are more than their diagnoses.

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VA Consumer Advocacy Councils are another resource for VA health care providers, researchers, and educators. Consumer Advocacy Councils can provide input on policies and materials and review them for possible stigma. Contact your Local Recovery Coordinator for more information on your Consumer Advocacy Council.

Another strategy is for VA health care providers, researchers, and educators to reflect on our own practices and beliefs. Ask yourself whether you are doing something for a Veteran that she or he could do for her or himself. Consider the Veteran's perspective; doing for someone may be perceived at times as patronizing.

Given the significant negative impact alienation and social withdrawal have because of stigma, it is also important to work to reduce these. Alienation can be reduced through interpersonal engagement. Clinicians can provide some opportunities for interpersonal engagement by making available self-help groups when possible, encouraging Veterans to utilize peer support staff, engaging Veterans in CWT, and enrolling eligible Veterans in Psychosocial Rehabilitation and Recovery Centers (PRRC). Social engagement can be increased by providing Veterans the opportunity to tell their recovery stories. Recovery stories bring the concept of recovery to life and are extraordinarily effective in combating stigma on the individual level.

Together, no matter where in the organization you are, we can all work together to combat stigma about mental illness.

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RURAL HEALTH RESOURCES UPDATE

The Medicare Physician Quality Reporting Initiative: Implications for Rural Physicians (Final Report)

The Health Resources and Services Administration Office of Rural Health Policy funded the NORC Walsh Center for Rural Health Analysis to study the impact of rurality on primary care physicians' participation in the 2007 Physician Quality Reporting Initiative (PQRI). PQRI is a pay-for-reporting program (P4R), whereby physicians and other eligible professionals may receive an incentive payment for reporting on specific quality measures for their Medicare patients. PQRI is CMS' first nationwide initiative that provides incentives to encourage reporting of quality data by physicians. NORC utilized PQRI as a proxy to explore the broader implications of P4R and pay-for-performance programs for rural primary care physicians.

The objectives of this study were to explore the design and implementation of PQRI, in order to identify the implications of the program for rural physicians, and assess whether there are any unique challenges related to participating in PQRI that would be systematically different for rural versus urban primary care physicians. The study involved a literature review, interviews with representatives from medical societies about their memberships' experiences participating in PQRI, and interviews with representatives from medical practices that participated in PQRI. Key findings were related to factors that affect rural physicians' participation in PQRI, challenges to participation, and recommendations to improve PQRI. For more information contact Alycia Infante, MPA, Walsh Center for Rural Health Analysis, 301-634-9371, infante-alycia@norc.org . To download a copy of the report, visit http://www.norc.org/NR/rdonlyres/BFF4D25F-6989-4DC7-9A61-C6BDCB6EE412/0/FinalReportThePhysicianQualityReportingInitiativeAugust2010Final.pdf.