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“Closing the efficacy-effectiveness gap”

National Mental Health Performance Measures for FY05

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VHA developed a performance measurement system in 1996 and currently leads both private sector and other governmental agencies (Medicare/Medicaid) in almost all the clinical performance indicators as measured by the National Committee for Quality Assurance (NCQA). As NCQA primarily monitors medical management, service utilization, and patient satisfaction, VHA has clearly led the way in the development of mental health indicators. This year is no exception!

There are 16 national mental health performance measures for FY05. Ten measures are new for this year. With limited resources, complex methodology, and lack of measurement targets or outcome data four months into the fiscal year, this will be our most challenging year to date. Below is a brief description of each new measure:

- ***Mental Health in Community Based Outpatient Clinics (CBOCs)*** – % of CBOC’s serving at least 1,500 unique patients will provide mental health specialty services in 10% or greater total patient visits.
- ***Mental Health/Primary Care Services for Homeless Veterans (4 measures)*** – (1) % of homeless veterans who receive specialty mental health or substance abuse disorder services within:
 - (a) 60 days of outreach/eligibility
 - (b) 60 days of admission to homeless program
 - (c) 60 days of discharge from homeless program(2) % of homeless veterans who receive primary services within 60 days of admission to homeless program.
- ***Mental Health Intensive Case Management (MHICM) Capacity*** – each facility with 60 or greater MHICM eligible patients with receive outpatient care in MHICM.
- ***Major Depressive Disorder (MDD) (2 measures)*** – (1) % of patients with a new diagnosis of depression who have at least 3 clinical follow-up visits during the acute phase of treatment (84 days), and (2) % of patients with a new diagnosis of depression who receive at least 84 days of antidepressant medication coverage.
- ***Waiting Times (2 measures)*** – for mental health (stop codes 502, 509, 510): (1) % of new patients seen within 30 days, and (2) % of established patients seen within 30 days of desired date.

Each of these measures has their strengths and limitations. The network has invested over \$2.2 million in the last two years to provide mental health services in our most rural clinics. Although recruitment of mental health providers and physical space limitations have been challenging, this has been a very wise investment. Seventeen (17) CBOCs currently provide telemental health services from parent facility to

CBOC. To date, the network has delivered specialty mental health care to almost 25,000 veterans in the CBOCs. Currently, we have only four CBOCs that are not meeting this new measure.

MHICMs are, likewise, an extremely good investment. Based on the assertive community treatment model, this is an evidence-based standard of care practice that reduces hospital admissions and ER visits, increases functionality of the patient, and provides considerable cost avoidance to the facility. Our network currently has 4 MHICMs in Biloxi, Houston, Little Rock, and New Orleans. To meet the performance measure, 4 new teams (Florida panhandle, Houston, Jackson, Oklahoma City) and expansion of two other existing teams will be needed. However, the cost to implement these programs is \$1.9 million, and new MHICMs will only be initiated as the budget allows.

Although FY05 data is not available for many of the other new measures, the MDD and Waiting Time measures will produce their own challenges. At the end of FY04, no facility was meeting the target for the three-visit requirement for MDD and only one facility met the medication coverage requirement. Many facilities are implementing clinical reminders and depression education groups to address these deficiencies. Waiting times for new patient appointments are currently below the recommended targets. Although some facilities have been slow in implementing advanced clinic access principles in mental health, this new measure will hasten the process. As the methodology for the homeless measures is still being addressed, no data is currently available.

As if these additional measures were not enough, most of the mental health clinics have been added to the NEXUS clinic cohort. What this means is that many of the NEXUS quality measures will be required with mental health patients not seen (or measures not addressed) by a primary care provider. These measures include cancer screening, blood pressure and lipid monitoring, diabetic measures (including foot and retinal exam), and influenza immunization.

And, yes, there are still six mental health measures from the previous year. These include alcohol screening, substance abuse continuity of care, MHICM screening, tobacco counseling and use in last year, and homeless independent housing. For more information about these measures, go to the Performance Measures Technical Manual at

http://vaww.oqp.med.va.gov/oqp_services/performance_measurement/tech_man.asp.



Web Presentation on Seeking Safety

The MIRECC *Bringing Science to Practice* web-based series presents **Robyn Walser, Ph.D.**, on “**Management of Substance Abuse and PTSD: Seeking Safety,**” **February 17, noon to 1:00 PM CT.** Dr. Walser is a psychologist for the National Center for PTSD at the Veterans Affairs Palo Alto Health Care System and Trauma and Life Consultation Services. She is currently developing innovative ways to translate science-into-practice and is responsible for the dissemination of state-of-the-art knowledge related to PTSD to health care professionals and trainees across all VA facilities nationally. She is also responsible for several research projects in PTSD, including Acceptance and Commitment therapy and PTSD in older adults.

The PowerPoint for Dr. Walser’s presentation can be downloaded at <http://vaww.visn16.med.va.gov/mirecc.htm> beginning February 16 from a VA-networked computer. The live audioconference can be accessed at **1-800-767-1750, access code 45566#**. This presentation is not accredited for CEUs. For additional information about this program, contact Tonya.welch@med.va.gov

Brief Report

Posttraumatic Growth: Positive Responses to Adversity

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Adjustment following a traumatic event can only be fully understood when one accounts for the positive and negative changes that a person experiences following exposure to adversity. Most research on the psychological consequences of trauma has been limited to examining maladaptive responses to distress. Little attention has been paid to the possibility of positive changes following negative events, although many survivors of traumatic events perceive positive changes.

Posttraumatic growth (PTG), the perception of positive responses attained as a result of struggling with adversity, is based upon the premise that the process of struggling with misfortune drives individuals to an elevated level of functioning beyond the level that existed prior to the event. Tedeschi and Calhoun (1) have documented three areas of PTG: changes in self-perception, interpersonal relationships, and life philosophy. Clinicians should be aware of the potential for positive change as a foundation for therapeutic work and means of providing hope that negative effects of trauma exposure can be overcome (2). Facilitating PTG may be a way to augment therapeutic interventions with trauma survivors.

The most commonly used measures of PTG are the Posttraumatic Growth Inventory (3) and the Stress-Related Growth Scale (4). In longitudinal studies of PTG, positive and negative affect, and personality variables such as self-efficacy, extraversion, and optimism are significantly associated with PTG (2,5,6). It appears that the individual's subjective experience of the adverse event (e.g., helplessness, controllability, life threat) influences PTG (7), along with intervening events and processes that take place following trauma exposure. Ruminations, intrusions, and avoidance are positively associated with growth (2), and it may be that this form of cognitive processing is necessary for PTG to occur (8). Evidence of gender differences in PTG is mixed (2); however, other demographic variables including higher level of education and income are related to increased PTG (9).

Research on PTG is in the early stages, and no studies have examined PTG in PTSD diagnosed combat veterans. This is surprising given the large population of individuals with PTSD in the VA system. Understanding the relationship between combat-related PTSD and PTG may lead to new and innovative treatments for PTSD symptoms and ways of promoting PTG in those individuals who have been exposed to trauma.

1. Tedeschi RG & Calhoun LG (1996). Posttraumatic Growth Inventory: Measuring the positive legacy of trauma. *J Traumatic Stress, 9*, 455-471.
2. Linley PA & Joseph S (2004). Positive change following trauma and adversity: A review. *J Traumatic Stress, 17*, 11-21.
3. Tedeschi RG & Calhoun LG (1995). *Trauma and transformation: Growing in the aftermath of suffering*. Thousand Oaks, CA: Sage.
4. Park CL, Cohen LH, & Murch R (1996). Assessment and prediction of stress-related growth. *J Personality, 64*, 71-105.
5. Abraido-Lanza AF, Guier C & Colon RM. (1998). Psychological thriving among Latinas with chronic illness. *J Social Issues, 54*, 405-424.
6. King LA & Miner KN (2000). Writing about the perceived benefits of traumatic events: Implications for physical health. *Personality & Social Psychology Bul, 26*, 220-230.
7. Briere J & Elliott D (2000). Prevalence, characteristics, and long-term sequelae of natural disaster exposure in the general population. *J Traumatic Stress, 13*, 661-679.
8. Calhoun LG & Tedeschi RG (1998). Posttraumatic growth: Future directions. In RG Tedeschi, CL Park & LG Calhoun (Eds), *Posttraumatic growth: Positive changes in the aftermath of crisis* (pp.215-238). Mahwah, NJ: Erlbaum.
9. Milam J, Ritt-Olson A & Unger J. (2004). Posttraumatic growth among adolescents. *J Adolt Res, 19*, 192-204.

Giving VA Credit Where Credit is Due

Recently, Stephan D. Fihn, MD, MPH, Acting Chief Research and Development Officer, issued a reminder about acknowledging VA research support in publications, presentations, and/or media interviews. The VHA policy regarding appropriate acknowledgement of VA research support is published in VHA Handbook 1200.19 (dated June 19, 2001). The Handbook states:

- **This requirement extends to all research results where either direct or indirect support for research emanated from VA**, either in the form of research funding, resources such as space or patients, or as a result of the investigator's full-time, part-time, or without compensation (WOC) appointment.
- **VA must be acknowledged first** when: 1) the investigator has a 5/8ths or more VA appointment (regardless of the source of funding/administration of funding; 2) work was funded primarily (50% or more) by VA resources, either directly or indirectly; 3) the research was conducted primarily in VA facilities; or 4) the first author is a junior scientist (e.g., resident, fellow trainee) who, although his/her salary may not have been provided by VA, used primarily VA funding or facilities, or whose mentor was primarily funded/employed by VA.

The policy also applies to research funded by other agencies (e.g., NIH) when the investigator derives most or all of his or her salary from VA. Although a university public relations office, an agent from the media, or a medical journal editor may resist listing VA first, this does not release the investigator from the responsibility of proper acknowledgement of VA support.

Dr. Fihn added that improper acknowledgement of VA support reflects badly on the VA and the investigator and does not go unnoticed. The VA depends heavily on appropriate attribution of support to enhance awareness of VA research among the general public, in the scientific community, and particularly within the executive and legislative branches of government. We should all be proud of our VA affiliation and the VA's support of research.



Funding Opportunities

The National Institute on Aging (NIA) announced funding of projects related to retirement economics. Retirement has emerged as an extended phase of life for most Americans. Extended periods of retirement are a result of increasing longevity on the one hand, and a long-term trend toward younger retirement on the other. As much as one-quarter of our years is now spent in retirement; almost half as long as a typical worker will spend in the labor force. NIA encourages applications on research on the work and retirement decisions that people make at older ages and the health and economic circumstances of individuals as they evolve before retirement, at the time that work transitions take place, and throughout retirement. For more information, go to <http://grants.nih.gov/grants/guide/pa-files/PA-05-036.html>

The National Institute of Mental Health (NIMH) announced funding for projects addressing a functional assessment of people with mental disorders. Mental illnesses are characterized not only by symptoms, but also by impaired functioning in everyday context. The target of treatments for mental illnesses must extend beyond symptom improvement to functioning in social, occupational, and instrumental domains. The intent of this program announcement is to encourage research that applies methods and approaches from biobehavioral sciences to develop new and more useful definitions of and measures for functioning across multiple domains relevant to people with psychiatric disabilities. For more information, go to <http://grants.nih.gov/grants/guide/pa-files/PA-05-037.html>

Publications, Presentations and New Grants

Below is a partial list of publications, presentations and new grants by MIRECC investigators since May 2004. Please contact the primary author for more information about a particular paper, study or grant.

PUBLICATIONS:

Al Jurdi R, El-Serag H, Tabasi ST, Krishnan LL, **Kunik ME**: Diagnosis and treatment of depression in patients infected with Hepatitis C. *Resid Staff Physician*, 50(6), 19-24, June 2004.

Galovski T, **Lyons JA**: Psychological sequelae of combat violence: A review of the impact of PTSD on the veteran's family and possible interventions. *Aggression and Violent Behavior*, 9, 477-501, 2004.

Kibler JL, **Lyons JA**: Perceived coping ability mediates the relationships between PTSD severity and heart rate recovery in veterans. *Journal of Traumatic Stress*, 17, 23-29, 2004.

Kunik ME, **Cully JA**, **Snow AL**, Souchek J, **Sullivan G**, Ashton CM: Treatable comorbidities as predictors of VA health service utilization in dementia patients. *Psychiatric Services*, 56(1), 70-75, 2005.

Mashek D, **Sherman M**: Desiring less closeness with intimate others. In D Mashek & A Aron, (Eds.) *Handbook of Closeness and Intimacy* (pp. 343-356). Mahwah, NJ: Lawrence Erlbaum, 2004.

Rowan PJ, Abdul-Latif M, **Kunik ME**, El-Serag HB: Psychosocial factors are the most common contraindications for antiviral therapy at initial evaluation in veterans with chronic hepatitis C. *Journal of Clinical Gastroenterology*, 38(6), 530-534, 2004.

Sherman MD: A review of *New family interventions and associated research in psychiatric disorders*. *Community Mental Health Journal*, 40(5), 495-496, 2004.

Stein MB, Sherbourne CD, Craske MG, Means-Christensen A, Bystritsky A, Katon W, **Sullivan G**, Roy-Byrne PP: Quality of care for primary care patients with anxiety disorders. *American Journal of Psychiatry*, 161(12), 2230-2237, December 2004.

Valdes IH, Kibbe D, Tolleson G, **Kunik ME**, Petersen LA: Barriers to proliferation of electronic medical records. *Inform Primary Care* 12(1), 3-9, June 2004.

Vasterling JJ & Brewin CR (Eds): *Neuropsychology of PTSD: Biological, cognitive and clinical perspectives*. NY: Guilford. 2005.

Vasterling JJ, **Duke LM**, Tomlin H, Lowrey N, Kaplan E: Global-local visual processing in posttraumatic stress disorder. *Journal of the International Neuropsychological Society*, 10, 709-718, 2004.

Young AS, **Sullivan G**, Bogart LM, Koegel P, Kanouse DE: Needs for services reported by adults with severe mental illness and HIV. *Psychiatric Services*, 56, 99-101, January 2005.

GRANTS:

Stanley M (PI), **Kunik, ME** (Co-Investigator): *Treating late-life GAD in primary care*. National Institute of Mental Health, Grant No.IIR 01-53-932; 10/1/03-9/31/08, \$1,538,388.

Tan G (PI): *Treating spinal cord injury pain with cranial electrotherapy stimulation.* Veteran Administration Rehabilitation Research and Development Service; 1/05-12/07, \$648,600. This is a multi-site study that will include Chicago Hines VA, Cleveland VA, Birmingham VA, and MEDVAMC in Houston.

Tan G (PI): *Individualized marinol dosage for central neuropathic pain after spinal cord injury.* Paralyzed Veterans of America Research Foundation. \$67,018.

PRESENTATIONS:

Henderson KL, Hudson TJ: Increasing awareness of antipsychotic monitoring in a VA health care network. Poster presented at *American Psychiatric Association 56th Institute on Psychiatric Services*. Atlanta, GA, October 9, 2005.

Henderson KL, Hudson TJ: Network-wide dissemination of an antipsychotic monitoring protocol. Poster presented at the *VHA Best Practices in Network Mental Healthcare Systems Annual Meeting*, Boston, MA, June 25, 2004.

Hudson TJ, Henderson KL, Owen RR: Use of a performance measure to improve safety of antipsychotic medications. Poster presented at the *Complexities of Co-occurring Conditions Conference*, Washington, DC, June 23-25, 2004.

Manguo-Mire G, Lyons JA, Sautter FJ, Perry DM, Han X, Landis R, Sherman MD, Sullivan G: Caregiver burden and distress in partners of veterans with PTSD. Presented at the annual meeting of the *International Society for Traumatic Stress Studies*, New Orleans, LA. November 2004.

Martone L, **Henderson KL**, Bates J, Fort CA: Evolution of a network mental health outpatient provider workload reporting system. Poster presented at the *VHA Best Practices in Network Mental Healthcare Systems Annual Meeting*, Boston, MA, June 24, 2004.

Murphy RT (Chair): Implementation of motivation enhancement in treatment of war trauma. Symposium presented at the *Annual Meeting of the International Society for Traumatic Stress Studies*, New Orleans, LA, November 2004.

Murphy RT, Rainey Q, Murray M: Running a PTSD Motivation Enhancement Group for combat veterans. Workshop given at the *Annual Meeting of the International Society for Traumatic Stress Studies*, New Orleans, LA, November, 2004.

Murphy RT, Thompson KE: The PTSD Motivation Enhancement Group in a randomized control trial. Symposium presentation at the *Annual Meeting of the Association for the Advancement of Behavior Therapy*, New Orleans, LA, October, 2004.

Murphy RT, Thompson KE, Rainey Q, Murray M: Early results from an ongoing randomized trial of the PTSD ME Group. Poster presented at the *Annual Meeting of the International Society for Traumatic Stress Studies*, New Orleans, LA, November 2004.

Murphy RT, Thompson KE, Rainey Q, Murray M: The PTSD ME Group in a randomized trial: Methods and early results. Symposium presentation at the *Annual Meeting of the International Society for Traumatic Stress Studies*, New Orleans, LA, November 2004.

Sautter FJ, Sherman MD, Lyons JA, Perry DM, Manguno-Mire G, Roca V, Han X, Sullivan G: Predicting partner treatment engagement. Presented at the annual meeting of the *International Society for Traumatic Stress Studies*, New Orleans, LA, November 2004.

Sherman MD: Creation and implementation of a family intervention program in the VA system: The S.A.F.E. Program. Invited workshop at *VISN 5 MIRECC conference: Working with Families of the Mentally Ill: Meeting the Challenges and Reaping the Rewards*. Baltimore, Maryland, October 2004.

Valdes I, Kibbe D, Tolleson G, Kunik M, Petersen L: Metcalfe's law predicts reduced power of electronic medical record software. Poster presented at *American Medical Informatics Association (AMIA) Symposium*, Washington, DC, November 8-12, 2003.



February Conference Calls 1-800-767-1750

7—Education Core, 2:00 PM CT, access code 16821#
7—Schizophrenia Team, 3:00 PM CT, access code 20061#
8—Directors Call, 3:00 PM CT, access code 19356#
9—Neuroimaging Group, 9:00 AM CT, access code 24394#
15—Substance Abuse Team, General, 1:00 PM CT, access code 23400#
16—Program Assistants, 2:00 PM CT, access code 43593#
22—Directors Call, 3:00 PM CT, access code 19356#
28—PRECEP Call, 11:00 AM CT, access code 39004#
28—Disorder Team Leaders, 2:00 PM CT, access code 20143#



Happy Mardi Gras!



The next issue of the *South Central MIRECC Communiqué* will be published March 7, 2005. Deadline for submission of items to the March newsletter is February 25. Urgent items may be submitted for publication in the *Communiqué Newsflash* at any time. Email items to the Editor, Michael R. Kauth, Ph.D., at Michael.Kauth@med.va.gov or FAX to (504) 585-2954.

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

SC MIRECC intranet site: vaww.visn16.med.va.gov/mirecc.htm

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