

FORUM

VA HEALTH SERVICES RESEARCH & DEVELOPMENT

JUNE 2002

DIRECTOR'S LETTER

"Celebrating the Past, Shaping the Future" was the theme of this year's Health Services Research & Development Service (HSR&D) National Meeting held February 13-15 in Washington, DC. Hosted by HSR&D's Midwest Center for Health Services and Policy Research, the meeting celebrated 25 years of HSR&D funding, featuring a retrospective exhibit and video and several honored guests, including past HSR&D directors and VHA Chief Research and Development Officer John R. Feussner, M.D., M.P.H.

The national meeting brought together more than 550 researchers, clinicians, and policy makers who participated in presentations, paper sessions, workshops, and a poster and exhibit session. There were many highlights, such as Secretary for Veterans Affairs Anthony J. Principi's address, in which he emphasized VA's commitment to providing the best possible care. In addition, the prestigious Under Secretary's Award for Outstanding Achievement in Health Services Research was presented to Stephan Fihn, M.D., M.P.H.

I would be remiss if I did not acknowledge the sadness we feel about Dr. Feussner's retirement in August. Jack has had a dramatic impact on VA research as a whole, and on HSR&D in particular. Along with increasing resources for VA research, he focused HSR&D on integrating research into practice, while always emphasizing the need for measurable impact of our work. He will be moving to Charleston, SC, where he will become chair of the Department of Medicine of the Medical University of South Carolina.

All of HSR&D wishes Jack the very best in his future position.

John G. Demakis, M.D.
Director, HSR&D

COMMENTARY

Mental Health Care: Using Research to Inform "Best Practices" in the VA

By Frederic C. Blow, Ph.D., Serious Mental Illness Treatment Research and Evaluation Center and HSR&D Center of Excellence, Ann Arbor

Mental illness exacts enormous costs — both financial and human — on this country. The 1999 Surgeon General's report on mental health documents ample evidence of these costs. Approximately 28 percent of the U.S. population has a mental illness, but only 15 percent uses any mental health care services.

People with mental illness suffer in very real terms. Four of the 10 leading causes of disability in the U.S. are mental disorders: major depression, bipolar disorder, schizophrenia, and obsessive-compulsive disorder. Mental illnesses frequently strike more vulnerable members of our society. Post-traumatic stress disorder (PTSD), for example, is common among war veterans and victims of rape, mugging, domestic violence, terrorism, and natural disasters. Approximately 5.2 million Americans ages 18 to 54 — about 3.6 percent of people in this age group — have PTSD. Alzheimer's disease, the most common cause of dementia among people 65 and older, affects an estimated 4 million Americans. The duration of the illness from onset of symptoms to death averages eight to 10 years. Mental illness also plays a huge role in suicide: More than 90 percent of people who kill themselves have a diagnosable mental disorder.

This terrible level of human suffering also carries a huge price tag. In 1996, direct costs of mental

health care totaled \$69 billion. The indirect costs of mental health care were not measured at that time, but were later measured in 1990 totaling \$78.6 billion. Most indirect costs were due to disability, as opposed to mortality.

The care of veterans with mental illnesses is of great concern to the VA. According to the VA's North East Program Evaluation Center (NEPEC), in FY00 452,890 veterans had a service-connected psychiatric disorder and 677,519 veterans received some type of mental health treatment in the system. Total mental health care costs in the VA for FY00 exceeded \$1.5 billion.

Given the magnitude of the problem and the costs associated with it, mental health services research has become a priority for the VA. To help address this priority, the VA's Serious Mental Illness Treatment Research and Evaluation Center (SMITREC) has developed the ongoing National Psychosis Registry (NPR) to monitor the care of veterans with these debilitating conditions and provide information to help answer a variety of questions related to practice and policy. SMITREC reported that 192,982 patients with psychosis were treated in the system in FY00, with \$2.8 billion spent on their medical and mental health care combined.

In addition to their financial

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COMMENTARY

Commentary

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costs, mental illnesses carry high personal, family, and societal costs. All these costs underscore the importance to the VA of many issues, including: access to both medical and mental health care, the quality of mental health care, morbidity and mortality, migration in and out of the VHA system, the effectiveness of specialized intensive community-based programs for veterans with serious mental illnesses, psychosocial rehabilitation interventions, community-based care versus care in other settings (domiciliaries, residential care facilities, nursing homes), effective treatments for post-traumatic stress syndrome, appropriate care for veterans with depression, innovative approaches to treating substance abuse, optimal translation of mental health treatment guidelines, medication prescribing and adherence, treatment outcomes, and costs of care.

“Best Practice” Guidelines Improve Treatment

Results of studies on these and other pertinent issues provide “best practice” guidelines that affect policy and clinical care decisions for the population of veterans in need of mental health services. For example, a long-term mental health evaluation of three innovative care models at 14 VHA facilities has produced information about the functional status of veterans with serious mental illnesses (SMI) during and after treatment, and suggested best practices for treating such veterans. Studies of the cost-effectiveness of innovative, specialized treatment options for veterans with SMI have found that, in weighing both patient outcomes and costs, specialized outpatient-oriented treatment programs are a significant improvement over standard care, and have led to an emphasis on these outpatient treatment models.

Best practice guidelines have been developed for the treatment of veterans with schizophrenia and for the treatment of those with major depressive disorder. Recommendations center on issues of access to care; specialized treatments providing assistance for community-based living; the treatment of veterans with co-occurring disorders, such as mental illness and substance abuse; and the optimal use of psychoactive medications. These best practice guidelines are being augmented by work evaluating the treatment of aging veterans with SMI, use of antipsychotic medications and provider compliance with psychosis guidelines, use of community residential care facilities with these veterans, and care for veterans suffering from PTSD.

New guideline research is focusing on methods to provide optimal mental and physical health care to the large number of veterans with mental health disorders, including those with major depressive disorder, PTSD, substance abuse, and serious mental illnesses. Other research is exploring alternative approaches to care and methods to best address the needs of specific subgroups of veterans with psychosis, including minorities, women, and veterans with bipolar disorder.

QUERI Seeks To Improve Mental Health Care

As part of the VA’s mission to monitor, evaluate, and implement best practices, the Mental Health Quality Enhancement Research Initiative (QUERI) was established to translate innovative research into the real world of clinical practice. Among other projects, the Mental Health QUERI initiatives are studying the challenges in implementing mental health guidelines for the VA system, determining methods to integrate VA primary care and specialty care for veterans with major depression or substance abuse, and monitoring variations in practice for veterans

with major depressive disorder or schizophrenia.

For many years, HSR&D has sponsored research and evaluation studies to identify approaches that best meet the intense but varied needs of veterans with mental health disorders. Models of specialized treatment that effectively target the needs of these veterans are urgently needed to address the concerns highlighted by the Surgeon General’s report on mental health.

New guideline research is focusing on methods to provide optimal mental and physical health care to the large number of veterans with mental health disorders, including those with major depressive disorder, PTSD, and substance abuse.

More research is needed to answer key questions, including: What are the best methods to improve access to mental and physical health care for veterans with mental and substance use disorders? What programs will best assist in preventing morbidity and premature mortality in veterans with serious mental illnesses? What are the determinants of best practices that optimize the cost-effectiveness of mental health and substance abuse care? What strategies can be employed to better treat underserved populations, including women, minorities, and veterans with co-occurring mental and physical health disorders?

Answering these questions will provide critically needed treatment and policy information that can improve care for a particularly vulnerable population of veterans, those with mental and substance use disorders.

RESPONSE TO COMMENTARY

HSR&D Researchers Explore Links Between Mental Health Research and Clinical Care

*By Richard R. Owen, M.D., Director
HSR&D Center for Mental Healthcare and Outcomes Research*

Mental illnesses and their treatment are important areas for VA research. As Dr. Blow observes, these disorders are associated with impaired health-related quality of life, substantial disability, excess mortality, and high health care costs. There is good news, however, for veterans who suffer from these illnesses: Efficacious treatments have been developed involving psychopharmacologic, psychotherapeutic, and psychosocial approaches.

Evidence-based recommendations have been incorporated into VHA's clinical practice guidelines for major depressive disorder (MDD), psychotic disorders, and substance use disorders. The challenge for VA mental health care providers and managers in the next decade will be how to incorporate "best practices" for assessing and treating mental disorders into routine practice. HSR&D investigators are off to a great start, with projects examining mental health guideline implementation strategies and innovative models for delivering mental health services to primary care patients.

In addition, the Office of Research and Development funded two Quality Enhancement Research Initiative (QUERI) groups for mental health and substance use disorders, respectively. Mental Health QUERI focuses on both MDD and schizophrenia. The QUERI groups identify gaps in knowledge, recommend solicitations for projects to close these gaps, and work to translate research findings into clinical practice. The ultimate goal is to improve patient outcomes and health-related quality of life.

But how do we translate research findings? The word "translation" suggests a change in

language; perhaps some interpretation of research results will help clinicians understand how to apply findings to their own patient populations. However, translation involves much more than simple dissemination of results. Research has shown that multiple strategies targeted at key participants are needed to change clinical practice. These approaches need to go beyond standard educational methods, to remind and reinforce to providers and patients to "do the right thing" at "the right time." Moreover, organizational change may be necessary to promote translation. Ongoing monitoring and feedback of performance may be employed both for accountability and quality improvement.

The Substance Abuse QUERI group, with funding from QUERI's Service Directed Project (SDP) mechanism, is conducting a translation project aimed at increasing access to opioid agonist treatment and at implementing evidence-based practices for opioid agonist

therapy using facilitated quality improvement methods. Mental Health QUERI is using SDP funding to study the effectiveness of a multi-component quality improvement intervention to improve antipsychotic prescribing practices for schizophrenia. In addition, Lisa Rubenstein, M.D., M.S.P.H., is conducting a study of evidence-based quality improvement for implementing collaborative care for MDD in primary care settings.

These projects, with their emphasis on translating evidence-based practice into real-world clinical care, will likely have a major impact on the delivery of mental health and substance abuse services, as well as on patient outcomes and quality of life. They will also enrich a relatively new field, "translation science."

More research is needed — interested investigators can refer to the HSR&D web site at www.hsr.d.research.va.gov/ for ongoing HSR&D and QUERI solicitations.

Under Secretary's Award for Health Services Research Presented to Stephan Fihn

Stephan D. Fihn, M.D., M.P.H., director of the highly successful Northwest VA HSR&D Center for Outcomes Research in Older Adults, has received the Under Secretary's Award for Outstanding Achievement in Health Services Research. Acting Under Secretary for Health Frances Murphy, M.D., presented the award at the 20th HSR&D National Meeting, held Feb. 13-15 in Washington, DC.



Dr. Fihn also heads the University of Washington's Division of General Internal Medicine and is the research coordinator for the Ischemic Heart Disease (IHD) QUERI group that works to improve the care and outcomes of veterans with IHD. In addition, Dr. Fihn leads the Seattle VA's HSR Fellowship Program and has mentored numerous VA fellows and Career Development awardees.

ORGANIZATIONAL PROFILE

CeMHOR Investigates Ways to Improve Veterans' Mental Health and Care

*By Richard R. Owen, M.D., Director
HSR&D Center for Mental Healthcare and Outcomes Research*

CeMHOR, the Center for Mental Healthcare and Outcomes Research, has as its mission the development, implementation, and dissemination of policy-relevant health services research that will improve the mental health and care of veterans. Its goals are to:

- Examine variations in service delivery to identify best practices and policies.
- Develop and test innovations to enhance the quality, outcomes, and value of patient care within complex health care systems.
- Promote and effect the translation of research discoveries, and innovations into routine practice.
- Increase capacity in the mental health services research field through training, recruitment, and collaboration.

CeMHOR was founded in 1990 as an HSR&D Field Program. Today it is an HSR&D Center of Excellence housed at the North Little Rock campus of the Central Arkansas Veterans Healthcare System and a collaborative effort with the University of Arkansas for Medical Sciences (UAMS). CeMHOR investigators contribute to knowledge on mental health treatment, outcomes, and stakeholder issues through research projects funded by VA and non-VA sources. The investigators collaborate and hold dual positions with UAMS and VA entities, including the South Central Mental Illness, Research, and Education Clinical Center (MIRECC).

In CeMHOR's first year, researchers started developing disease-specific outcome measures, prepared proposals for schizophrenia and substance abuse outcome modules, studied cost-effectiveness of VA alcohol treatments, and undertook

pilot work with the hospital's post-traumatic stress disorder treatment units. The budget was \$1.3 million (\$390,863 in HSR&D funding and \$785,076 from other sources). G. Richard Smith, Jr., M.D., was director and founder, with five research health scientists. A non-VA funded project that year brought financial support from the National Institutes of Mental Health (NIMH) to establish the Center for Rural Mental Health Care Research at UAMS.

CeMHOR continues to grow and expand, pursuing research aimed at improving access to care, quality of care, and outcomes of care for veterans with prevalent and serious mental disorders. In 2001, CeMHOR's 13 core investigators received almost \$5.5 million in funding (30 percent from the VA) for 27 projects. The Center's total budget was \$6.3 million.

The Work of the Mental Health QUERI

Since 1998, CeMHOR has been the headquarters for the Mental Health QUERI, one of eight HSR&D groups nationwide that target high-risk conditions prevalent among veterans. MH QUERI's goal is to improve the quality of care and health outcomes of veterans with major depressive disorder (MDD) and schizophrenia. These two disorders were chosen because of their prevalence, significant impact on the lives of patients, and the substantial cost to society. In addition, gaps between known best practices and usual clinical care are significant. Despite the availability of efficacious treatments for both disorders, individuals with MDD or

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AHRQ Director John Eisenberg, M.D., Dies

VA mourns the loss of John Eisenberg, M.D., who died March 10 at age 55. Dr. Eisenberg served as director of the Department of Health and Human Services (HHS) Agency for Healthcare Research and Quality (AHRQ) since 1997. A former president of both the Association for Health Services Research and the Society of General Internal Medicine, Dr. Eisenberg also served five years at Georgetown University, where he was chairman of the department of medicine and physician-in-chief.



As head of AHRQ, Dr. Eisenberg played a key role in government efforts to use health services research to reduce medical errors, improve patient safety, and enhance the effectiveness of health care services while containing costs and expanding access to care. While leading AHRQ, Dr. Eisenberg also served as the senior adviser to the HHS secretary and as principal deputy assistant secretary for health.

Dr. Eisenberg was founding commissioner and past chairman of the Congressional Physician Payment Review Commission and was elected to the Institute of Medicine. The author of more than 275 articles, he wrote the book *Doctors' Decisions and the Cost of Medical Care*.

Dr. Eisenberg was a 1968 magna cum laude graduate of Princeton University and of Washington University's medical school in St. Louis.

DIALOGUE

Treating Depression in Primary Care Settings: No Simple Guarantee for Success

By Joann E. Kirchner, M.D., *HSR&D Career Development Awardee*
HSR&D Center for Mental Healthcare and Outcomes Research

Q. *What is the best way to integrate care for depression in primary care settings?*

— James J. Nocks, M.D., of
*Veterans Integrated Service
Network 5*

A. The easy answer to this question is that there is no *best way*. Rather, key elements must be considered before attempting integration to ensure a stable integration model.

Depression, frequently unrecognized and untreated, is the most common, persistent, and reoccurring mental health disorder afflicting primary care patients. Fewer than half of individuals with major depression seek professional help for their disorder, and, of those that do, most seek treatment from a primary care provider rather than from a mental health specialist.

A great deal of professional and research interest has focused recently on integrating mental health into primary care clinics and settings. Integrated primary care has been defined as “a service that combines medical and behavioral health services to more fully address the spectrum of problems that patients bring to their primary medical care providers. It allows patients to feel that, for almost any problem, they have come to the right place.”

Integrating mental health and substance abuse services into primary care may improve management, communication, and patient outcomes and help hold costs down. For patients, the benefits of integrated care may include early identification of mental health or substance abuse disorders, improved health status, relapse prevention, easier access to care, enhanced adherence, reduced stigma, and better continuity of care.

There are several potentially effective models for integrating mental health and substance abuse services in primary care settings, mostly for depression. These include consultation and case management models. With consultation models, mental health professionals provide specialty services within the primary care setting. Case management models designate primary care staff to coordinate patient care for mental health problems. Implementation of these types of models has improved the quality of depression treatment, outcomes, and patient satisfaction.

Within the VHA, interest in integrating mental health services with primary care has accompanied VHA’s transformation from a primarily inpatient, hospital-based institution into a more efficient, primary care-based health care system. As part of this process, community-based outpatient clinics (CBOCs) have been established as one way to provide health care to veterans living in rural areas. Integrating mental health and substance abuse services in rural primary care settings may help improve access to care, but few definitive answers or solutions have been offered regarding what might work best in routine settings.

Although many health care systems have been experimenting with integrated approaches, the knowledge base in many ways is still in its infancy. To date, the research and professional literature addressing barriers to integrating mental health services in primary care has shown that lack of space, differences in professional orientation (culture clash), and administrative issues are inherent challenges. Simply adding mental health care to an already overburdened primary health care service

is likely to be met with negative attitudes by service providers.

In addition, there are unique issues and challenges to integrating mental health services in rural primary care settings, such as a lack of qualified providers or services, patient resistance to seeking mental health care because of stigma, or provider awareness of the importance of treating mental health problems.

Several factors facilitate the integration of mental health services within primary care settings, including:

- Teamwork, particularly across disciplines.
- Infrastructure and systems that support collaboration among mental health and primary care providers, such as physical proximity, joint medical records, and patient care protocols.
- Long-term commitment by staff to improving service quality.
- Multidisciplinary training to educate providers.

A “one-size-fits-all” approach will not work. Even VHA’s primary care clinics operate within heterogeneous communities where patients’ preferences, workforce issues, and the availability of non-VA resources all differ.

In summary, integrating mental health and substance abuse treatment services into primary care settings is not simple, but it can be done. To succeed, system administrators and providers must know the needs and organizational structure of their clinics, engage clinic staff and assess the fit of the model they develop with the culture of their patients’ communities and the available community resources.

R ESEARCH HIGHLIGHTS

HSR&D Studies Explore Ways to Improve Depression Treatment in Primary Care Settings

Depression is the second most prevalent medical condition in VA and has an impact on function and quality of life that is worse than that of many other chronic physical conditions. Although there are effective treatments for this disorder, significant gaps remain between best practices and routine care.

HSR&D funds a number of studies exploring ways to improve depression treatment, as well as treatment outcomes for VA patients. Following are summaries of three of those studies.

Collaborative Care Improves Depression Outcomes

This study of depression treatment adapted a successful collaborative care model for managing chronic illness in non-VA managed care settings to the VA primary care setting and compared this approach with traditional consult-liaison treatment.

In collaborative care, a mental health specialist team consisting of a psychiatrist, psychologists, and social workers developed a treatment plan based on the initial assessment and provided the plan to the primary care provider. Primary care provider efforts were reinforced by patient education materials and brief social work phone calls to support patient adherence, address treatment barriers, and monitor symptoms. Treatment results were systematically reviewed and suggestions for treatment modification were fed back to the primary providers. In the traditional consult-liaison model, primary care providers were informed of the diagnosis and the study clinicians facilitated referrals to psychiatry residents in the primary care clinic as requested.

Collaborative care resulted in significantly greater improvement in depressive symptoms and psy-

chosocial function than the more traditional consult-liaison treatment. Collaborative care also significantly increased the proportion of patients given prescriptions and engaging in cognitive behavioral therapy. Collaborative care also resulted in fewer mental health treatment visits and only slightly more total primary care visits (8.9 versus 8.5 per patient per year) than in consult-liaison usual care.

As more chronic conditions are treated in the primary care setting, using this model may improve patient outcomes. If the collaborative care model continues to demonstrate improved patient outcomes at reasonable cost, its potential impact on care and outcomes for depression and other chronic conditions could be great.

Team-Based Quality Improvement for Veterans with Depression

Primary care practices are searching for effective ways to improve quality of care for depression.

Team-based quality improvement (QI) methods, such as continuous quality improvement, are attractive options. These methods place a high value on having the health care organization's own health care professionals and staff participate in QI design and implementation. But clinical QI for complex problems such as depression requires substantial technical knowledge and resources. Thus, in practice, health care organizations often turn to experts to design QI interventions.

Investigators from the VA Center for the Study of Healthcare Provider Behavior, an HSR&D Center of Excellence, participated in an important new study that set out to assess the impacts of QI teams and their environments on team success in designing and implementing high-quality depression care improvement programs in primary care practices. In particular, this study compares how local clinician participation in QI pro-

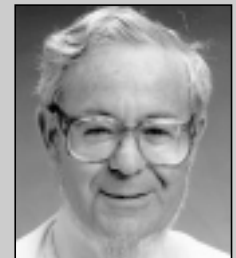
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Rudolf Moos Steps Down as CHCE Director

Rudolf Moos, Ph.D., stepped down this year as director of the HSR&D Center for Health Care Evaluation (CHCE) in Palo Alto, CA, a position he held since the Center was established in 1985.

Dr. Moos led the CHCE in its mission to conduct and disseminate health services research that results in more effective and cost-effective care for veterans. He also served as co-chair of the Executive Committee for the Quality Enhancement Research Initiative's Substance Abuse Module (QSAM) from its inception in 1998 through 2000.

Dr. Moos retains his position as an HSR&D senior research career scientist, and will continue his exemplary work as an HSR&D investigator, including his involvement with QSAM. He will also pursue his interests in areas such as the process and outcome of substance abuse and psychiatric care; the influence of life stressors, social resources, and coping on health and well-being; and the impact of health care work environments on the quality of care.



Research Highlights

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gram design versus delegating design to regional experts affects the quality of intervention programs for depression in primary care. The investigators also identified other characteristics of QI teams and their organizational environments that predict implementation of a high-quality, enduring depression intervention program.

Over the last decade, health care organizations in the U.S. have used team-based QI methods to address specific quality-of-care problems. Better understanding of how QI teams function and of how to structure these teams to promote their success can promote evidence-based models for improving depression care in primary care practices.

Results from this important study will be published later this year.

Treating Depression in Patients with PTSD

Post-traumatic stress disorder (PTSD) is a serious mental health problem among both male and female veterans. Patients with PTSD often have co-morbid illnesses, most commonly alcohol or substance abuse disorders, anxiety disorders, personality disorders, major affective disorders, and depression. The 40 percent of veterans with PTSD and concurrent, clinically significant depression are particularly difficult to treat. In addition, well-validated treatments of PTSD and its complications are rare.

Male veterans suffering from both depression and combat-related PTSD and female veterans with depression and trauma related to sexual assault participated in an HSR&D study. This ongoing study is the first to evaluate the impact of two psychosocial interventions on clinical outcomes and the use of hospital resources by veterans

with these co-existing disorders. Veterans in the study were randomly assigned to either self-management therapy (SMT), a cognitive-behavioral treatment program for depression, or to a psychoeducational group therapy (PGT). Both programs involved short-term, 14-week group therapies designed to teach veterans about their disorders and to provide new strategies and skills for overcoming the disorders.

Preliminary findings show that nearly 80 percent of the male veter-

ans in the study completed the therapy regimen, and felt that the course of therapy was beneficial and clear. Preliminary results on standardized measures indicated a significant improvement in depression in the SMT condition only and a significant difference between the conditions at post-test. Therapy appears to be less effective for severely depressed veterans. Female veterans have completed therapy and their assessments will be available soon.

John Feussner, M.D., M.P.H., Retires From VA

John R. Feussner, M.D., M.P.H., VA's Chief Research and Development Officer, recently announced his retirement from VA. Dr. Feussner has held this position since 1996 and has been a strong leader and advocate of VA research. In August, he will leave VA to become chair of the Department of Medicine at the Medical University of South Carolina in Charleston.



In a VA career that spanned more than 25 years, Dr. Feussner held a number of important roles and made many contributions to veteran health care. Notably, he served as director of the Center for Health Services Research in Primary Care in Durham, NC (1983-1996). His academic appointments include serving as a professor of medicine at Duke University and as chief of the Division of General Internal Medicine at Duke University Medical Center (1988-1996).

Dr. Feussner has received continuous funding for research since 1982 and is the author of numerous publications. He has received a number of prestigious awards, including the 2001 John D. Chase Award from AMSUS (American Military Surgeons of the United States), an award for Sustained Excellence in Executive Leadership. Most recently, he became the second recipient of the John Eisenberg National Award for Career Achievement in Research in General Medicine, presented at the 25th annual meeting of the Society of General Internal Medicine this year.

During his tenure as Chief Research and Development Officer, Dr. Feussner worked diligently with VA leadership to provide the highest quality, most cost-effective and efficient health care for veterans. A strong advocate for patient-centered care and evidence-based medicine, he oversaw research in biomedicine, rehabilitation, health services, and clinical trials. Together with then Under Secretary for Health, Kenneth Kizer, M.D., he developed the concept of VA's Quality Enhancement Research Initiative (QUERI), a nationally recognized program that focuses on translating research findings into practice. His dedication to keeping VA at the forefront of science and medicine led to a renewed concentration on the discovery of new knowledge that advances the health and care of veterans and the nation.

HSR&D thanks Dr. Feussner for his contributions to VA research and congratulates him on his achievements, with best wishes for continued success in all his future endeavors.

CeMHOR

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schizophrenia often receive less than effective care.

MH QUERI hopes to make an impact on quality of care for veterans with these two disorders through the translation of research knowledge into clinical and organizational practice. Research focuses on closing gaps in the knowledge of best treatment practices and developing effective strategies to implement clinical guidelines. These efforts center on two translation initiatives: increasing the appropriate use of antipsychotics and incorporating—into routine VA practice settings—the collaborative care model for treating depression in primary care.

Research shows that prescribing rates vary for the newer antipsychotic agents (such as risperidone, olanzapine, and quetiapine) and for clozapine, reserved for treating refractory patients. Moreover, both traditional and newer antipsychotics are often prescribed at doses outside guideline-recommended ranges.

MH QUERI’s translation goal is to increase the guideline-concordant use of antipsychotics, switch refractory patients (when appropriate) to newer medications, and reduce the frequency of antipsychotic prescribing outside guideline-recommended dose ranges. The translation

effort has included a multi-site demonstration project in one VISN that demonstrates the effectiveness of an intensive implementation strategy. This strategy was effective at decreasing the proportion of patients who are prescribed very high doses. MH QUERI plans to disseminate its materials and programs and to expand this translation effort to include improving the use of clozapine and side effect management.

The goal of the collaborative care model project, headed by Lisa Rubenstein, M.D., is to translate, across multiple VISNs, a previously tested model for improving the quality of depression care. The team of researchers is conducting a process evaluation of evidence-based quality improvement, a dissemination method that relies on expert design and local implementation.

Other Research at CeMHOR

Here is a sampling of other CeMHOR research initiatives currently under way:

- Integrating primary and mental health care for alcohol disorders and depression, and evaluating an intervention to provide mental health and substance use services in VA community-based outpatient clinics (CBOCs).
- Studying stakeholder perspectives on sustaining involvement in schizophrenia care, looking at what

factors influence or motivate people with schizophrenia to seek treatment and stay in long-term care.

- Examining how a shift from inpatient to outpatient treatment has affected the care of veterans diagnosed with psychotic disorders (with Frederic C. Blow, Ph.D., Ann Arbor, principal investigator).

For more information, please visit <http://vaww.va.gov/cemhor/>, or contact Dr. Owen: phone 501/257-1710; fax 501/257-1707; e-mail Richard.Owen2@med.va.gov.

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