Promoting equity in engagement, access, and quality of mental health care for Veterans facing barriers to care, especially rural Veterans

www.mirecc.va.gov/visn16

November 2012 Vol 14, Issue 11

Communiqué

In This Issue

Interview with Dan Winstead	p. 1
Meet the SC MIRECC Researcher	p. 1
Message from the SC MIRECC Director	p. 3
FY2013 Off-Cycle Call for Clinical Educator Grant Applications	p. 6

South Central MIRECC Anchor Sites:

LITTLE ROCK
HOUSTON
NEW ORLEANS
OKLAHOMA CITY

Greer Sullivan, M.D., M.S.P.H.
Director

Michael R. Kauth, Ph.D.
Co-Director and Associate Director for Education

John Fortney, Ph.D.
Associate Director for Research

Mark Kunik, M.D., M.P.H.
Associate Director for Research Training

Patricia Dubbert, Ph.D.
Associate Director for Improving Clinical Care

Interview with Dan Winstead, M.D.
Chair, Tulane University Department of Psychiatry

Q. You have a distinguished career in psychiatry that has been the work of about forty years. How has your career evolved during this time?

I guess I always knew that I wanted to be involved in academics and academic administration after my stint in the Army as a psychiatrist (Major, Medical Corp). In 1976, I came to New Orleans as Chief of Psychiatry at the New Orleans VA medical center and Assistant Professor at Tulane, thanks to Bob Heath. Perhaps the most important change that I made was to start a separate psychiatry consult/liaison service that was then used for teaching the Tulane residents in psychiatry. Three years later, I accepted the position of Associate Chief of Staff for Education at the medical center with additional teaching responsibility at Charity Hospital for Tulane. During this time, a gifted social worker in the department, Susan Willard, wanted to start an Eating Disorders Clinic at Tulane. I got involved in supervising various trainees in the clinic and seeing some of the patients for medication management. Throughout this time, the VA was supporting my research with Barry Schwartz, Ph.D. as we were studying the deficits in information processing in schizophrenia. This support,

See WINSTEAD on page 2

Meet the SC MIRECC Researcher

John Crilly, Ph.D., M.P.H., M.S.W.
SC MIRECC, Tulane University Department of Psychiatry

Q. What is your area of interest in mental health research or clinical practice?

My main area of interest is health information technology (HIT) as it applies to mental health and difficult-to-reach populations. This includes electronic communication, electronic health records (EHR), health information exchange (HIE), and the Internet. Target populations include high-risk individuals (e.g., at risk for suicide) and individuals isolated in some way (e.g., rural). I do this by being involved in conventional research projects and innovation (similar to research and development).

See CRILLY on page 4

WINSTEAD (continued from page 1)

and the various courses that the VA sent me to, greatly enhanced my academic credentials and career.

I have been the Chair of the Department of Psychiatry at Tulane since 1987. Over the years, I have successfully rebuilt the department financially and academically while continuing to arrange contract work with the State to grow teaching and training in clinical care. I have a great senior leadership team with Charley Zeanah, M.D., John Thompson and Pat O'Neill and great senior leadership staff with Candy Legeai and Jim Landry.

Throughout my career, I have served on the Residency Review Committee for Psychiatry, on the American Board of Psychiatry and Neurology (ABPN), and on various committees for the American Psychiatric Association and the American College of Psychiatry. This led to leadership positions in these organizations and the opportunity to make contributions on a different level. I also served as the Medical Director for the State Hospital in Jackson, LA, which lead to our forensic division.

I am now interested in leadership development, mentorship and how to predict or measure success along the way. I have announced that I intend to step down as the Chair on June 30, 2013. I plan to remain at Tulane and do some research with the ABPN and the College. Hopefully, this will keep me busy enough that I don't drive my wife, and others, crazy!

Q. What have you enjoyed the most about your work?

I enjoy working with people, developing new programs and seeing our trainees succeed. We have developed a directory of our alumni, send out a newsletter twice per year, and encourage them to come to our continuing medical education programs.

Q. What are your proudest accomplishments?

I have enjoyed building the Department. Unfortunately, Hurricane Katrina gave me the opportunity to do it all over again!

Q. What have been the biggest changes in psychiatry during your career?

Psychiatry has moved toward a neuroscience base while (hopefully) maintaining a psychosocial and cultural framework for understanding the diseases of our patients. The other change has been the managed care movement along with the electronic medical record. These changes have not been very well received by my psychiatric colleagues, but I believe they are here to stay.

Q. You have been a valued stakeholder of the VA and the SC MIRECC for many years. Please tell us a little about your work with the SC MIRECC during this time.

I have been on the SC MIRECC External Advisory Board and have enjoyed the wisdom of the other members, especially Dr. Greer Sullivan. Dr. Sullivan has served as a research consultant to our department and she has been most helpful. In turn, I have always tried to support researchers at the VA when help was needed. We have provided space, computer equipment and IT support, as well as part-time or temporary personnel support.

Q. You are known for enjoying good food. What are your three favorite restaurants in New Orleans and why?

Now that's a tough question. I would have to say Galatoire's, Emeril's, and Commander's Palace. Now my mouth is watering. Although it's time for lunch, I'll head to the Tulane University Hospital & Clinic cafeteria, which isn't bad, but wouldn't make the top 20 or 30 even!

Patient Centered Outcomes Research Institute (PCORI)

The Patient Centered Outcomes Research Institute (PCORI) is a new non-profit, Washington-based research initiative funded through the Affordable Care Act. PCORI's goal is to make health care information available to the public and to providers so that they can make informed health care decisions. PCORI is guided by a Board of Governors that represents many areas of U.S. health care, including persons from the health care industry, academics, and leaders from a range of health care disciplines. Dr. Grayson Norquist, Chair of Psychiatry at the University of Mississippi School of Medicine and longstanding member of the SC MIRECC External Advisory Board, is the only psychiatrist on the PCORI Board of Governors.

To promote a new vision of health care, PCORI is pushing the research envelope in a way it has never been pushed before. The main thrust of PCORI is the inclusion of "end users" in the development and conduct of research. End users may include patients, providers, and communities. This seems especially timely since we know that many of the interventions developed in academic centers are not necessarily "user-friendly," may not be used widely, and, even when implemented in systems of care, may not be sustained over time in the "real world." PCORI is requiring investigators to interact and partner with end users very early in the research process with the goal of producing research that has an impact on care. To some extent, the PCORI approach is similar to that of the VA Quality Enhancement Research Initiative (QUERI) program and the new push in VA Health Services Research & Development (HSR&D) to promote greater involvement of partners from VA administration and clinical services. Again, the common goal across these VA programs and PCORI is to produce more relevant research that can improve care.

The SC MIRECC was fortunate to obtain one of 50 initial PCORI pilot awards. With PCORI support, we are studying the process and outcomes of obtaining information from African American community members in the Arkansas Delta region. We will compare the traditional research approach to obtaining such information (focus groups) to a new approach being used by many community-based organizations: community "deliberative democracy" forums. The SC MIRECC affiliated investigators on this project include myself, Geoff Curran, Ph.D., Tiffany Haynes, Ph.D., and Ann Cheney, Ph.D. Our community partner is Tri-County Rural Health Network, led by Naomi Cottoms, M.A., and based in the Arkansas Delta. This year Ms. Cottoms received the Jocelyn Elders Award from the Arkansas Minority Health Commission and the Community Health Leaders Award from the Robert Wood Johnson Foundation for her exemplary work in improving healthcare in the Delta. We are delighted to be partnering with Tri-County.

I strongly encourage SC MIRECC investigators to learn more about PCORI at its website: www.pcori.org. Responding to PCORI requests for proposals may push your thinking in new directions, as it did mine. PCORI is truly an exciting, even revolutionary, new initiative.

Greer Sullivan, M.D., MSPH
South Central MIRECC Director

CRILLY (continued from page 1)

Q. How did you get started in this area of research?

Several years ago, I led a team to write the first mental health-oriented health information exchange grant application, pulling together a group of New York State medical centers and the New York State Office of Mental Health. This application was the result of my work to link municipal and county datasets (jail, social services, mental health services, probation, etc.) to use the data to streamline services for people with mental disorders. Developing a health information exchange platform that could eventually host this kind of data linkage would be ideal. We didn't get the grant, but it launched me into this area of research and I got to know some very smart people in the health information technology world. I then became involved in evaluating electronic health record systems for a large medical center, first for psychiatry and then for the pharmacy. I realized that understanding the mechanics of complex systems and how they interact with large corporate data warehouses allowed me to appreciate how important it is for research involving health information technology to be practical and directly relevant. If it weren't, it would only be of limited value. The field moves ahead so fast!

Q. What person or experience had the most influence on your research career?

Lots of experiences and people, of course, but for the VA it has been the fun of innovating. My work with innovation started when I was asked to take the lead to develop a chat line that would operate alongside the Suicide Prevention Hotline (now Crisis Chat). At the time, it had never been done before and we had no previous models to draw from. Since users would be in crisis, it was very important to ensure safety, quality, and positive outcomes from effective interventions that occurred only via typed text. We also had to build it in a way that was acceptable internally, anonymous, and consistent. I had a great team of people to work with and after months of design, testing, prototypes, and training, it was launched. At that point, it was taken up by another great team, but my intent was to eventually use the data for research around this novel approach. I try to get in on the ground floor of evolving technologies such as Chat or the New York State Health Information Exchange project, make them practical and usable, and then look at outcomes.

Q. What active studies or projects do you have?

I am involved in some research projects evaluating forms of contact with people on the suicide high-risk list and other types of patient engagement projects with wonderful collaborators in Baton Rouge, New Orleans, and VISN 2. But the project I am most interested in is the result of a VA innovation grant-funded project we completed last year. We built a prototype of a patient decision support tool using data from Veterans Health Information Systems and Technology Architecture (VistA), called Outcomes-Based Prescribing. The purpose of the prototype is to help patients search for clinical outcome information from similar patients taking medications they are considering. This would support patients' decision process. This work won a 2012 Top Government Innovation award for the VA.

Q. What are the implications or potential benefits of your research?

It is important to me that the things I work on have a clear path to being implemented, which allows further research and development. The Crisis Chat was one such product and Outcomes-Based Prescribing is another. If development is done properly and thoughtfully, these products can take off without a hitch, which really makes research later happen very smoothly. We are now seeking funding for the next stage of development of Outcomes-Based Prescribing. Both products directly increase engagement with patients and can affect patient outcomes.

Q. Anything else you want our readers to know about you?

As part of a community agency I work with, I co-lead a team that has successfully developed innovative methods to use the Asian Carp commercially. This work has created jobs in the New Orleans area.

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

The best and most stable way is good old-fashioned email: John.Crilly@va.gov.

Recent SC MIRECC Publications

PSYCHOLOGICAL TRAUMAS OF WAR: TRAINING SCHOOL COUNSELORS AS HOME-FRONT RESPONDERS

Waliski A, Kirchner JE, Shue VM, Bokony PA

Journal of Rural Health, 2012, 28(4), 348-55.

With nearly 3 million US troops having deployed for Operations Enduring Freedom, Iraqi Freedom, and New Dawn (OEF/OIF/OND) since the conflicts began, an estimated 2 million children have been separated from a parent. This manuscript describes a collaborative project between a state's Veterans Healthcare System, a branch of the American Counseling Association, and a medical university on the OEF/OIF/OND deployment experience. Methods: The project sought to educate school counselors about experiences of OEF/OIF/OND families and learn from their observations as home-front responders in public schools during a 2-day summer workshop. This manuscript describes the framework of the workshop, pre/post evaluation results, and implications for counselors, educators, and supervisors. Findings: School counselors identified childcare and parenting, emotions and behaviors, finances, and barriers to counseling services as challenges for military children and families. Following the workshop, school counselors reported a greater knowledge concerning understanding aspects of outreach for schools and communities in working with Veterans and their families. They also reported a better understanding of the impact of war on military families and knowledge of local and state resources for this population. Specifically, attendees felt they could better identify issues and needs of OEF/OIF/OND families with young children, recommend parenting skills to assist these families, and recognize their psychiatric or medical issues. Conclusion: In addressing the mental health disparities of military children experiencing combat-related parental separation, it is important to identify protective environments that could provide prevention interventions for this population. Collaboration between the Department of Defense, Department of Veterans Affairs (VA), and Department of Education could help support military families and a society facing continued conflicts abroad.

A RANDOMIZED CONTROLLED TRIAL OF TELEPHONE-DELIVERED COGNITIVE-BEHAVIORAL THERAPY FOR LATE-LIFE ANXIETY DISORDERS.

Brenes GA, Miller ME, Williamson JD, McCall WV, Knudson M, **Stanley MA**

American Journal of Geriatric Psychiatry, 2012, 20(8), 707-16

Older adults face a number of barriers to receiving psychotherapy, such as a lack of transportation and access to providers. One way to overcome such barriers is to provide treatment by telephone. The purpose of this study was to examine the effects of cognitive behavioral therapy delivered by telephone (CBT-T) to older adults diagnosed with an anxiety disorder. The study was a randomized controlled trial set in participants' homes. Participants (N=60) were age 60 and older with a diagnosis of generalized anxiety disorder, panic disorder, or anxiety disorder not otherwise specified. The intervention was CBT-T versus information-only comparison. Co-primary outcomes included worry

continued on page 6

ATTRIBUTION: ACKNOWLEDGEMENT OF MIRECC RESEARCH SUPPORT/EMPLOYMENT

SC MIRECC researchers and educators have a responsibility to ensure that the SC MIRECC receives proper credit for SC MIRECC-supported studies or projects in articles, presentations, interviews, and other professional activities in which the results of those projects are publicized or recognized. All investigators should credit the SC MIRECC if they receive either direct or indirect support from the SC MIRECC. For example, "This work was supported in part by the VA South Central (VISN 16) Mental Illness Research, Education, and Clinical Center." If you receive salary support from the SC MIRECC, you should list the SC MIRECC as an affiliation.

continued from page 5

(Penn State Worry Questionnaire) and general anxiety (State Trait Anxiety Inventory). Secondary outcomes included clinician-rated anxiety (Hamilton Anxiety Rating Scale), anxiety sensitivity (Anxiety Sensitivity Index), depressive symptoms (Beck Depression Inventory), quality of life (SF-36), and sleep (Insomnia Severity Index). Assessments were completed prior to randomization, immediately upon completion of treatment, and 6 months after completing treatment.

Results showed that CBT-T was superior to information-only in reducing general anxiety (ES = 0.71), worry (ES = 0.61), anxiety sensitivity (ES = 0.85), and insomnia (ES = 0.82) at the posttreatment assessment; however, only the reductions in worry were maintained by the 6-month follow-up assessment (ES = 0.80). These results suggest that CBT-T may be efficacious in reducing anxiety and worry in older adults, but additional sessions may be needed to maintain these effects.

Fiscal Year 2013 Off-Cycle Clinical Educator Grants Call for Applications

The South Central MIRECC will accept off-cycle fiscal year 2013 Clinical Educator Grant proposals until November 30. These grants of up to $10,000 (for projects involving multiple facilities) support development of innovative, unique clinical education tools for quality Veterans' health care that can be exported to other facilities. Funded projects must also support the mission of the South Central MIRECC: *"To promote equity in engagement, access, and quality of mental health care for Veterans facing barriers to care, especially rural Veterans."*

Grants are typically used to deliver existing educational content in a new way or to pilot a new educational intervention. We strongly encourage people with a good idea to talk to their SC MIRECC site leader (Little Rock: Jeffrey.Pyne@va.gov, Houston: Melinda.Stanley@va.gov, New Orleans: Joseph.Constans@va.gov, or Oklahoma City: Thomas.Teasdale@va.gov) or Dr. Geri Adler (Geri.Adler@va.gov) about how to develop the idea into a fundable submission. The caveat for off-cycle grants is that funding is limited to one fiscal year and, whenever awarded, must be spent by mid-September 2013.

- Download Application at http://www.mirecc.va.gov/VISN16/docs/CEGApplication2013.pdf.
- Download Example Application 1 at http://www.mirecc.va.gov/VISN16/docs/Sample_application_I.pdf.
- Download Example Application 2 at http://www.mirecc.va.gov/VISN16/docs/Sample_application_II.pdf. ♦

Published by the South Central MIRECC
Editor: Ashley McDaniel, M.A., E-mail: Ashley.McDaniel@va.gov
Reviewer: Carrie Edlund, M.S., M.A.
South Central MIRECC Internet Site: www.mirecc.va.gov/visn16
National MIRECC Internet Site: www.mirecc.va.gov

VA HEALTH CARE | Defining EXCELLENCE in the 21st Century