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Session: Colorado Afterhours Rural Mental Health Quality Improvement Program Pilot: Lessons for Increasing National VA MH Access

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Molly: Hello, we’d like to introduce our speakers for today. We have Dr. Comilla Sasson. She’s from the VA Eastern Colorado Health Care System and is part of emergency medicine and part of the American Heart Association. Joining her today is Rachel Johnson. She’s also part of the VA Eastern Colorado Health Care System and the Denver and Seattle Center of Innovation. She is also part of the University of Colorado College of Nursing. So I’d like to thank our presenters for joining us today and at this time, Comilla, I will turn it over to you.

Dr. Comilla Sasson: I am an emergency medicine physician and I’m very happy to be able to introduce my partner in crime, if you will, Rachel Johnson, who is our program manager for the Colorado Afterhours Rural Mental Health Program as well, who is also a social work researcher and PhD student, college for nursing. And I will, also would like to introduce one of our national partners, Johathan Hartsell, who is also joining us for this call as well. Jonathan, do you want to go ahead and introduce yourself?

Jonathan Hartsell: Sure. My name is Jonathan Hartsell. I’m a licensed clinical social worker, and beginning in October, I became the Suicide Prevention Clinical Officer for the Veterans Crisis Line. Before that, I was a suicide prevention coordinator/supervisor at the Mountain Home VA in Northeast Tennessee.

Dr. Comilla Sasson: Excellent. And Jonathan will be helping us talk a little bit about the background on why we think this program has been so important. So specifically, the reason that we had initially started this program to look at what kind of after hours access our mental health services can provide for our Veterans. I’m a physician in the Denver VA Emergency Department, and what I was finding, I work a lot of overnights and so I was finding oftentimes is that we would see Veterans who were driving very long distances to be seen for mental health needs after hours from our rural communities specifically. So just to give you a little bit of background in Denver it’s not uncommon for many of our Veterans to come from the Western Slopes, which would mean traversing the Rocky Mountains, come in through a snow storm to come see me in the emergency department at two o’clock in the morning because they maybe felt that they were unsafe or maybe had some issues with substance abuse or were not feeling like they could be at home by themselves.

And so what we also saw was that there were limited resources for Veterans outside of the emergency department in terms of after hours access. And when we speak to after hours access that really does mean after that 4:30 pm timeslot, Monday through Friday, and then of course, we know on holidays and weekends it can be more challenging as it is probably for many of you guys to also be able to get care services for Veterans for mental health resources.

And so what we were finding was that one of three things would happen essentially. People would either go to their local emergency department, so maybe they were out on the Western Slopes and they would go to a local ER because they were feeling unsafe, and we would have disjointed care because they were seeing a new physician there maybe who doesn’t know them as well. Secondly, we were seeing a lot of calls to the Veterans Crisis Line, and Jonathan will talk a little bit about that as well. And we saw that as another way that our Veterans with mental health needs were trying to access after hours resources. And then the third option, like I had mentioned, was that they would actually show up in our emergency department coming four, six, sometimes even eight hours to come see somebody just to be able to have some resources, especially on those long weekends when they knew that their clinics that were closer to them were going to be closed.

So we know that there are some, three specific barriers to providing high-quality psychiatric care. I think, as an emergency department physician, it’s always really challenging to know which patients are at high risk of suicide, and that’s why oftentimes we will consult and our social workers and really work hand in hand with many of the folks that are probably on the line today listening to the seminar to help us determine whether or not someone does have criteria potentially for an inpatient admission. Emergency providers, we also know, assess these patients. And then we have very limited training in conducting psychiatric risk assessment, so oftentimes when these patients, let’s say, would go to a local ER, they may meet criteria [unintelligible 4:11] by an ED doc, but when they were actually seen by their social worker or someone who knows them well, maybe this isn’t an unsafe situation for them and maybe there is an option to keep them out of the hospital, which I think many of us would prefer for our Veterans. And then finally, we know that there is limited access to outpatient mental health resources, especially outside of standard business hours.

And so in terms of kind of assessing the overall need for after hours programming, we looked first at the national perspective. And so we know that there’s obviously prevalence in mental health conditions and substance abuse disorders that are on the rise for a Veteran. We know that there’s a new initiative to actually increase the number of Veterans that we will be providing services for, specifically that we haven’t had to before, so we know that there’s going to be a rise in population of Veterans that we will, as a system, need to care for. From 2001 to 2014, the proportion of Veterans with these conditions of mental health and substance abuse disorder increased from 27% to 40% of all Veterans. There’s also an increase in demand for mental health services as our Veteran populations continue to grow, and we know that we need to be innovative and practical in terms of trying to think about how to meet that demand. Obviously, we have a limited supply of providers, and so if we were going to be able to really provide more care to more Veterans, we need to start thinking about what are some of the other alternative ways in which we can do this.

And so we were fortunate, Daniel Blonigen is one of our co-researchers on our project and he actually had conducted a qualitative study at the Palo Alto HSR&D to look at doing some semi-structured phone interviews with psych emergency services directors and providers across 22 VHA medical centers. And he did find that there were some barriers and facilitators to reducing high utilizers, PES utilization, and the most important one that I would say that has really kind of helped shape some of the work that we’re doing is that the importance of interdisciplinary care coordination case management with an emphasis on the role of psychiatric social workers. And as you’ll see in our after hours mental health program, our psych social workers really are the core to everything that we’re doing. And oftentimes more than anything else what we’re trying to do is to really make sure there’s care coordination across the entire spectrum of the clinical setting.

So our national and local partners for this grant, specifically, were from the Veterans Crisis Line. Jonathan will talk a little bit more about the VCL. The Office of Rural Health and the office of access, which were both our co-funders for this program, and then our Office of Connected Health which we have now reached out to and we’ll talk a little bit more about some additional tele-mental health opportunities. And then our National EM, Emergency Medicine and Mental Health Work Groups that we’re also working with as well, and then of course locally, mental health, social work, and emergency medicine have been our partners on this program.

So I’m going to switch this over to Jonathan so he can talk a little bit about the Veterans Crisis Line and some of the things that he’s seeing from a national perspective in terms of the needs that they have. Jonathan?

Jonathan Hartsell: All right, thank you. Talking about the VCL, all these things that you were talking about stand true for what we’ve seen, too, that there’s been an overall significant increase in demand for services for mental health specifically. We’ve gone, specifically, at the VCL this past year we took over 170,000 calls from Veterans and loved ones and other third party of interest to help with the mental health needs of the community. We do know that a lot of our calls come in from the rural communities, Colorado, other rural parts of the United States because it is so hard to drive two, three, four hours sometimes to their closest VA, or they don’t want to go to a private or a community based hospital. They want treatment at the VA, so they are driving those long distances and it’s very hard to get there.

We do refer our Veterans to the local suicide prevention coordinators when they call in with a crisis, when they need local resources. But again, that is hard to accomplish due to the layout of the land and the proximity of everything. And SPCs are not there for weekends or holidays whereas we are here 24/7. There’s not [inaudible 8:48-9:31] 16% of our calls are classified as high-frequency callers. So it’s not a small number by any means that we have to re-engage those Veterans because something has gone wrong or some sort of barrier has come into place where they have not connected with their local VA. So those are some things that we’re working on with that.

So just to know how, when a call comes in to the Veterans Crisis Line, we have a couple of different categories for responding to the call. And so you know that all of our responders handle all of the calls. We’re not bunched into only these set of providers will answer the most acute calls or these set of providers will answer the routine calls. We’re all trained to answer the calls in the same way so that we’re providing as consistent of service as possible. You can see there we do have some trees there. We do have a lot of routine callers calling in that are not in imminent harm. The do not present with suicidal ideation. They just need some sort of connection or some sort of resource to get them on the right path, to get them in the right direction. And the link for us is using the suicide prevention coordinator, and in that case, if it’s during the business week, the suicide prevention coordinator will reach out to that person within one business day. They have 24 hours essentially to reach out to that Veteran. Usually that works. There can always be a few hang-ups but we’ve been pretty successful in that.

Our other area is what we call acutely ill. We can have urgent or emergent situations there. If it’s urgent, we’re going to do our best to try to deescalate the situation, try to get the person to seek outpatient treatment, to seek whatever the least restrictive setting is as possible, whether it’s outpatient, residential care referral. It could be an inpatient stay for detox. It could be an inpatient stay for a psych issue, whatever the case may be. And we’ll help that person with motivational interviewing or different techniques to make sure that they get to the right place for the right kind of care. For emergent situations, we do use a lot of community partners such as 911 and police services.

So to put it into a framework on how this works, from the time that the VCL opened in 2007 to present, we’ve answered over 3.2 million calls. We’ve only had to use emergency services 84,000 times of that. I’ve not done the math to say what the percentage of that is, but I would say if only 84,000 of the callers needed emergency services, I think we do a pretty good job of turning those urgent and emergent cases into something that we can work with, get the Veteran more involved in their care. We do help people transport to the local ED through police, and we can talk about the next slide.

So there you see some different things with our demand for our calling there, repeat callers and referrals. It’s kind of all over the map. It depends on when, what time of year it is. We had an uptick in repeat callers over the Christmas holidays. We just recently got through with that. We’re going back down to kind of the downward slope of that bell curve, which there’s not really a good bell curve on this. Just the volume, though, has grown constantly. We are opening a third call center in Kansas that they just actually started taking calls last week. So they’re up and running in a limited capacity, but we also had to open up our call center in Atlanta last year. They’ve been opened up for a year.

And since then, we’ve made some drastic improvements even with the repeat callers and referrals. Right now, or before we opened Atlanta, these high-frequency callers were a contributor to a rollover rate of close to 15 or higher percent where they were having to go to backup call centers because we could not handle the load. Now we’re opening Atlanta and now Topeka. We’ve been able to get that rollover rate down to less than 1%; it’s at .59%. So we’ve been able to manage some of these high-frequency callers. We’re putting into play some other things to help with case management for, especially some of the folks that are out in hard-to-reach areas where they can do some case management through the VCL down the road. We’re not ready yet, but that is coming.

Our average speed to answer even with the high demand, we’re answering our crisis calls in less than nine seconds. Usually we’re around eight and a half seconds when we can answer the call. So that is our demand.

Dr. Camilla Sasson: Thanks, Jonathan. I really appreciate that and VCL has just been such an amazing partner for us in terms of really framing this Afterhours Mental Health Program and also trying to start thinking about solutions. Rachel will talk a little bit about the high-frequency utilizer that we actually, I think, took care of in our program, so we’ll talk a little bit about that as well. But I think that one of the reasons that the partnership with the VCL is so important is that they do serve de facto as an after hours program in many ways. But there was really this need for trying to figure out how to do a better handoff between providers and also making sure that those Veterans that did call the VCL who needed some additional resources didn't, maybe if they called at 4:30 pm on a Friday, didn’t have to wait until Tuesday morning, if it was a long weekend, to get some of those services. And so that was part of the reason that we had wanted to really engage with the VCL. And we also think that they could be a great partner for us as we start thinking about more of a regional program that could actually help us sort of refer, do some of those warm handoffs that patients who maybe have urgent or routine needs that maybe we could help with after hours.

And so just to give you an idea of some of the current gaps in care in Colorado, Colorado is one of the top 10 states for suicide rates per 100,000 per the CDC. We have some changes that are now coming up to our HUD/VASH program that may leave some Veterans without any resources outside of daytime and weekday hours. In 2016 we had, we just ran some data within our own emergency department after hours, and we saw 132 rural Veterans with 171 encounters who had come in after that Monday through Friday timeframe. We know, as we had mentioned, that there are some limited resources after 4:30 pm for rural Veterans. And in the emergency department here in the Denver VA, we do have a psych social worker who works until 11:30 pm, and then we have a psychiatric resident who covers call overnight who is in house. But that psych resident is also answering VCL calls, outside facility calls, is running two specific psychiatric inpatient floors, and then also is trying to do consults in the emergency department. So it’s not uncommon, especially working overnight, that we will see two, three, six, eight Veterans that need mental health services, and so that psychiatric resident can be stretched fairly thin.

And then, as I had mentioned, currently our Veterans access are at the VCL, emergency department, and obviously outside facilities [unintelligible 17:28] outside of our regular business hours. And so there is that challenge where, if they are going to an outside ED, they may have, we may or may not get information on that. They may try to call the VA administrator on duty. They’ll let us know that that person is in the ED at an outside hospital. And if we have space, we can transfer that patient into our site for, but if not, then they may be taken care of and have their entire hospital visit at an outside emergency department in an outside hospital. And then we would, hopefully, at some point get those records. And so you can see how there is obviously opportunities for disjointed care.

So in terms of our current, one other, some other gaps that we’ve had in care, this is actually from our different providers in terms of giving us some specific quotes on some of the gaps that they’re feeling. So from our Psych Emergency Services Program Director, staffing limits coverage 24/7. With national policy changes to include less than honorably discharged Veterans, there could be an even higher need for mental health services. So that was what I had mentioned a little earlier that there is obviously potentially more and more Veterans that will be needing our services.

From one of our rural CBOC mental health providers, there isn’t a lot of coverage for Veterans' mental health needs after hours. Frequently veterans have to just go to the local behavioral health center or local EDs. Staffing shortages in rural areas really limit access to mental health services.

From another one of our rural health providers, most mental health providers aren’t available after 4:30 pm, and there are not a lot of resources for rural Veterans to get mental health care.

And then finally from one of our psych residents, we could really use the extra support for Veterans who aren’t in immediate risk but still need the help. And that’s really from that kind of feeling stretched and not being able to provide as much care as they would hopefully like to do as our psychiatric residents.

So just finally, our current Eastern Colorado Health Care System psychiatric care process, we know that there’s that gap in care from 10 pm to 8:30 am, Monday through Friday, and then of course 24 hours on holidays and weekends, and that’s where our psych resident usually has to try to cover as well as the emergency department physician. Our psych residents can be called for emergent risk assessments, but they also have to oversee multiple inpatient units as well. And then after hours needs may require care coordination, case management, and additional psychotherapeutic support that we know ED docs are just not good at. And I will say that very blatantly and very honestly. You know when we’re trying to manage an entire emergency department, it does become challenging to be able to provide as much of the support services that some of our Veterans do require.

And so with that, Molly, I think we’re going to go to our first poll question.

Molly: Thank you. So for our attendees, as you can see up on your screen, we do have the first poll question. So if you can go ahead and select all that apply, so we would like to know what are your major gaps in accessing mental health care in your area? The answer options are shortages of mental health providers, limited after hours mental health services availability, lack of funding support for programs, difficulty placing Veterans who need inpatient services, and the lack of care coordination for Veterans. And as I said, you can select all that apply. Looks like just under half of our audience have replied, so we’ll give people a few more seconds to get their responses in. Okay, it looks like responses have tapered off, so I'm going to go ahead and close this and share those results. About 73% of our respondents selected shortages of mental health providers, 57% limited after hours mental health service availability, 51% lack of funding support for programs, 46% difficulty placing Veterans who need inpatient services, and 59% lack of care coordination for Veterans. So thank you to those respondents, and I will turn it back to you now.

Dr. Comilla Sasson: Definitely that was all the above is what that seems like from a lot of, from pretty much all of our respondents here. So with that, I think we’ve, I think, accurately hopefully expressed the situation for not just the Eastern Colorado Health Care System. It sounds like that’s pretty much the same gaps that you guys are all seeing as well across the nation. So that’s good to know that we are at least consistent in that way. With that, I’m going to go ahead and turn this over to Rachel Johnson so that she can talk a little bit about the Afterhours Rural Mental Health Pilot that we have started.

Rachel Johnson: Thank you so much, Comilla. So basically this first slide is an overview of our Afterhours Pilot Program. We designed this program in order to meet some of those needs that a lot of you have just talked about identifying. We were trying to meet mental health needs for rural and after hours for Veterans here in the Eastern Colorado Health Care System. You can see our hours were 10:30-7:30, Monday through Friday, and then 24 hours on holidays and weekends. And we had our program for about two months that we were able to collect data and staff our program. So if you don’t mind going to the next slide.

Thank you so much. So as you can tell, we provided with supplemental mental health services. This isn’t something that we were taking place with the mental health services that were already being provided by our Eastern Colorado Health Care System staff, but it’s something that we were providing to partner with their current mental health provider to partner with the suicide prevention coordinator and with the VCL. This is something that we wanted to provide as an additional service and that would be specifically available during hours where we knew there wasn’t that coverage available.

As you can tell from the other side of this slide, the risks and threats, in the beginning when we had originally anticipated this program, we identified potential risks that included that we wouldn’t be able to get enough referrals, that we wouldn’t have staff that would be able to sign up for shifts and provide the coverage, or that staff wouldn’t be able to respond to calls when they were able to receive them. But that ended up not being the issue. We actually were able to get referrals for this program and we had staff that were willing and able to sign up. They actually were able to do overtime in the evenings and weekends, and they were already employed within the VA itself to be able to do this coverage. And then all of our staff returned phone calls within the 24 hour timeframe in which we had originally designed. If you don’t mind, next slide, thank you very much.

So then some of the more specific milestones that we had were that we designed a training session that included one of our team members. She is the head of the psychiatric emergency services who had a lot of good clinical experience and understood how the system worked. And then I also helped to design the training session. We had a manual that we gave to staff as well as putting together a SharePoint website that had central information and announcements that came up, especially as people weren’t always working with each other. They were working to pass off coverage from one person to the next. It was a great way for us to be able to coordinate the care that we provided. We also did a data tracking system that we implemented, and we were able to implement a consult system as part of our kickoff as well.

We conducted some qualitative interviews with people who were involved either on the side of the staff themselves who were staffing the program or they were involved as mental health providers, VCL staff, to be able to get a little bit of a feel for how the program had rolled out. And so you can see on the right-hand side how many people we had that were involved as stakeholders and that we had talked to as all part of this program. So the next slide is actually some of the results that we had from the program.

As you can tell, the majority of our referrals came from the emergency department. But we did have referrals from the VCL, from our suicide prevention coordinator, and even from psychiatric emergency services. The referrals that came from the suicide prevention coordinator and psychiatric emergency services were people who specifically needed follow-up during those weekends and holiday hours. Some of the services that provided the most common one, as you can tell, is the case management. But we did have a lot of people who required a little bit of just general follow-up during those hours where they wouldn’t normally get follow-up.

And as you can tell from some of our key quotes on the bottom, the first one is talking really about how the crisis occurs after hours for a lot of people, which is part of the reason why there’s been such an increase in VCL utilization for people who are experiencing those types of crises. And then the second and third quote are really about how this program could potentially help to alleviate staff burden. The first one is for the person who is a suicide prevention coordinator and then also for the psychiatrist who is doing that type of coverage. And then the last quote is really talking about how the trends feel like someone cares about them by having someone who is able reach out, and especially when someone who may feel like they’re having an urgent or emergent need presents to the ED but the ED determines that they’re not appropriate for hospitalization or for some type of an immediate treatment and they may discharge them to go back home. This is a way that we can reach out to them and still provide care for a need that they have identified as being highly important to them. So a lot of people had a positive reaction because of that type of service.

So our key findings from our implementation of our pilot was that the staff both locally here at the Eastern Colorado Health Care System and nationally see a need for this type of care, which is very similar to the question we just asked that even our attendees today are talking about a need for this type of care as well. Then the key lessons that we learned in implementing this program is that it is important to be able to have a smart phone so staff can access the technology that’s associated with that smart phone as well as having a phone number that our staff here within the Eastern Colorado Health Care System can access and Veterans can access to be able to reach our program. That it was important for us to have a system to track contacts, which we used through setting up a consult system in CPRS so we were able to run reports and see who had been referred and make sure that they’re getting follow-up within a timely manner.

We also made sure that we had a central database, that we were able to do training and be able to do announcements for to coordinate the whole program across the board. And then we will be able to find mental health staff and social work staff that were willing to do this type of overtime. They talked specifically about how they wanted to help out Veterans who are in rural areas. They wanted to help out Veterans who are having these types of needs after hours, and they also wanted to help alleviate staff on other, or burden on other mental health staff. And the biggest barrier that we found is that there was a hesitation from staff to fully implement this type of program because it was temporary. They knew that there would be an end date, that it wouldn’t be a very long-term thing, and so it was hard for them to utilize changing their entire system.

One of the things that we also found is in addressing the needs for people who are high-frequency callers like Comilla was talking about before. We had a particular referral that we had received where this man had called, I think it was over a thousand times a year to the VCL, and so he was getting connected with the Suicide Prevention Coordinator when he was calling, but our staff were actually able to do a more proactive outreach to him in order to try to help prevent him from having this type of crisis later on. So that’s really another section in which our type of program might be able to be helpful by being more proactive. So then our next slide is actually about one of the poll questions. We have another one for you to take part in.

Dr. Comilla Sasson: I’m just going to add, Rachel, one other thing, too. We had initially hoped that the VCL would be able to implement so that for all of the urgent and routine calls that they would actually be able to call into our on-call, after hours mental health providers or social worker and be able to sort of set that into the workflow, but given that the program itself is only about six weeks long that we were able to implement, due to time constraints they weren’t able to fit that into their workflow. But that is something, and maybe Jonathan can speak to this in our next section when we talk about kind of upcoming solutions and ideas, that is something that we’re talking about where for the routine and potentially for some of the urgent calls, could there be an ability to do that warm handoff to somebody, whether they’re located within the healthcare system or at the VISN level where the VCL actually could, we could fit this into the workflow for what the VCL does. So unfortunately, we weren’t able to get as many referrals from there, but we do know that there is excitement about the program and if we can have some, kind of a longer running program that hopefully then it could be built into an algorithm that they could use for their callers, specifically within either the Colorado Health Care System or in the geographic VISN 19 area. So with that, Molly, go ahead.

Molly: Thank you. So for our attendees, as you can see, that the second poll question up on your screen. Again, this is a select all that apply question. So what are unique barriers rural Veterans face in your area? Long travel times/distance for in-person care, not comfortable using telehealth services, lack of trust in healthcare system, disjointed care between non-VA and VA, long wait times for access to care. Looks like people are quicker to respond to this one. That’s great. We’ve already got about half of our attendees replying, so we’ll give people a few more seconds to get those in. All right, it looks like the answers have tapered off, so I’m going to go ahead and close this and share those results. Eighty-one percent of our respondents selected long travel times/distances for in-person care, 56% not comfortable using telehealth services, 53% selected lack of trust in healthcare system, 63% disjointed care between non-VA and VA, and 59% selected long wait times for access to care. Thank you again to those respondents, and I will turn it back to you.

Dr. Comilla Sasson: I think we actually have one additional poll question, Molly.

Molly: Oh, excellent. [Unintelligible 32:03] just one second.

Dr. Comilla Sasson: [Unintelligible 32:05]. Sorry. We had them back to back. Sorry about that.

Molly: No problem at all. Okay, so we’ve got the third poll question up on your screen now. What are the best opportunities for improving mental health services locally? And again you can select all that apply. Utilize tele-mental health services, increase capacity through VISN-level programs, alternative treatment and care options for Veterans, outsource to other non-VA providers, improve care transitions for Veterans. And we’ll give people a little more time to get their responses in. Again, you can select all that apply here. Okay, it looks like the answers are starting to taper off. I’m going to go ahead and close this out. And 83% of our respondents selected utilize tele-mental health services, I’m sorry, 45% increase capacity through VISN-level programs, 62% alternative treatment and care options for Vets, 45% outsource to other non-VA providers, and 69% selected improve care transitions for Veterans. So thank you, and I’ll do the last transition over to you now.

Dr. Comilla Sasson: [Unintelligible 33:35] and Rachel continue.

Rachel Johnson: So it sounds like a lot of your experiences have been pretty similar where part of the barriers have been around that long-distance travel times for doing in-person care like what we have experienced here. And the disjointed care has also been an issue. And so looking forward, your top solution was around utilizing tele-mental health services, which is very similar to the type of program that we had been trying to connect with. And so if you look at our key partnerships, sorry, if you look at our key partnerships that we have been working with the Veteran Crisis Line, which is around the tele-mental health services, and also the Office of Connected Health, which is looking at new and innovative ways, and I’ll talk a little bit about each one of these more in a second, and the Office of Rural Health about connecting people in rural areas, and then our VA National EM and Mental Health Work Group. So we’re trying to work with these local and national partners that we had connected with in the very beginning of our program in order to continue to try to find innovative and practical ways to meet that increase in mental health demand. So okay, sorry. Next slide now.

So first off we’re working with the Office of Connected Health. We’re specifically trying to find new technologies to connect providers and Veterans. We’re looking at iPads for providers as well as using iPads for Veterans to be able to utilize, to provide mental health services by using an app. Veterans would be able to use potentially their own device or use an iPad that we would issue for them in order to be able to increase their connection to care. And so that’s one of the components looking forward that we’re exploring.

And then another one is that we’ve continued to work with the VA National Emergency Medicine and Mental Health Work Groups to be able to talk about the results that we found through this pilot program. The conversations that we’ve been having with our other partners about possible gaps and trying to find new and innovative ways to be able to deliver mental health care nationally across the VA as well as locally here in Colorado.

And then our opportunities that we’re looking forward into the future is that we’re looking for additional partners to be able to pilot similar programs to see if there are similar needs and a similar way to meet those needs outside of Colorado. We’re also looking for new and innovative ways to use mobile health technologies to increase access for Veterans and also to increase effectiveness for mental health providers. And we’re also hoping to continue to work with the VCL to help implement strategies to identify their frequent callers and also to be able to meet the increased demand not only from those high-frequency callers but all the way around just having a more population of Veterans who are utilizing the VA services.

So our last slide here is that we’d like to open up the presentation to any questions that people had and then any other input that they would like to give, but if you would prefer not to send it through the system, feel free to reach out to any of us and email us at these addresses that we’ve provided with any additional questions or suggestions or any ideas about ways that we can continue to meet our mission need around increasing the access to mental health care.

Dr. Comilla Sasson: Jonathan, I don’t know if you want to speak briefly to just some of the work the VCL is doing as well. I know one of the conversations that we’ve been in is that having, part of this program is that we had an after hours beta mental health worker who already was hired into the VA system, so already had all their passwords and already was in the HR system. And we had a series of these folks who would volunteer to take call overnight and they would be paid to take call and then obviously they would have one direct phone number that we as the ED doc or at VCL, whoever, could call and reach that person. And so one of the conversations that we’ve had with the VCL is that if there isn’t the ability to necessarily staff one social worker at every emergency department in every VA, is there a possibility of putting a social worker or a mental health provider in the call center at the VISN level who could potentially serve in that role for a number of VA facilities? Now much of the work that we had thought was going to be very local, you need to know the ins and outs of the Colorado Health Care System to be able to provide those services in this very small pilot program, we didn’t necessarily see that. We saw that there was a lot of care coordination and a lot of follow-up and just checking in and doing some psychiatric risk assessments, etc., that could be done presumptively by somebody who maybe is Utah, for example, wouldn’t necessarily be a huge difference in terms of our Veterans, and so there is potential for putting that after hours mental health, or putting someone as a mental health provider at the VISN level at the call center who could serve some of those resources, serve in some of those capacities.

The other program, too, that we had talked to Office of Connected Health about is this new beta mobile app that would allow, and it had the secure environment that the patient, the Veteran could access a provider by using a mobile app that is freely available on either their own phone or an iPad that we’ve issued. And it could connect face to face and do video conferencing with a mental health provider as well after hours. And so those are just some of the other things that we’re exploring right now. Jonathan, I don’t know if you had some additional thoughts from the VCL perspective as well?

Jonathan Hartsell: Well, just what on you were talking about, I think we at the VCL would very much welcome any type of work that you all could put together at the local level or at the VISN level so that we could have some of that after hour care. That’s probably one of our biggest challenges is that the Veteran or the caller does not need to go into the hospital. But they need some sort of local follow-up, what’s available right then and right there, and if we’re across the country, we’re not necessarily going to know the local aspects whereas somebody at the VISN level might. So we would welcome that very much. Happy to partner with that. And also we're realizing that wraparound services is very vital in crisis work and suicide prevention.

We are in the process of expanding our services to where we will have a small team to work with the most high-frequent callers with the highest needs to do some clinical case management from our perspective, primarily for Veterans who either have a hard time connecting with the VA or this is the first time they’re reaching out to any type of big VA service whatsoever and they haven’t been seen at a local VA. We can do some clinical case management and some care coordination until they are connected with somebody locally to help wraparound and make sure that they have someone to reach out to, someone that they can count on where we can use the crisis line for more acute services and acute care. So that’s something we’re working on right now, too.

Dr. Comilla Sasson: Molly, did you have any questions from the audience as well that have come up?

Molly: Yeah, we do have some pending questions. And for those of you that joined us after the top of the hour, to submit your question or comment, go ahead and just use the GoToWebinar control panel located on the right-hand side of your screen. Just click the arrow next to the word questions. That will drop down the dialogue box and you can submit your question or comment there. And we’ll go ahead and get to the first one. Can you talk a little bit about how you handle homicidal ideation and/or screen for that?

Dr. Comilla Sasson: In the ED setting, what we would do is someone who does have HI or does at least verbalize that, what we would do if they had presented to the emergency department is probably similar to what you do in most of your other facilities as well. But we would obviously get them into a safe or secure room, do a one-to-one sitter, we get them in PJs or our pajamas that they can get into. We do take their belongings and then actually call our, do some baseline labs on them, blood alcohol, [unintelligible 42:15] breath, of course as well, and then we do consult our psych resident right away. But that’s for the emergent homicidal patient. I don’t know if, Jonathan if you wanted to speak to it from the VCL perspective what you guys do?

Jonathan Hartsell: Pretty much what you do there except for it’s just by phone. We assess for homicidal ideation. We try to assess for any intended victims, if there is intent, if there is means. And we treat it a lot like suicidal ideation where if there is imminent harm, we provide a rescue situation where we get emergency services involved. We do a duty to warn if there is imminent harm. Most of our calls are about the VA themselves. It’s very rare that we get a call that they’re homicidal towards a loved one or someone in the community. So we work very closely with local VA police officers so we can report off and say, hey, be on the lookout in case this rescue does not go as planned to where they can get to an emergency room setting or a hospital setting so that they can be on the lookout and provide adequate safety for the VAs that are the intended victim.

Dr. Comilla Sasson: We do oftentimes having worked, again, overnights quite a bit in the ED, we do also get lots of phone calls from our VCL partners as well, directly to the emergency department saying, heads up, there’s somebody coming or there’s someone that we think needs an urgent evaluation, etc. So I think there is a lot of that communication as well.

Jonathan Hartsell: Yeah, we do our absolute best to get that information out there to everybody.

Molly: Thank you. Yeah, so just wondering, can a presenter’s comment on the decision to set this up as OT rather than modified tours of duty or other options?

Dr. Comilla Sasson: Rachel, who is our HR wizard/program manager, I’m going to let you answer that one.

Rachel Johnson: A lot of it had to do with if we had set up a regular program, I guess, oh, the word is escaping me because that is not something I do. Duty? But it’s part of a regular position that having people work on the evenings and weekends that hiring in such a short time period for us to be able to get staff would be extremely difficult. But it also was that so many of our staff were excited about conducting it as overtime. It was an opportunity for them to be able to make a little bit of extra money utilizing the skills that they had in helping out Veterans in their community as well as their own mental health staff for their burden. So I think that it was the really strong response that we had gotten from staff about offering it as overtime as well as the delay through HR as being a barrier towards hiring people to start in this position to just do that, especially with our short timeframe.

Dr. Comilla Sasson: And I think we were very concerned initially about whether or not people would volunteer for the OT. And we actually had over, we had, I think it was six people right away who were able to go through the full training and who were able to take calls for us over that six-week period. And we had more that were interested in doing the program as well, too. So that was one of those feasibility things that I would say was actually not as challenging as we had thought. So that was great news.

Molly: Thank you. This one is more benefits related. Do any of you have any information on when Veterans with less than honorable discharge may be eligible for VA mental health care?

Dr. Comilla Sasson: No, I’m not sure if Jonathan maybe if you have more information on it? I personally don’t. I think we’re kind of just hearing rumblings of that right now, and the fact that we are going to have additional Veterans to take care of. I’m not sure if Jonathan if you guys have heard more from the VCL?

Jonathan Hartsell: Sure. Well, not from my time at the local VA, too. So that is one of the rumors that’s coming down the pike that they’re just going to extend benefits, which is different than what we have now, and extend the benefits to cover any Veteran that’s been discharged from the military for mental health. Right now we do have the other than honorable services where they can receive care for 90 days, and within that 90 days you should have a case manager set up to where they will be transitioned to community-based care if they need follow-up or long-term mental health services. So we have a version of it now that’s good for 90 days, and there is no timeframe set for when we will be establishing ongoing care for other than honorable. Does that answer your question?

Molly: Thank you. That is more information than was previously out there. It’s helpful. The next person writes I am the National Director of LGBT Veteran Care Coordinator program. I am wondering if your program and/or the VCL program have connected with our office at LGBT Health? I wanted to reach out and partner if needed.

Dr. Comilla Sasson: I think we would love to, and if that person who had written that comment would be willing to email either, all three of us if you will or even just one of us and we can connect, we’d love to set up some additional conversations. I know we were looking at this as a pilot program and hoping that this would lead to additional local and national partnerships, and so I think that would be a fantastic one, so very excited to be able to talk more.

Molly: Thank you. So I will encourage that question submitter to go ahead and contact you offline by email. The next question: This person is joining us from Ireland. For Vets, I translate into fellow Irish citizens who are involved in an Irish conflict and who are now older and ill, both as victims and survivors, physically and otherwise. The only help available is on statutory, meaning voluntary or charity. Any ideas how we might learn from you?

Dr. Comilla Sasson: A really great question. I would ask if that person also could maybe email us separately. I think I wouldn’t have information necessarily on the international perspective. I don’t know if Jonathan, if you guys do as well, but I think we would, through our other kind of local and national partnerships, we would love to hopefully connect you maybe with some folks who maybe do or have some other additional ideas.

Jonathan Hartsell: Yeah, I think we would have to do a little bit of research on that.

Molly: Thank you for making yourselves available offline, so I will encourage that submitter to contact you. What kind of work, if any, have you done with local crisis centers or similar behavioral/mental health services?

Dr. Comilla Sasson: Rachel, do you want to talk a little bit about that? I know you were doing kind of the survey initially that went into our manuals to look at sort of what are the current resources that are available in our rural Veterans' communities?

Rachel Johnson: Definitely. So if there were a few different local crisis centers, particularly, that people in rural areas were reaching out to and those partnerships frequently were really well-connected to our staff who had worked there in the past. So one of the rural CBOC mental health providers had worked at a particular crisis center before he came to work for the VA, and so he talked a lot about how he just called his friends that he knew from his previous job to get people connected, to put in referrals, that he knew what number to call, that he really knew how to navigate it. But it’s such an important part about this program that there needs to be a connection with those local crisis centers and other types of mental health services that are available so that those places know that a program like this would be available and how to refer people to that. A lot of these local crisis centers are just maybe providing a phone call to help support people during those after hours time period, but they’re not really providing more in-depth mental health care. At least that’s what I had ran in to in talking with the different providers. But there are some that have more integrated care that they provide that’s normally a more informal process.

Molly: Thank you. In the after hours time period, do you see a significant LGBTQ+ Veteran population seeking support for their mental health issues?

Dr. Comilla Sasson: I can say that on kind of the ED perspective. I feel like, yes actually, and in the recent, I’ve worked in the emergency department here for about five years and I would say that I do feel like there is actually a higher number of folks, especially our transgender Veterans who are coming into the ED to seek mental health services, at least on the after hours perspective, again, with an N of one, of myself. I’ll say that a little more anecdotally. I’m not sure Jonathan from the VCL perspective if you guys looked at it from an LGBT perspective?

Jonathan Hartsell: Not currently. That would be an interesting thing to break out. But right now that is not a question that we ask. We want all Veterans to feel comfortable sharing what they’re calling for, so we try not to direct questions towards things of that nature at this moment. If they bring up sexual orientation as a need, then that’s fine. But I’m not sure we’ve ever broke out that kind of data.

Dr. Comilla Sasson: Actually could be an opportunity, so maybe if that national coordinator, if that's you again asking us your question, if you want to reach out to us afterwards, maybe that would be another opportunity.

Molly: Excellent. Well, thank you all for those replies. That is the final pending question at this time. But I would like to give each of you a moment to make any concluding comments if you’d like to in no particular order. Comilla, would you like to start?

Dr. Comilla Sasson: Sure. I just want to say thank you to everyone for letting us have an hour of your day in presenting these pilot results. And we do look forward to hopefully using this as an opportunity to start a discussion and a collaboration, hopefully nationally and locally with our different partners, many of you who are on the phone, so looking forward to future opportunities for collaboration.

Molly: Thank you. Rachel, did you want to...

Rachel Johnson: Yeah, I also want to thank everyone for participating and being able to talk to us about our results for this and just in our conversation being able to talk to some of you. Your questions have really been able to help us to think more about how to expand this out and how to work with other partners, so it’s very exciting, and thank you very much for the opportunity.

Molly: Jonathan, did you want to wrap up with anything?

Jonathan Hartsell: Obviously, [unintelligible 53:46] to thank you. Thank you for letting me participate, be a part of this presentation, and enjoyed it very much. And I’ve learned things as well as hopefully I’ve shared things that were very valuable to you all. So thank you.

Molly: Well, thank all three of you for coming on and lending your expertise in the field. We really appreciate it. And we do run these suicide prevention sessions every other month, so please keep an eye on your emails for those. And for our attendees, I am going to close out the session now. Please wait just a second while the feedback survey populates on your screen. It’s just a few questions, but we do look closely at your responses, and it helps us improve individual sessions as well as the program as a whole. So once again, thank you for joining us, everyone. And this does conclude today’s HSR&D Cyberseminar.

[ END OF AUDIO ]