



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

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Communiqué

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RESEARCH TO PRACTICE

Telemedicine-Based Collaborative Care for PTSD

Summary by Kathy L. Henderson, M.D.

Geographic barriers often prevent rural Veterans from accessing and engaging in mental health treatment. This article published by John Fortney, et al, in *JAMA Psychiatry*, January 2015, describes findings of his Telemedicine Outreach for PTSD (TOP) project that was conducted in VISNs 16 and 22 (including Central Arkansas and Shreveport CBOCs). This study was designed to test whether a telemedicine-based collaborative care model would improve the engagement of rural Veterans in evidence-based treatment for PTSD.



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Bridging Funds: Supporting SC MIRECC Researchers

Q&A with Melinda Stanley, Ph.D.

Q. In 2014, you received a SC MIRECC bridging award to support the completion of your Calmer Life pilot study while you sought grant funding. Will you give us an overview of your work and tell us how the bridging award helped you to accomplish your goals?

Since 2009, our late-life anxiety research group has been working on developing and testing Calmer Life (CL), an intervention for clinically significant worry/anxiety among older adults in underserved, low-income, mostly minority communities. CL is anchored in evidence-based cognitive behavioral treatment (CBT), but is person-centered with regard to both content and delivery of care. CL offers modular skills-based care, options to incorporate religion or spirituality, resource counseling to address unmet basic needs, and facilitation of communication about anxiety with health care providers. The intervention is delivered in partner community settings, participants' homes, or by telephone. Providers are a mix of experts in CBT and community providers with no prior mental health training. This work

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Veterans meeting diagnostic criteria for PTSD were recruited from eleven CBOCs over a 22-month period from November 2009-September 2011. During the 12-month study period, 265 Veterans were randomly enrolled, half receiving usual care (UC) and half receiving the TOP interventions. UC involved Veterans received psychotropic medication either through a primary care physician or an off-site telepsychiatrist and evidence-based or supportive psychotherapy by a CBOC mental health provider. The TOP intervention was designed to support the on-site CBOC provider by providing an off-site telephone nurse care manager for symptom monitoring and education, a telephone clinical pharmacist and telepsychiatrist for medication consultation and management, and a telepsychologist to deliver individual cognitive processing therapy (CPT) through interactive video.

Study highlights for clinicians:

- Veterans enrolled in the study were primarily rural, unemployed, middle-aged men with a military service-connected disability for PTSD. Symptoms of PTSD were severe.
- 55% of TOP group received CPT compared to only 12% of UC group
- 27% of TOP group received at least 8 CPT sessions compared to 5% of UC group
- The TOP group attended significantly more CPT sessions than the UC group (mean, 4.2 vs. 0.8)
- At both 6 and 12-month follow-up, patients in the TOP group had significantly larger decreases in Posttraumatic Diagnostic Scale (PDS) scores compared to UC group.
- Attendance at 8 or greater sessions of CPT significantly predicted improvement in PTSD symptom severity

- Although there was no significant difference in the number of PTSD medications prescribed or medication adherence, the TOP group was more likely to be prescribed prazosin

We know that many of our Veterans must travel long distances to receive evidence-based care. These findings clearly show that the TOP intervention increased engagement in evidence-based psychotherapy, and that symptom severity was significantly less for those Veterans after treatment than Veterans receiving usual care. This study is another example of how well telehealth technology can work and how its use engages Veterans in mental health care. Now, let's expand our use of technology to treat Veterans in their homes!

This article may be viewed at <http://www.ncbi.nlm.nih.gov/pubmed/25409287>.

Citation

Fortney, J. C., Pyne, J. M., Kimbrell, T. A., Hudson, T. J., Robinson, D. E., Schneider, R., Moore, W. M., Custer, P. J., Grubbs, K. M., & Schnurr, P. P. (2015). Telemedicine-based collaborative care for posttraumatic stress disorder: A randomized clinical trial. *JAMA Psychiatry*, 72(1), 58-67. ♦

ATTRIBUTION: ACKNOWLEDGEMENT OF MIRECC RESEARCH SUPPORT/EMPLOYMENT

SC MIRECC researchers and educators have a responsibility to ensure 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 SC MIRECC if they receive either direct or indirect SC MIRECC support. 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 SC MIRECC, you should list SC MIRECC as an affiliation.

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is the most recent step in our overall goal to enhance access to evidence-based care for worry or anxiety among underserved older adults. Early MIRECC pilot funding supported our work to develop the CL model, and funding from the Archstone Foundation and the Retirement Research Foundation supported initial pilot testing of the intervention. Throughout all of these pilot phases, we pursued additional NIMH funding to support a larger hybrid type 1 trial. Although we had previously been successful at maintaining long-term NIMH funding for our late-life anxiety work, the proposals we submitted between 2010 and 2013 were unsuccessful, and we decided to shift to pursuing PCORI support. Because our sources of funding were running low, the opportunity to apply for MIRECC bridge funding was perfectly timed. We were able to request continued funding for staff and supplies to allow our group to continue with pilot data collection and maintain our partnership activities while we waited to hear from PCORI. Without this funding, we may have had to discontinue key pilot tasks that enabled us to move smoothly into a larger study. Fortunately, PCORI approved our project for funding, and the larger trial was launched on 11/1/14.

Q. Are there any results from your research about the treatment you provided or the patient population you were studying that you can share with our readers?

We are currently analyzing data from our pilot trial, which show solid feasibility (95% reach; 5% attrition) and

positive outcomes relative to a control condition, Enhanced Community Care (ECC), on key outcome variables. Psychometric data also will address the utility of measures to address worry or anxiety in this unique sample that was 83% African American, 85% women, and 66% with income less than \$20,000/year. Of participants who received CL, 80% chose to incorporate religion or spirituality. Integrity data suggest adequate adherence and competence among community health workers and case managers trained to deliver CL and ECC.

Q. How has the knowledge you gained from this study informed your research?

Since receipt of MIRECC bridge funding, we have presented preliminary findings of this work at the Gerontological Society of America and published one case study (Ramos et al., 2014, Spirituality in Clinical Practice). As noted above, we also were successful in obtaining PCORI funding for a larger effectiveness trial. Funding started 11/1/14, and inclusion of participants began in February 2015. We also are pursuing supplemental funding from VA to support targeted recruitment of community-dwelling Veterans, which will address the gender imbalance in our pilot sample and increase relevance of our data for VA.

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Q. SC MIRECC launched the bridging award program in 2014 and you were one of the first award recipients. What did you think about the application process? What advice do you have, if any, for investigators interested in applying for one of these awards in the future?

The application process was simple, and the program was extraordinarily useful to maintaining our ongoing program of research at a time when alternative sources of external funding were winding down.

Q. Is there anything you want to say about your project or the bridging award program that I have not asked you?

I would like to express sincere appreciation to MIRECC for not only this bridging support, but for the multiple avenues of support offered to our group over the past 11 years. ♦

CBOC Mental Health Rounds

Sponsored by the South Central MIRECC

VA mental health providers are invited to attend the next CBOC Mental Health Rounds session titled “**Adapting Cognitive Behavioral Therapy for VA CBOC and Primary Care Settings**” on Wednesday, April 8 at 8:00-9:00 a.m. CT and Thursday, April 9 at 11:00-12:00 p.m. CT. This Microsoft Lync session will be presented by Jeffrey Cully, Ph.D. At the conclusion of this educational program, learners will be able to:

1. Understand the unique challenges and opportunities of providing mental health care in non-specialty mental health settings (e.g. primary care and community-based outpatient clinic);
2. Describe potentially important modifications to the use of cognitive behavioral therapy in non-specialty mental health settings; and
3. Review specific “skill-based” CBT elements that may be particularly important to meet Veteran needs in CBOCs and primary care settings.

Call 1-800-767-1750 and use access code 37009# to participate. Email Ashley.McDaniel@va.gov or call (501) 257-1223 for registration and continuing education credit information.

Upcoming CBOC Mental Health Rounds
Second Wednesdays
(8:00-9:00 am CT)
and
Thursdays
(11:00-12:00 am CT)
Monthly
(800) 767-1750; 37009#

May 13 & 14, 2015
Hoarding

June 10 & 11, 2015
Opioid Risk Management & Mental Health

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