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

south central mirecc

Mental Illness Research, Education, and Clinical Center

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COMMUNIQUÉ

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MIDAS Statisticians Discuss SC MIRECC Research Project Support Services

Drs. Nancy Petersen (left) and Shubhada Sansgiry (right)

MIRECC Implementation, Design and Analysis Support (MIDAS) offers centralized design, methodologic and analytic support to researchers in the South Central VA Health Care Network. This month, Drs. Nancy Petersen and Shubhada Sansgiry discuss their work supporting the statistical arm of the MIDAS team.

See MIDAS on page 2

Meet the SC MIRECC Affiliate: Korak Sarkar, MD

Neurologist, Brain Injury Physician, Southeast Louisiana Veterans Health Care System

Q. Tell us a bit about your educational and career background. In particular, what about research piqued your curiosity and when did you know that a career in this field was right for you?

I completed my undergraduate education at Johns Hopkins University where I obtained degrees in applied

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South Central MIRECC Communique

October 2017

Ashley McDaniel, MA
Editor

Sonora Hudson, MD
Contributor

https://www.mirecc.va.gov/visn16/index.asp

MIDAS (continued from page 1)

Dr. Petersen is a senior biostatistician and investigator at the HSR&D Center for Innovation in Quality, Effectiveness and Safety (IQuEST) Methodology & Statistics Core at the Michael E. DeBakey VA Medical Center (MEDVAMC), and an associate professor at the Baylor College of Medicine in Houston, Texas. Dr. Sansgiry is a methodologist at the HSR&D IQuEST and an assistant professor with the Baylor College of Medicine.

Q. What are your statistical areas of expertise in MIDAS?

NP: My main area of expertise is the design and analysis of randomized clinical trials and observational studies. I have also worked a lot with analysis of VA's large claims databases. I have experience with survival analyses, linear and logistic regression, and longitudinal modeling, which can be used when investigators have gathered data over time.

SS: I have expertise in observational studies, prospective and retrospective studies, and randomized clinical trials.

Q. What are the most common problems that you help investigators solve when they request MIDAS statistical assistance?

NP: Many investigators need help with sample size calculations, but we have also helped with developing testable, feasible hypotheses and with selecting the best study design. We have written portions of a grant's methods and analyses sections, as well as the methods, analyses and results sections of reports and manuscripts when needed.

SS: Investigators mostly seek help with analytical consulting.

Q. On average, how much time does it take for you to help investigators with statistical support for a project?

NP: Statistical assistance from MIDAS biostatisticians is generally meant to be time-limited, providing

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methodological assistance for an investigator's grant proposal or limited help with analyses of existing datasets. The time it takes varies depending on the type of help required and the extent of the analyses. Some projects require help with the study design and analytic plan for a pilot study or a grant submission. Because MIDAS methodologists spend only a portion of their entire work time on MIDAS projects, it might take at least a month to work with the investigator on the design, sample size, and proposed methods.

If the project has already been designed and datasets already exist, the time required depends on whether the datasets have already been checked for accuracy and on the extent of analyses needed to address the study questions. Because we often help with analyses that are part of an investigator's manuscript or grant submission, we may need to provide additional assistance several months after our initial consultation to help with responses to reviewers' comments.

SS: Time taken on projects vary and depends on the individual investigator needs. Consulting on study design or type of analyses takes a few hours; but more involved projects that require help from study design to manuscript writing has taken over a year.

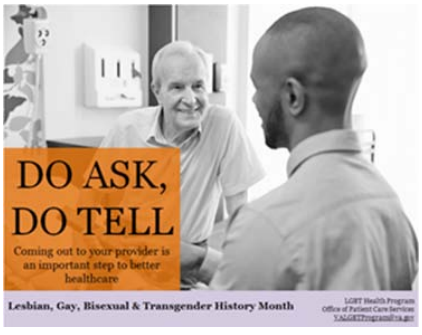
Q. What's your best piece of statistical advice for investigators developing new research projects?

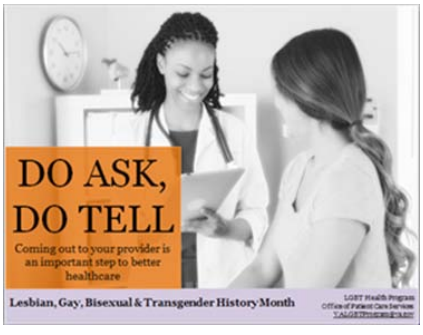
NP: Always try to talk with a statistician as early as possible, preferably in the planning phases of your study. We can provide help with study questions and with appropriate design and analyses in a way that can save the investigator time and effort.

SS: I advise investigators to consult with a methodologist or statistician during the earliest phase of their project. A good study design, knowing which data to collect, where to collect data from, and how to analyze data is invaluable; that's where the MIDAS team can help.

October is LGBT History Month

The LGBT Health Program has chosen the theme, "Do Ask, Do Tell: Coming Out to Your Provider is an Important Step to Better Healthcare," to help remind Veterans of the importance of trust and open communication in the healthcare environment.





Download, print, and display the poster in common areas of your facility, including reception areas. Download the **2017 history month posters** or access other **posters/factsheets about LGBT Veterans**.

RESEARCHER (continued from page 1)

mathematics, biomedical engineering, and neurosciences. I earned my Doctorate of Medicine from the University of California at San Diego School of Medicine. I completed a neurology residency at the University of California at Davis, in Sacramento, California. I am also completed a fellowship in brain injury and medicine at Northwestern and the Rehabilitation Institute of Chicago. I am double-boarded in neurology and brain injury medicine and rehabilitation.

I recently joined the Section of Physical Medicine and Rehabilitation at the Southeast Louisiana Veterans Health Care System in New Orleans, Louisiana. I became interested in research and innovation during training when I saw how these avenues could be impactful for my patients. My research on traumatic brain injury (TBI) has been published in peer-reviewed journals and was awarded the American Academy of Neurology's (AAN) Founder's Award in Translational Research. I am particularly interested in the role of digital health in facilitating the transition from a fee for service to a value-based health care system.

Q. What do you like about doing research with Veterans?

This is an underserved population where there are multiple low-risk and high yield interventions to assess for safety and efficacy.

Q. How will you use your SC MIRECC affiliation to grow your research career?

I have already received a tremendous amount of feedback, guidance, and mentorship. I recently applied for a small education grant. I hope to continue using these tools that a SC MIRECC affiliation provides to grow my research.

Q. What would your dream research study be in funding weren't an issue?

I would like to assess the utility of virtual reality in medical education, care delivery, and community reintegration of Veterans with TBIs. I have provided some links to some preliminary work on virtual reality and medical imaging. The password to view the videos is Burdette.

- Video 1: Spine - https://vimeo.com/214550534
- Video 2: Hip, Liver, and Heart: https://vimeo.com/220808943
- Video 3: Aneurysm: https://vimeo.com/226642193
- Video 4: Co-immersive Medical VR demonstration: https://vimeo.com/228118798

Q. Is there anything that I haven't asked that you would like our readers to know about you or your work?

Digital health tools and specifically virtual reality are new and untested modalities of care delivery that could efficiently and safely improve our ability to deliver care to Veterans.

Recent Publication

Teaching Caregivers of Persons with Dementia to Address Pain

Kunik ME, Snow AL, **Wilson N,** Amspoker AM, **Sansgiry S**, Morgan RO, Ying J, Hersch G, **Stanley MA**

American Journal of Geriatric Psychiatry, 2017, 25(2), 144-154

Summary by Sonora Hudson, MA

Problem Addressed by Study

At least half of persons with dementia (PWD) living in the community become aggressive, and most risk developing behavioral disturbances, making them twice as likely to have to move into an institution sooner than they would have otherwise. Aggression affects both the PWD and his/her caregiver and often results in poor quality of life and depression. Atypical antipsychotics are one treatment; however, evidence for their usefulness is mixed, and they cause adverse effects. Nonpharmacologic management is widely recommended as best treatment.

According to systematic literature reviews, most interventions target caregivers in an attempt to improve communication between them and patients, providing caregiver education and encouraging patient participation in meaningful activities. Although evidence modestly supports reduction of behavioral symptoms by caregiver interventions, few have focused on treating or preventing aggression. Factors causing aggression include acute medical conditions, unmet needs, sensory changes, poor sleep hygiene, and being male. Pain and low pleasant activity levels were also found to be significant predictors. Preventing Aggression in Veterans with Dementia (PAVeD) was designed to prevent aggression by addressing pain and improving the patient-caregiver relationship and communication. Outcomes compared the results of PAVeD with those of enhanced usual primary care (EU-PC) in decreasing aggression and pain and improving depression, pleasant events, caregiver burden, and quality of the patient-caregiver relationship.

Results of the Study

Total attrition was similar for both groups, except completers were more likely to have a caregiver with at least a college degree. Incidence of overall aggression was also similar for both groups, with no significant difference in time until incidence of overall verbal or nonverbal aggression. In addition, treatment groups did not differ in pain, change in pain over time, depression, burden, pleasant events, or change over time. The EU-PC group did, however, significantly decline in mutuality (quality of the patient-caregiver relationship) over time, compared with the PAVeD group. Overall, caregivers were pleased with PAVeD.

Implications and Impact of the Study

Although the comparison of PAVeD and EU-PC did not show significant differences in aggression incidence, the EU-PC group had lower-than-expected incidence of aggression at all time points, which may have obscured outcome differences between groups. In addition, PAVeD caregivers who learned to more effectively recognize pain might have

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caused their group's pain scores to rise more than the control group's. However, despite study limitations, PAVeD significantly increased mutuality between patients and caregivers, which is important because mutuality strongly predicts psychosocial well-being. The authors conclude that PAVeD might require modification to address ". . . a broader range and more in-depth coverage of aggression risk factors (pain, relationship, depression, caregiver unmet needs, dementia education), with person-centered tailoring to target certain types of distress."

Research Core Updates

Dr. Amanda Raines Begins New SC MIRECC Pilot Study to Improve Rural Veteran Access to Evidence-Based Care

We congratulate Dr. Amanda Raines on the start of her SC MIRECC pilot study, "Improving Access to Evidence-Based Care Among Rural Veterans Using a Transdiagnostic Treatment Approach." Dr. Raines is located at the SC MIRECC anchor site at the Southeast Louisiana Veterans Health Care System (SLVHCS) in New Orleans, Louisiana.

Abstract

Approximately 5.2 million Veterans reside in rural communities across the United States, making it difficult for them to access quality medical and mental health (MH) care. The VA established community-based outpatient clinics (CBOCs) to improve access to healthcare for rural Veterans. Group-based cognitive behavioral protocols that target a number of different diagnoses are likely to be more attractive in these settings and therefore more readily disseminated. Such protocols, often referred to as transdiagnostic treatments, are based on the theory that emotional disorders share common features and therefore respond to common therapeutic procedures.

One such treatment, Safety Aid Reduction Treatment (START), has received increasing empirical support. This group-based transdiagnostic treatment is designed to address cognitive and behavioral strategies, otherwise known as safety aids, that are common across a number of psychiatric conditions (e.g., anxiety disorders, trauma- and stressor-related disorders, obsessive-compulsive and related disorders, and depressive disorders) and used to reduce anxiety. START has been found to effectively reduce psychopathology in community-based clinical samples and more recently among Veterans at SLVHCS. However, the utility of this treatment has yet to be examined in rural settings.

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The primary aim of this study is to test the acceptability and feasibility of a group-based transdiagnostic treatment, termed START, delivered to rural Veterans at CBOCs. A secondary aim of the project is to examine the utility of START by gathering data on symptom change, which will be used as pilot data for a subsequent grant proposal.

This study supports the SC MIRECC mission by improving access to evidence based psychotherapy for rural and underserved Veterans. Further, this study has the potential to lead to a federally funded project to improve delivery of services to Veterans by directly addressing access and resource obstacles.

SC MIRECC Investigators Featured in HSR&D Forum on Rural Health

We congratulate Drs. Ellen Fischer and Teresa Hudson on articles in the recent issue of the *HSR&D Forum on Rural Health*. The *Forum* also highlights the work of former SC MIRECC Associate Director for Research, Dr. John Fortney. **Access the *Forum* Rural Health issue**.

Articles

Identifying Barriers to Engagement in Mental Health Care: Perspectives of Rural Veterans and Providers

Ellen P. Fischer, PhD, Jean C. McSweeney, PhD, and Patricia Wright, PhD

Partnered Research to Improve Health of Rural Veterans

Teresa Hudson, PharmD, PhD

The Virtual Specialty Care QUERI Program: Improving Access to High-Quality Specialty Care for Rural Veterans

John Fortney, PhD, Greg Reger, PhD, and Alexis Beatty, MD, Heather Reisinger, PhD, Caroline Turvey, PhD, and Michael Ohl, MD

VA U.S. Department of Veterans Affairs
Veterans Health Administration
Health Services Research & Development Service

FORUM
translating research into quality health care for Veterans

Summer 2017

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Commentary

Increasing Rural Veterans' Access to Care Through Research

Thomas F. Klobucar, PhD, Acting Executive Director, Office of Rural Health, Washington, DC

Excellence in medical care is a product of research, innovation, and a passion for patient care. Nowhere is that more evident than at the U.S. Department of Veterans Affairs (VA). When a Veteran walks through the door of a VA medical facility it is our responsibility to deliver consistent, high-quality care—regardless of where the Veteran lives. However, in our routine efforts to identify new treatments and deliver existing ones, we sometimes overlook one of our most vulnerable populations: rural Veterans. Their advanced age, comorbidities, and combat-related injuries complicate their care, and when compounded by provider shortages and the simple reality of distance to care, rural Veterans may find themselves at a disadvantage. To the extent that rural Veteran dependency on VA health care continues to grow relative to urban reliance, it is imperative that researchers strengthen their efforts to focus on Secretary Shulkin's priorities of access and modernization to give Veterans "true choice."

It is fair to say that the demographic and health-related characteristics that define "rural" may well be the harbinger for what is to come, and has lessons that will apply to an aging, medically complex, and increasingly reliant *urban* population. Rural to urban dissemination of research and innovation in health care is already happening in VA. The research community knows this, and the partnerships that the Office of Rural Health has with so many of their number bear witness. Nonetheless we need to do more.

The health care of America's 5.2 million rural Veterans is at risk. While 18 percent of the U.S. population lives in rural America, only nine percent of primary care physicians and seven percent of psychologists practice there. In addition, since 2010, 1.2 million rural patients lost access to their nearest hospital—30 of which closed in the past two years alone.

These constraints are amplified when we consider that over half of VA-enrolled rural Veterans are age 65-plus.[1] According to the American Geriatric Society, those over age 65 use a disproportionate percentage of health care services and more than 80 percent require care for chronic conditions such as hypertension, arthritis, and heart disease. Aging rural Veterans, who need health care the most, have the hardest time accessing it.

The Office of Rural Health (ORH) was chartered by Congress in Public Law 109-461 "to work with all personnel and [VA] offices to develop, refine, and promulgate policies, best practices, lessons learned, and innovative and successful programs to improve care and services for [rural] Veterans..." As we look to solve future challenges, ORH has identified significant research gaps in the areas of transportation, rural women's health, and rural mental health services.

For many rural Veterans, simply getting to care is the challenge. An average rural Veteran travels over 30 minutes to receive primary care, and almost 90 minutes to

CBOC Mental Health Rounds

Ethics in the CBOC

Peter D. Mills, PhD, MS and Delores Hendrix-Giles, LCSW, BCD, CGP

Wednesday, October 11 at 8:00-9:00 am CT
Thursday, October 12 at 11:00-12:00 am CT

Registration: Select the links below to register for this training in TMS. Only register for one day; registering for both days will cause delays when completing the program evaluation for CEU.

Click here to register in VA TMS for Wed 10/11

Click here to register in TMS for Thur 10/13

About the Topic: At the conclusion of this program, learners will be able to define three core functions of medical ethics, describe ten common myths associated with decision-making capacity, describe how decision-making capacity is assessed, explain six sources of ethical dilemmas, and define six ethical risk areas.

Audio: Call 1-800-767-1750 and use access code 37009#

Visual: Join Adobe Connect through VA TMS

Contact: Ashley.McDaniel@va.gov

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#

November 8 & 9, 2017
REACH VA

December 13 & 14, 2017
REACH VET

Learn more about SC MIRECC by visiting www.mirecc.va.gov/visn16/index.asp

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