Veteran Defined Treatment Engagement and Access to Mental Health Services

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Outline

- General principles about engaging rural Veterans in care and research
- Specific research study examples of engaging rural Veterans
  - Mental health access project
  - Mental health treatment engagement project
  - Community engagement project
Who are the relevant stakeholders for rural VA research?

- Veterans who represent population of interest
- Family members
- Caregivers
- Veteran organizations that represent patients, family members, and caregivers
- Local VA clinicians and administrators
- Central Office leaders
- Community leaders
- Other healthcare systems, payers, policy makers
- Researchers
When to include stakeholders in research process?

- Topic selection
- Formulating research questions
- Defining essential characteristics of study participants, comparators, and outcomes
- Identifying outcomes that the population of interest notices and cares about
- Monitoring study conduct and progress; and
- Designing/suggesting plans for dissemination and implementation activities
Why should we include stakeholders in research process?

- Improve relevance of research question
- Prioritize Veterans’ interests and concerns
- Increase stakeholder buy-in and uptake
- Improve recruitment
- Improve intervention implementation
- Include more patient relevant outcomes
- Increase confidence in findings
- Help interpret findings
- Improve accountability and transparency
- Improve dissemination and sustainability
How to include stakeholders in research process?

- Involve stakeholders early in research process
- Set up shared leadership and decision-making processes with stakeholders
- Be flexible
- Use lay-person language
- Establishing trust and respect take time
- Stakeholder and researcher training will be needed
- Patient stakeholders should be compensated financially for their involvement
- Work toward win-win processes and outcomes
Veteran Defined Access Project

1. Collect qualitative data from VA patients about their experience accessing mental health services.

2. Assess the content validity of the items and construct a preliminary version of the Perceived Access Inventory (PAI).

3. Evaluate and refine PAI (concurrent and predictive validity and reliability).
Background

- Access and engagement to MH services continues to be a challenge for VA and non-VA health care settings
- Rural status is associated with decreased MH treatment initiation and engagement
- Rural status is associated with increased suicide rate
- VA SOTA Access model
  - Access definition: “the potential ease of having virtual or face-to-face interactions with a broad array of healthcare providers”
VA SOTA Access Model
Methods

- Mixed Methods
  - Qualitative & Quantitative

- Sites
  - Arkansas (VISN 16)
  - Maine (VISN 1)
  - Northern California (VISN 21)

- Participants
  - 80 Veterans age 18–70
  - Screened positive for at least one MH problem (PTSD, depression, alcohol) within the past year
  - Experienced any stress–related or emotional problems related to PTSD, depression or alcohol within the past year
**Qualitative Sample**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Qualitative Sample (n=80)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, mean (SD)</td>
<td>46.7 (13.8) range 20–70</td>
</tr>
<tr>
<td>Male, n (%)</td>
<td>60 (75.0)</td>
</tr>
<tr>
<td>Caucasian not Hispanic, n (%)</td>
<td>49 (61.2)</td>
</tr>
<tr>
<td>High school education only, n (%)</td>
<td>18 (22.5)</td>
</tr>
<tr>
<td>Married or Cohabitating, n (%)</td>
<td>37 (46.2)</td>
</tr>
<tr>
<td>Employed full or part-time, n (%)</td>
<td>30 (37.5)</td>
</tr>
<tr>
<td>VA service connected disability, n (%)</td>
<td>23 (29.5)</td>
</tr>
<tr>
<td>Rural residence, n (%)</td>
<td>37 (46.2)</td>
</tr>
<tr>
<td>Mental health visit in past year, n (%)</td>
<td>53 (66.2)</td>
</tr>
<tr>
<td>Depression (PHQ–9 ≥10), n (%)</td>
<td>28 (35.0)</td>
</tr>
<tr>
<td>At–risk drinking (male), n (%)</td>
<td>25 (41.7)</td>
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<tr>
<td>At–risk drinking (female), n (%)</td>
<td>11 (55.0)</td>
</tr>
<tr>
<td>PTSD (PCL&gt;50), n (%)</td>
<td>36 (45.0)</td>
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</tbody>
</table>
## Qualitative Data Summary

<table>
<thead>
<tr>
<th>Domain</th>
<th>Definition</th>
<th># Segments</th>
<th># Codes</th>
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<tbody>
<tr>
<td>Logistics</td>
<td>Geographical, temporal, and financial issues</td>
<td>757</td>
<td>6</td>
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<tr>
<td>Culture</td>
<td>Veterans' beliefs, values, and attitudes regarding mental health symptoms and treatments.</td>
<td>1,838</td>
<td>8</td>
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<tr>
<td>Digital</td>
<td>Any existing technology Veterans use for mental health information and communication.</td>
<td>1,324</td>
<td>11</td>
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<tr>
<td>Systems</td>
<td>VA mental health structures and processes and how those affect Veterans’ experiences or perceptions of access to mental health services.</td>
<td>1,247</td>
<td>11</td>
</tr>
<tr>
<td>Experiences of Care</td>
<td>Veterans’ perspectives about past or current interactions with VA or non-VA providers or facilities.</td>
<td>1,356</td>
<td>7</td>
</tr>
<tr>
<td>Experiences of Treatment</td>
<td>Veterans’ perspectives about symptoms, interventions, side effects, and outcomes related to mental health.</td>
<td>1,869</td>
<td>6</td>
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</tbody>
</table>
## Contrasting Access Frameworks

<table>
<thead>
<tr>
<th>VA SOTA Access Model</th>
<th>Qualitative Analysis</th>
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<tr>
<td>Geographical</td>
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<td></td>
<td>Experiences of Treatment</td>
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</table>
Current Version of PAI

- 43 items: Logistics 5, Culture 3, Digital 9, Systems 13, Experience of Care 13
- Validation and reliability phase will begin in October 2016
- For use with Veterans who have used VA mental health services in past year
- Other possible versions:
  - Choice Act Veterans
  - Veterans who screen positive but have not used MH services in past year
Sample PAI item

1. In the past 12 months, did you ever feel that you should just “tough it out” and not seek mental healthcare?

   Yes
   No (*skip to next page*)

   How much did that feeling interfere with getting the VA mental healthcare you needed?

   Completely 5
   A great deal 4
   Somewhat 3
   A little bit 2
   Not at all 1
Veteran Defined Treatment Engagement Project

1. Conduct a formative evaluation of perceived barriers to MH engagement among rural veterans and adapt a motivational interviewing (MI) engagement intervention.

2. Compare the effectiveness of MH Referral alone versus MH Referral plus MI-based peer coaching.

3. During the RCT, conduct an implementation-focused formative evaluation with stakeholders to refine the intervention.
Methods

- Evidence Based Quality Improvement (EBQI) is a multi-stakeholder process to promote uptake of evidence-based practices
  - Researcher / clinician / administrator partnership that activates staff participation in the implementation effort and promotes buy-in
  - Plan-Do-Study-Act (PDSA) cycles provide opportunity to revise intervention based on stakeholder audit and feedback.

- Sites
  - Northern California (VISN 21) and Louisiana (VISN 16)

- Participants
  - 52 CBOC staff, 37 CBOC patients
Results

- CBOC staff
  - Overwhelmed by Veteran MH needs
  - Identified need for additional VA and non-VA rural MH resources
  - Peer MI coaching intervention seemed to address many Veteran and system barriers

- CBOC Veterans
  - Mismatch between VA and Veteran definition of engagement
    - VA definition = 8 or more MH visits or at least 2 months of MH medication and more than 4 visits within 1 year
    - Veteran definition = use of community resources and self-care to manage stress and improve quality of life
Impact

- Directory of community-based resources updated
- Veteran qualitative interview data used in role plays to train peer coaches
- Self-care and health work strategies identified by Veterans included as a secondary engagement outcome
Community Engagement Project

1. Develop partnerships between VA mental health researchers, VA chaplains, and local clergy and faith communities to develop local programs to promote mental health treatment of Veterans in need.
2. Partner with National Chaplain Center Rural Clergy Training Program
3. Facilitate Community Action Boards evolution to self-sustainment
Methods

- Use of Community Based Participatory Research methods – Principles of Community Engagement
  - 3 Phases: Entering Community, Strengthening Collaboration, Moving to Self-sustainment
- Initially VA staff collaborated with community clergy and later incorporated more community partners into Community Action Boards
- Peer navigators facilitated VA Clergy and Community Partnerships
Results

- Building CAB identity takes some time
- Clergy/Community relationship with VA staff facilitated with local Pew and Couch lunches
- Ongoing community clergy training
- More recent shifting of VA focus to community collaboration
- MH providers acknowledging need for community to help meet Veterans’ needs
Impact

- 4/6 Arkansas CABs are self-sustaining
- National Chaplain Center expanding community clergy training on community engagement
- Network of trained community clergy providing support for recent VA HSR&D pilot proposal (Mental Health Clinician Community Clergy Collaboration (MC4) to address moral injury in Veterans)
Conclusions

- Stakeholder engagement is critical to research and community engagement success.
- Models exist for guiding stakeholder engagement.
- Veteran and community engagement is not a “top down” activity.
- Sometimes the results can be surprising.
Comments and Questions?