



BREAKOUT SESSION

Taking Better Care of Our Veterans

Moderator:

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Speakers:

David Atkins, MD, MPH

Beth Cohen, MD, MAS

Discussants:

Elisa Borah, PhD, MSW

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SESSION TRANSCRIPT

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>> Good afternoon. Welcome to all of you who are here in the room. Thank you for coming. I know that it's the latter part of Thursday afternoon, and so we're going to try to keep this moving along. And I have good news. I don't have any slides to show you.

So I'm the director of the Clinical Effective and Decision Science Program at PCORI which is one of the programs in the science program that actually manages research projects. We put together this focus to really focus on a priority population for PCORI. You know, PCORI has a lot of interest in looking for research opportunities in population groups that may have had -- when we choose an opportunity to do research about the effectiveness about various kinds of approaches to managing those patients. And we've recognized that we would like to put a focus on the health of veterans and so we've assembled a nice group of individuals to talk about that, including David Atkins, Beth Cohen, Cheryl Krause-Parello, and Elisa Borah, all of whom except for David have had involvement with PCORI research projects.

So we'll start out with David Atkins, who is the director of the health research and development program at the VA, at the Department of Veterans Affairs. He manages a large research funding program that pretty much is all about improving care for veterans. So David, take it away.

>> Thank you, thank you. It's a beautiful day outside, so I'm surprised to see anybody here. But I'm grateful, and grateful that other funders like PCORI have an interest in veterans. I thought I was going to be making closing comments, but now I'm told to set up and set the stage. I'm going to do just two things, one which is sort of talk about the

challenges of research in a learning healthcare system and what I've learned over ten years at the VA and how we're trying to tackle the need to get more of our research into practice, and then talk about how veteran engagement, which you'll be hearing about from the next three speakers and other research using our large database sort of fit into that. And address some of these problems. And that's a debt we owe to PCORI.

So I have nothing to disclose. I've been a government employee for 25 years now. So, the first thing is the VA is a great place to do research as a learning healthcare system. We're the largest integrated health system. Kaiser, I think has more patients, but we really function as a national system. Kaiser is a little more of a conglomeration of independent groups. We have a diverse number of facilities, including 172 medical centers and over 1,000 outpatient settings. That gives us a lot of advantages that we have. The other advantage that we have compared to other integrated systems is Congress gives us a pool of money to do research on it. And that's a luxury that other private health systems don't have. So our research budget, which is over \$700 million covers everything from basic science and rehabilitation research through clinical and health services research and implementation. And we have a well-known implementation program called QUERI to get research into practice. We've also had electronic health record for a decade longer than the private sector. We have over 20 years of national health record, which is now in a national corporate data warehouse and you'll be hearing about research using that.

But the other thing is we are an integrated health system that has wrap-around care, so we can tackle problems that are in many places viewed as outside the health system, including educational, housing, disability service. And including a commitment to caregivers, Congress has passed legislation allowing the VA to actually support a limited set of caregivers, but that is now being expanded.

And so we have the ability to test the importance and the value of things outside of traditional clinical services. And we have patients that are committed to giving back to their fellow veterans by being participants in research.

But, I wanted to make one take-home point. It's as we think about things that we think need to improve in the healthcare system, it's important to distinguish three types of questions. One is sort of what should we do, which is really a knowledge question. And so we just concluded a conference on opioids in the VA and critical questions. And so a knowledge question is how should we handle all our patients who have been on long-term opioids? Should we taper them quickly? Should we taper them slowly? Should we give them adjuvant buprenorphine? Those are a bunch of knowledge questions.

Often, though, the challenges in the healthcare system aren't really knowledge questions. They're implementation questions. So we know what we should be doing, but we're not doing it. And there, the question is really what are the best ways to do what we want to do. And so that's a type of question. We know we want to give more medication-assisted therapy to patients who have substance abuse. We're still not

doing enough of that. What's the best way to implement that on a national scale?

And then lastly, there are some things that aren't even really implementation questions. They're really just execution questions. So we are a diverse healthcare system. We have 172 medical centers. Unfortunately, on an average month one of them gets sent to the news. And those are really just questions how do you build a system that holds people accountable and ensures consistent care. And that I would argue is not really a question that research is going to solve. That is a management, business schools are probably better than research in solving those problems.

But the fundamental problem is, I think for PCORI, as well as for the VA, is for too little of our research really achieves liftoff, meaning getting into widespread practice. So we have interventions that are successful. We have a lot of interventions that aren't successful. That's why it's called research. But even the successful ones don't spread or get sustained.

And the reasons for that are we haven't necessarily aligned the question with the customer, the people who are going to be responsible for sustaining the service. And a busy system and a reactive system like the VA, we have to really be paying attention what the top priorities are.

And I think this all gets at what the mission of PCORI has been from the beginning, which is really engaging all the stakeholders at the beginning to really think about this question, which is how do you get interventions into practice. But also researchers often don't think about value in the way that their customers are thinking about value. So what does it really take to convince a medical center director or a network director to actually sustain and support nurse care managers to take care of depression?

Or to enhance the staffing to allow you to deliver prolonged exposure therapy in mental health?

So it's important to think about how do you engage the people you want to sell your project to when it's done. So, there are three common reasons why your research might not make a difference. Unfortunately they're not all easily solvable. David, are you monitoring time? I want to make sure. Okay. So one, it takes too long. That is a problem I think for all funders. There are ways that many of us are working to think about phase funding. We talked about the incentives being aligned with your customers, and planning for implementation from the beginning. You really should be thinking even before you know whether something works how you would implement it if you're lucky enough to have hit on something that is really successful.

So these are just four solutions I'm going to walk through quickly about how the VA is thinking about it. We're thinking about new funding mechanisms that would allow sort of serial funding to get things started and then invest in things that are working. We're doing a lot as is PCORI to think about improving the partnership in research with all levels of stakeholders. We're trying to do more to reward researchers who not only get

published and get funded, but whose research has really made a difference. And unfortunately, the work to actually get something from publication to making a difference is a lot of unfunded effort from your PIs. You really have to be an advocate. That isn't stuff that always leads to new papers and new funding. It means going to meetings and briefing Congress and talking to leaders and being passionate. So we really need to find ways to reward that.

And then, enhance attention to implementation.

So, in the close of my talk, I'm just going to say all right, so what's the importance of veteran engagement as a way of supporting this effort to try to make our research make more of a difference? And here we owe a clear debt to PCORI. I think it was probably four years ago that Jean Slutsky, my former boss, came to talk to a set of our research leaders about patient engagement. And that led to us setting up some funding activities at our centers to promote veteran engagement. I said I'm not sure what I want to do. I want you to go out and just try this. It sounds like the right direction to go. Go ahead and we'll give you some money and you can invent your path forward, and then we'll look at what seems to be working.

And I think everybody in this audience knows the purpose of engagement is to make sure we ask meaningful questions, we improve the relevance of our questions and the data that we're collecting, how we measure things to understand with insight of our patients what our data actually mean, and what they mean to our patient population. And then the hope is with all of that if we have a successful research project, the dissemination uptick will go more smoothly because the people who are going to be affected by that will be on board, and they feel invested in it.

So there are many levels of engagement in research. PCORI I think covers all of these. We have focused more on the intermediate levels, which are getting consultation from our veterans as we're thinking about research ideas, involving them as we put together research proposals, and sometimes as collaborators. We're lucky to have many VA employees who are veterans themselves. And some of whom are researchers. But even when they aren't, we have been trying to build engagement groups so that those people will be more at the table. We have not gone as far as PCORI has to try to engage veterans in our review process or as actual leaders of project. So that's the next step and we're looking to see what you're learning about that experience.

These are just some pictures from various veteran engagement groups. We have 18 research centers, each of which has set up veteran engagement meetings. So what are we still learning? Well, engaging these different perspectives requires a culture shift, I think for people who are used to just in their research silo and with their data and focusing on the validity of their data, bringing in the perspectives of patients seems new, it seems challenging, it's messy, it takes time, but I think we've made progress.

Obviously, we're interested as a research group to say can we show what difference it makes. How are our projects looking different for the fact of the veteran engagement? And I would be interested to hear what other people are thinking about how do we show that this is actually changed the way we do research in a positive way.

We have particular internal barriers to paying veterans for this work that may not affect other external funders in the same way. I think those are inside details. And then we're continuing to explore how to give more meaningful roles to our veterans and the right people to engage in more substantial roles.

I'm not going to say much about this, because you're going to be hearing more about it. But the next three projects you're going to hear about really touch on our critical areas. Caregivers are an increasing focus. We've set up a national center of excellence with support from the Dole Center in North Carolina, looking at excellence in caregiving. And as I said, we have mechanisms to actually support caregivers directly and have been asked to expand that by congress.

PTSD remains a critical problem for the VA. And we have real problems both from the delivery and the research end. We have effective treatments for PTSD, but adherence over the long term has proven challenging, and in part because we have been doing a lot of research on PTSD, it's getting increasingly hard to engage new patients in new studies. We're getting to the point of how do we continue to engage research subjects in new studies.

And then I think the VA is a great place to do comparative effectiveness research because we have such a wealth of national clinical data and you'll be hearing about that, as well. So I'll conclude my comments. I think research is critical to a learning healthcare system. But if you really want it to make a difference, you have to be thinking about a number of these issues. About your customer at the beginning and how to implement and engaging stakeholders is a critical part of that evolution. We are, I think everybody in this room recognizes we are not going to have a perspective randomized trial on every intervention. So we need to learn from real-world data. This has been a focus of the National Academy of Medicine over the past several years. What they call real-world evidence. And we need to learn from national experiments. Sometimes things that are being rolled out in the VA, they didn't come from research, but we can learn from them because we can roll them out in ways that we can do comparisons of people who have gotten it and people who haven't.

Planning from implementation from the beginning is critical. And then lastly, relationships are more important than evidence. And I think veteran engagement is just a part of that, that you can have all the great data and a high-profile publication, but if people don't trust you and feel like they understand where you're coming from, your evidence may not be very persuasive. Thank you.

[Applause]

>> Thank you, David. So we're going to kind of hold questions until the end. We're going to devote about 12-15 minutes for each of these presentations and so we will move on. So I apologize. I am probably going to mispronounce your first name. So I'm sorry about that.

>> He said it correctly.

>> So it is Eliza

>> Elisa.

>> Elisa. So Elisa Borah is a faculty member at the University of Texas in Austin and also at the Dell Medical School in Austin. And she's been focusing on doing work focusing on the needs of veteran spouses. And so I look forward to your presentation, Elisa.

[Applause]

>> Hi, everyone. Thank you for inviting me to speak about this topic. This was an engagement award only. So you've heard a lot of research projects talk about their work today and how they've engaged individuals into the research process. But this was an engagement award only, which I had to learn what that meant when I applied to it. I was very happy to have that opportunity, which is how do we engage family members, stakeholders, patients, et cetera, into the research process. That's what we called our task. And so as you can see, the title was engaging veteran spouses to identify research priorities to address veteran spouses needs. I would add to that, as well, that we really were engaging them to understand the whole family. We know that spouses have a very good insight into what the veteran or their spouse needs, in terms of healthcare, and they help navigate that healthcare process. It was very important to talk with them.

I have nothing to disclose.

So the project was called the Veteran Spouse Network. We wrote the grant in 2015, and I wanted to quickly explain how that came about, because I realized that it wasn't really my idea. I was part of a statewide evaluation for the state of Texas to look at the military veteran peer network, which is a state-funded veteran peer-support program. They offer one-on-one peer support, they train the veterans to serve in that role, and they also offer group peer support. My job was to go to a lot of different sites around Texas to see how it was going. What was working, what was not working, and how to improve it. And we put together a lot of focus groups at the various chapters of the peer support group. And lo and behold a lot of the people who showed up to these focus groups were the spouses, not the veterans. And they came on their own accord because some of them had even been trained to support the veterans on peer support.

But what they said to me over and over again is this is nice. We really love peer support for the veterans and we think it's helping them, but we don't have anything for us, and we are really struggling with life after the military, whether that was supporting an individual like their husband or wife who was struggling with PTSD or other mental health concerns or other chronic health concerns. They needed support. And they weren't always identified as caregivers for, you know, there are more formal definitions of that through the VA and other organizations. But they were definitely providing caregiving in a way that any spouse does.

And so that's what led me to write the grant because they told me this needs to happen. You're not hearing from us. So, luckily, it was funded, and our purpose was to develop a statewide network of veteran spouses or committed partners. You didn't have to be married. To help us inform research and programming that could support spouses and their families, including the veterans.

So our goal was to recruit 250 individuals across five chapter areas. We selected those based on the density of veteran population in the state of Texas, which is quite dense, but the big cities of course had the most. And we hosted big in-person events that shared or offered self-care because we thought that is one way to get a busy mom, spouse, or husband, to show up out of their very busy lives to focus on them and offer some things that could be supportive in their lives, while also talking about research. We know nobody really wants to come to an event from a research talk about things. So we peppered in the fun stuff, as well.

We also offered online webinars, trying to provide a foundation of knowledge around what are we doing when we talk about research, what does that mean, what are we studying, how do we study things, how could they get involved. And we also tried to highlight research investigators that were working in this field of supporting veteran mental health spouses and families so they could hear straight from the researchers what they were working on and create that dialogue to help inform their research. So, engagement was relatively new. As was just mentioned. First, it was funded in PCORI in 2015. So we were one of the first. And we didn't know exactly what engagement meant. So we thought okay, Facebook is a good place to start. It's pretty standard, pretty obvious, but it actually is effective. And we learned later that Facebook early adopters were military spouses. Because once they leave a military installation, many, many times in their military service lives, they wanted to stay connected to friends and family from across the world. They were early adopters and Facebook was definitely one way to go. Of course the in-person events because we want face to face time whenever possible to talk with a spouse and get them involved. Other things that I'm going to talk about are how we engage them to help them develop surveys, administer surveys, and then help to discuss results. What did it mean?

We hosted forums where they could interact with other policymakers and researchers related to policies in the state of Texas that could support veteran and family health. And an example here in this picture is we tried to get as creative as we could as, you

know, researchers at a university, which was how can we help them amplify their voice? How can we ask them the right question or activity? So one of our big networking events that we had, which has a great turnout of 100 people, we thought that was a great turnout so we did a little white board exercise. We had a photographer on staff all day. We had a repeated background that really highlighted that this is a new organization in Texas. We asked every spouse to write on the white board what it means to be a veteran spouse. Because I should have mentioned earlier this is a relatively new area in there is a lot of focus on veterans, and there is focus on caregivers, but there is not much focus, because the VA isn't authorized to spend money on family healthcare, but there are a lot of veteran service organizations that are focused on veteran families. But it's not an easy identity for a military spouse when he or she leaves active duty military life to connect and identify as a veteran spouse. There are lots of people in the world who are and were married to veterans, but they haven't necessarily identified as a group themselves. So it helped us to just put it into their own words and talk about what it means to them. She said being a veteran spouse means always keep the home fires burning, which is something you always hear, or holding down the fort in active duty military life. But it's also true afterwards, and there is a lot that we've learned from them what it means to do well by themselves, the veteran, and their families after military life. That's what we really focused on.

So one key thing that thankfully we thought this was a good idea, and we've probably seen it in other studies, which is establish a steering committee from each of those five regions that we identified. We put out a call on Facebook and through e-mail and other partner organizations that we asked veteran spouses to apply to become part of our steering committee, to guide us. We really relied heavily on them to help them determine the direction of the network, the things that were important to these five spouses, and they were already leaders in their community. We made sure they were already connected and they were speaking for more than just themselves. They had already started working in this area. I mentioned the webinars. I'll be honest, those didn't work out too well. It's hard to get people to attend a webinar to learn about survey development. Even we don't want to go to those webinars. I tried as hard as possible, but it didn't go as well as planned. I'll have to figure out other ways of doing that.

They did enjoy working on the survey. We polled them on Facebook. What are the top three issues that you are facing as a veteran family. The three top ones are veteran mental healthcare, marital relationships, and my own employment and education as a spouse, as a veteran spouse. Now that I have all of this freedom, I'm not moving around the world, I'm in one place, I can keep a job long-term, what do I want to do with myself? We surveyed on that topic around the state. And I developed a quick online draft of it and we sent it out to the network to refine the question, how long it would be. Nobody wants a long survey. And once we got it in good shape, we sent it out via Qualtrics on Facebook. We relied on sampling because it's just people on Facebook sharing it. So that wasn't bad. Seems like a good outcome. And I'll get to the results in a minute.

In addition, you know, many of the steering committee members and other volunteers in our network weren't necessarily employed yet after transitioning from the military or they weren't working full time. And so we had just made it, we felt it was important to give them professional titles and really recognize their work. We didn't have stipends, but we did offer travel support any time they were involved, any kind of reimbursements, et cetera. And I think they appreciated that and they put this title on their resume and they were proud of what they were doing.

In addition, one area of gap that we felt was happening in the state was there's lots of lists of resources for veterans. But we felt like many of these lists, whether online or handouts were really missing resources that would target veteran spouses and their family members. So we asked our network to help us identify those, kind of like a Yelp review. If you've gone out and you've tried ABC mental healthcare, did they have decent military culture knowledge? Were they able to understand your perspective. It may or may not have even come up. Maybe you were never asked do you have someone in your family who served in the military. We wanted to get their resource knowledge. So to the extent possible, we shared that back with an organization called Tex Vet, which is a state-funded website that tries to house all veteran service information for people to go seek care. So we tried to, and they did start a new tag on their website for family-related resources. So we thought that was a nice contribution.

So, we completed the survey. How much time do I have left? Just making sure.

>> About three minutes.

>> Okay. As I mentioned, we developed this survey, had good results. I presented that at a conference that has a military social work track at the Society for Social Work and Research. We're still working on the manuscript, but we're involving the spouses in looking at how the manuscript is written, making sure it makes sense. We don't want it to be too academic.

We invited the steering committee and they all came to our UT Military Social Work Conference. And they had a panel of veteran spouses to speak to what it was like to be involved in the network, their experiences as veteran spouses, which we heard from conference attendees who are many veteran service providers, VA service providers, et cetera, how eye-opening it was to hear directly from the family members how much involvement they have in the veteran mental healthcare journey. And it really I think helped them understand what role the family can play as well as what supports the family needs.

Since that time, I just want to cover what we have accomplished afterward. So this network was really a launch for all the other programs and research that we've been trying to put together. So we've gotten, so we started with the idea coming from veteran peer programs that weren't offering the same supports to spouses and we've

come full circle and now have developed with our network a peer support curriculum that is offered both online and in person for veteran spouses, which is really exciting. We just got our renewed funding from the state of Texas. There is huge interest. We fill our groups. It's very exciting. Because the spouses really want the support. They really need peer support and it's been so good for the whole network.

So, some of our lessons learned. Really rely on your stakeholders' input and expertise. I've learned a great deal from just listening to them and following their lead and really developing programs that fit their needs. Empower them to lead, because they really are capable. They've got loads of experience in their own lives and expertise around their population. Yeah.

So if you want to check out our website, there it is. We also have a Facebook page. We would love to have you join that. And then we have our institute website, where we have new programming that has come out of this initial PCORI grant. Thank you.

[Applause]

>> Thank you, Elisa. And our next presenter is Cheryl Krause-Parello, who is a faculty member at the College of Nursing at Florida Atlantic University.

[Applause]

>> Hi, everybody. So let me ask, how many people in this room are veterans or veterans' friends or family members? Can we please give you a round of applause? We really appreciate your service.

[Applause]

I'm a wife of a Marine veteran and a nurse scientist at Florida Atlantic University. And I really was taken by my husband's experience in the military and as a first responder in the rescue and recovery efforts of 9/11. So it's really near and dear to my heart the work that I'm doing with veterans in the community. Today I'm going to be presenting three of my PCORI-funded projects and giving you some overviews on the lessons learned and hopefully you can take that with you into your communities and make a difference as I feel that we are.

So I don't have anything to disclose. So the first project I'm going to touch on is Veterans Action League. This was a project that we created to give veterans an active voice in a safe space where they could dialogue on what's important to them and ways that they wanted to receive healthcare information, there's also ways that they would want to get engaged in PCOR and CER research and really trying to uncover the gaps in knowledge when it comes to comparative effectiveness work and research in general for the veteran community.

So, some methods and activities. We had a researcher, we called them CARMs, because we know in the military acronyms are really important. And also PCORI loves acronyms, as well. So CARMs are the Collaborative Academic Research Members. So we had one person who was a university-based researcher, and then we also had a veteran unit leader from that state. We had four states and six units. They were California, Texas, Florida, Pennsylvania, New York, and Ohio. And those states were chosen just like my colleague when she chose her counties based on the density of the veteran population.

So the VAL units engaged in what we call think-tank meetings. They were in person and we also had some virtual meetings. Each meeting took place in either a university setting. Some took place at a VFW. But all of the venues were in the community. And they lasted each one about an hour or an hour and a half. We provided a meal for each person who came. It was up to eight stakeholders. And then the researcher and the veteran. We provided them with a military challenge coin that was project specific. We provided them with a parking pass. And then we provided the researcher with a field note template that basically guided the discussion.

So I have a few of the people in the room that were part of that project, and one is Mr. David Hibler. He is in the back right corner.

[Applause]

He was our veteran unit leader in Ohio and he works with the Ohio State University researcher.

And it was really wonderful to have conversations and actually meet with the veterans and the researchers at these meetings because my co-lead and I, Dr. Linda Flynn did one visit to just kind of meet with everybody in person and let people know that there were people behind them that were supporting them from the state of Colorado, because that is where I was living at the time. So we had a total of two years. There were probably about eight meetings and then we had one town hall at the end. And the town hall was really great. It was able to bring the community together, kind of talk with each member in the community to say this is what this unit was doing in this state, and these are the things that are being prioritized by veterans and key stakeholders in your community, because it wasn't just veterans. It was also family members. There were local politicians, there were clinicians, there were other researchers that were engaged and involved in this. And then also in this project we thought it would be really great for each one of the researchers and the veterans who were leading these units to kind of meet each other, not just on the phone and virtual. So we had a two-day retreat in Denver, which was really amazing. A lot of fun. Just talking about things that worked, what didn't work, how to engage people, what maybe we could do in the future, and how we can build and expand on this project.

So our outcomes were what we sought out to do, which was to build a community

engagement and strengthen the research, you know, enterprise really with the veteran and the veteran community. And we wanted to disseminate PCOR and CER. So we were able to go through the literature and talk about literature reviews and things that may have been of interest in one of the units versus another unit. So we had papers that we distributed and then we developed a tool kit. And this tool kit is available on the PCORI website and you can take a look at that. And it really lists all the things that we uncovered over the two-year project across six states and all that information was synthesized and it's available for you to use.

So I encourage you to go to the website. Some of our lessons learned on this project. That they were really enthusiastic. The veterans and the stakeholders really wanted to participate in CER and PCOR, but they were really skeptical about the research enterprise based on past history. They were also unfamiliar with the research process. They didn't really understand it. And they also felt that if there is a research study going on, veterans should be included, you know, when we're developing the research project and also as full partners in the research enterprise.

And they also felt that it's really important to be authentic when you're collaborating with the researcher because trust was a big issue.

So, for many information on this project, PCORI has it up on their website. And then we also recently just got a publication in the Open Access Peer Review Journal, the Journal of Veteran Studies, which is nice because not all people have access to the academic libraries. This is open access and it didn't cost anything to publish in this journal. I encourage you, if you're interested in looking at current research and community engagement projects, they are publishing community engagement projects in this journal. As we know engagement awards aren't research awards, they're research-support awards. So they have a community profile that they support these types of projects. So I encourage you to go take a look at that.

So, with the first Veterans Action League, we found out and heard a lot about pain. That veterans were in pain. Whether it was psychological pain or physical pain. So I got to thinking, you know, these methods worked really well in the project that we just completed. Maybe we should think about some of the research ideas and topics that came out of the Veterans Action League, the first one. We were calling it Veterans Action League 2.0. It's a similar methodology. But the purpose here is to figure out what has been successful for chronic pain management in the veteran population in whom and in one circumstances. Again, we want to engage them in ideas and what works for them. A lot of times we talk about evidence-based interventions, and the veterans are telling us things they're doing that are not in mainstream healthcare. They want us to look at that and research that so it can be reimbursed. I have people doing underwater treadmill for back pain. We have veterans doing all types of non-pharmacological interventions. My biggest, you know, I guess my most important in my life are dogs and the use of service animals for veterans with PTSD and how that can help them in their recovery and reintegration process. But there is not a lot of

evidence on service animals and how that affects veterans with PTSD. And unfortunately, there's not a lot of funding to fund that type of work either. We try to find other ways and other mechanisms so veterans' voices can be heard. This project is really beautiful because we're going to develop a chronic pain research agenda coming from the veterans themselves, and we'll translate that into a white paper so now all the researchers and patients and clinicians in the room can take that information and create studies and then we can have more evidence to support things that maybe we aren't studying right now.

So we have four units this time because six was a lot. You know, lessons learned. Six was a lot to manage. We went down to four for this one. We have units in Georgia again based on the next four states out of the top ten that have the most veterans residing. Virginia, Illinois, and the D.C. metro area. We have again the same methodology. We have in-person and virtual meetings. We're creating think Tank Times newsletters, we're also going to have online meetings every month that we don't have in-person meetings. And it's worked really well. We actually have one of our nurses who was leading one of the units in Texas on the first VAL project that got funded by PCORI to use the same methodology with Filipino Americans. So the methodology works.

And I encourage you to think about it if you have some ideas how to engage your population and I'm happy to talk more about that after.

So again, you know, our project outcomes. We're in our first year right now. But again, we want to build and strengthen our community partners in PCOR and CER. We want to be able to disseminate information that is coming out regarding chronic pain management. We want to develop a national advisory board, and we want to develop a white paper so we can translate that so everyone can get a feel for what the veterans are telling us.

Lessons learned so far. Some research ideas that have come out only in the first year. Strength training, mind-body interventions. They don't really want to be on pharmacological intervention. They're really looking for other mechanisms to manage their chronic pain. We heard that this morning in one of the talks regarding opioids and the reduction of opioid use.

They're really interested and they don't know about other options.

For example, putting together a grant for qigong for chronic low back pain. They don't know what qigong is. So if they knew what some of these options were, then they could make more informed decisions, and we hope that these think tank meetings provide that venue for them.

Again, if you would like to learn more about the project, there is a nice project summary on PCORI's website. And then the last project is Operation PCOR. This is training veterans as partners in the PTSD enterprise. We actually have a poster here on the

second floor. Please come by and chat with some of our speakers who are going to be presenting that poster. I have one of our research veteran partners, Dr. Allen Peterson, who is going to be helping us with that poster, and then we have Julianna Marenco who is the project manager who is going to be there, as well. So we're happy to talk with you all about that. But this is about building veterans' capacity to engage in research as full partners. Not as participants in research, but actually as co-leads, as consultants, to spread the word, to engage other veterans in the process. So we developed our, our objective was to develop an online training program and establish a national advisory board, which we did, made up of veterans and key stakeholders. And really what we wanted to do was okay have a national platform where researchers and others could provide us information to put their research opportunities up on a website where veterans could then go to the website based on state and see what opportunities that they would be interested in, and then start reaching out to the researchers to get involved.

So the methods and activities. We did four modules. It was piloted by 50 veterans across the United States. And then we create add vet research hub. And this basically is a website for the training program and the hub are on my C-P.A.W.W. initiative, which is Canines Providing Assistance to Wounded Warriors. It's up now. You can click on it. It's free to use. And then the veterans go through the project. They go through the modules at their own pace. It takes about an hour, 20 minutes each module. And then they present out a certificate. And it's really all about research and what research means and how they can get involved as full partners. They are narrated by veterans and it's also in closed caption.

So project outcomes. Again, we did create the National Advisory Board for Operation PCOR. We have four veteran narrative online modules, and we have the online veteran research hub. And really, it is to engage veterans in PTSD related PCOR and CER. It is not a recruitable tool.

Lessons learned. Veterans said they wanted to be able to shape PTSD treatment option, but they often felt removed from the process. That they were asked after the fact, almost like a token to come on a project instead of helping to build it up from the ground up. So after the pilot program, we had a pre and post for the 50 veterans, and there was a significant difference in veterans being willing to participate in the research enterprise after taking the modules. So what we're thinking about doing is scaling this up and rolling this out again nationally and really trying to get some quantitative data based on the modules in the future. So hopefully that will go forward and we look forward to the outcome of that.

So for more information about the project, please go on the summary. Or come and chat with us up at the poster. And I want to thank PCORI for all of their support. I want to thank PCORI staff for being so supportive, as well. The veterans who participated, friends, and family members, and all of you for being here and caring for our nation's heroes. So thank you.

[Applause]

>> So thank you, Cheryl. So our final presenter is Beth Cohen who is an investigator at the San Francisco VA Healthcare System and a faculty member at UCSF.

[Applause]

>> Thanks so much. It's a pleasure to be here to talk with you today about our project, which focuses on medications, and I just want to before I start acknowledge that, you know, we know medications are just one piece of the toolbox in things we should use to treat PTSD, but our group was interested in studying these because we were getting a lot of questions from patients about medications and we felt we didn't have a lot of information to inform how we were advising patients. So the study that I'll talk about actually tried the use real-world VA data to compare the risks and benefits of several medications that are used as adjuncts to first-line treatments in PTSD.

Okay. It's the red button moves you forward, not green. Interesting. I have nothing to disclose.

Now the red button is moving me back. There we go. Okay. Just got to find the place to point it. So some of the challenges in medication treatment with post-traumatic stress disorder, we know from our clinical trials of what we consider to be the first-line medications, and these are all from a class called serotonin reuptake inhibitors, or SRI therapy, that they don't benefit everybody. So up to 40% of patients in these trials don't have what we would classify as a clinically significant improvement in their PTSD symptoms, and up to 70% don't achieve remission. And there's really not very much evidence about what to do next. And so some of the background work for this project was just in looking at what happened to those patients who were put on these medications and maybe didn't have a response that was adequate.

Are we running low on batteries? There we go. I think I just have to press harder maybe.

So what we found was that many of these patients get prescribed a class of another class of medication on top of that first-line therapy and these are anti-psychotic medications. These are medications that we know have benefits in treating patients with bipolar disorders or psychotic disorders, and they have been studied in PTSD, but the evidence has been very mixed. And there was one study that specifically looked at these medications in patients who were already on serotonin reuptake inhibitor therapy and didn't find that they provided any additional benefit in PTSD symptoms or other mental health outcomes. On top of that, we know they can have many side effects, but they're still widely used. And when we started to talking to providers about why they're still widely used we found that people didn't necessarily find the trials applied to their patients. So we know clinical trials, you can only recruit so many patients, it's often a

small number, they're often more stable than some of the patients we see for safety reasons. There's a lot of co-morbidities that get excluded. So providers didn't necessarily feel that those results applied to their patients. So our initial research question is we wanted to try and use real-world data, like Dr. Atkins was talking about from the VA, where we have access to a large national electronic health record to look more in-depth of the risks and benefits of adding anti-psychotics to these first-line therapies in patients with PTSD.

So as we worked with our patient and stakeholder partners, though, this question evolved. And one consistent message that we heard from our patient partners was that they didn't really have a specific concern about this one class of medication. They actually felt like they were getting a number of what were perhaps second-line medications added to their regimen without really a clear explanation of why. And as one of them put it, they felt like Guinea pigs. You can imagine it's hard enough to engage in mental healthcare. There's a lot of stigma to overcome. That feeling really damages the relationship with providers and building that trust that we want to engage veterans in care.

And they really wanted information about comparing which medications might be best so that they could participate in shared decision making with their providers. When we talked to our stakeholder partners who were clinicians and people involved in policy, one of our stakeholder partners had done very in-depth qualitative work with their providers to talk about their prescribing practice and why they were recommending certain medications. One of the things she heard echo from providers is they would try the first-line medications and their patients were still very symptomatic and they just wanted to do something. And so even though they recognized there was a lack of evidence, and there were no studies comparing strategies, they just used their clinical experience, maybe anecdotal evidence, and they would move forward and try another medication. But they really echoed that same thing from patient partners, that they really wanted something comparing these strategies.

With that feedback, our question evolved and we updated and broadened our research goal to compare the risks and benefits of several medications we saw were commonly being added to these medications.

Those were antipsychotics, which is what we were originally interested in. But we added several others. Those included mirtazapine and tricyclics. These are both types of antidepressants that have shown some benefit in PTSD, but unfortunately much like antipsychotics, they can have a lot of adverse metabolic consequences. And we also looked at prazosin, which is a medication that has been shown in some study to prove sleep and reduced nightmares, which is a very distressing and common symptom in PTSD.

So to do this, we looked at National VA electronic records from 2007-2015. We selected patients who had been diagnosed with PTSD, and I mentioned we wanted this to be real world. So we didn't want to have a lot of exclusions, but we did exclude

patients who also had bipolar or psychotic disorder. Because in those patients there would be a clear reason to choose an antipsychotic, and we wanted to focus on this group of patients where it was real clear what we wanted to do next. That was the only exclusion we made for comorbidities. We required that all patients be on the first-line medication, the SRI for at least 30 days, and then they had one of those classes of what we call an augmenting, so kind of a next-step medication added. And they filled it for at least a 60-day period. And this shows you the four classes and the numbers in parentheses are the number of patients who met criteria within each of those classes. You can see, those are numbers much bigger than you would ever be able to recruit in a clinical trial. And to look at outcomes within each of these groups, we decided to use each person kind of as their own control. What we did is we went through kind of every day of their medical record and we came up with a date when this augmenting medication, so this new medication was added. And we looked at the one year prior and looked at their outcomes in that time period. And that was before medication. And we looked at one year after it was started. So for each patient, we're kind of looking before and after within the same person.

And in terms of these outcomes that we were interested in looking at, we think with every medication, there is a balance of benefits and risks. So we wanted to look at both. And we talked to our patient and stakeholder partners about which outcomes they felt would be most important and we're somewhat restricted because we obviously can't survey all of these patients. We're relying on things we can capture within the medical record. But we're lucky at the VA there is a lot of detailed mental health information that is captured. And one thing that is captured is PTSD symptoms through a validated questionnaire called the PTSD symptom checklist. That was our primary outcome we wanted to look at before and after. We also looked at emergency room visits and hospitalizations, perhaps a marker of perhaps patients that were in crisis of some sort. And then the VA also does screening for suicidality and those results are also captured. So we looked at changes in suicidal thoughts. The risks that we were looking at because of the types of medications were largely metabolic. We looked at changes in weight, changes in blood pressure, changes in a number of lab values such as cholesterol, blood pressure, hemoglobin A1C, and we looked at hospitalization for cardiovascular disease events.

I updated my slides. I am missing one slide. But I just had a slide I added that talked a little bit about our general population. So the overall population of patients that were in this database study, the average age was about 52. It was pretty reflective of the VA demographics. 91% were male. We had about 70% were white. 20% were black. I believe 2% were Asian, Pacific Islander. And then we had smaller proportions of smaller subgroups and 7% identified as Hispanic. We did, unlike clinical trials had a lot of patients with co-morbidities. Over a third were diagnosed with major depressive disorder. One in three had a diagnosis of substance abuse disorder. About one in four had a diagnosis of alcohol use disorder. Or dependence. And then 5% had a diagnosis of traumatic brain injury.

So it's a lot of groups and a lot of different outcomes and I know that slides are going to be made available, so there's some pretty detailed information on the slides, but I'm going to try and focus you in on some of the big-picture findings that we had. So if you look at this slide, this is showing each of those four medication classes that were added and I want to focus you just on the column all the way to the right where it says percent change. So that is the percent change in PTSD symptoms from before starting the medication to the year after starting the medication, after we've adjusted for differences in a number of those demographic factors and co-morbidities because of course this isn't a randomized clinical trial where we can make sure, for example, we have the same number of women or the same number of people with alcohol use in each of these different medication classes. Those distributions may be different so we use some statistical methods to balance them.

If you look at that last column, what you'll see is on average each of these groups had a very small improvement after the addition of the augmenting medication. Just on the order of 1-2% and it was similar across the four classes. But we realized what we're doing is just averaging a year's worth of information of how you're doing before to how you're doing after. And we might miss some nuances.

So what we did next is we looked at symptoms continuously over the full kind of two-year time period. And we've lovingly started calling these types of figures our mountain plot, because it kind of looks like a mountain. But what this is showing you is PTSD symptoms, if you look at the vertical line down the middle, that's when that second class of medications gets added. To the left of that, that's the year before the medication gets added and each line represents one of those four medication classes. For all of them, PTSD symptoms are going up and they tend to peak before the medication was added. This was interesting to us because clinically we weren't sure when these medications were getting added. Were they getting added when a patient was trying a first-line therapy and their symptoms went down, but not very much. And what this told is the most common reason they were added was because patients were having an exacerbation of symptoms for whatever reason. So you'll see if you look then to the right of that line, that's after the medication gets added the symptoms do go down. And it takes about 3-4 months for the symptoms to go down. Then most of the groups plateau. They're sort of returning to baseline, but not necessarily getting any better than when they started. This is again not a trial so we don't have a placebo group so this kind of begged the question are these people getting better because someone added another medication to their regimen, or had we just kept them engaged in care but not added a second medication, would they have gotten better on their own? And now I'll show you some of the information from our own outcomes. So looking at mental health emergency room visits, and I'm not going to show you hospitalizations. In the interest of time, it was pretty similar. Just focusing on the right side, the percent change in emergency room visits. We can see that unlike PTSD symptoms where we had this relatively small change, just 1-2%, here in each of the groups we have a much more substantial reduction in emergency room use for a mental health reason in that year after the augmenting medication was started. It ranges between 16-22%

depending on the group.

And looking at the proportion of patients that endorse suicidal thoughts, again just focus on the right-most column. Somewhat smaller than the changes in emergency room use, but we would still argue really clinically meaningful to have reductions between 6-14% of patients endorse they had thoughts of harming themselves. It was pretty similar across groups. In this case there seemed to be bigger improvements in the groups prescribed Prazosin or antipsychotics. so those are some of the potential benefits. Looking at some of the potential harms, I would say weight was our primary potential harm that we were interested in, because we think it can drive a lot of other potential complications. This figure is showing just in the year after starting one of these medications what happens to weight. And you'll see all of the lines kind of go up a bit and then plateau and the groups that are worse, I know it's way too small to read the top line that has the most weight gain, that's Mirtazapine. The second-most weight gain is antipsychotics. Followed by tricyclics. And then Prazosin, which we expect won't have as much as a metabolic effect. There is a small increase in weight, but much less than the other groups.

And we found relatively similar results. I think there is one more. Hemoglobin A1c, which is a measure of blood sugar control. So this is not going to be everybody. This tends to be measured in patients who have known diabetes or who have high risk of diabetes. For most of the groups, there was an increase and then it stayed stable across the timeframe. And the biggest increase was in Mirtazapine and antipsychotics.

So just to summarize some of the other metabolic outcomes, triglycerides increased for all the groups except for Prazosin. We didn't see any significant increases for blood pressure or cholesterol, which was somewhat surprising because those usually follow weight. But then we also realize blood pressure and cholesterol are things we can treat pretty easily with a pill. Not that that is great, it means yet another pill to a regimen and all of the side effects that can come with that pill. We looked into that and we found indeed 20-30% of the patients either increased or started a new medication to treat either blood pressure or cholesterol. And that's why we probably didn't see a change in those numbers because providers were I think appropriately responding to the changes they saw clinically. But again, for the patient that means yet another medication.

And we're still working on some of the information on hospitalizations for cardiovascular disease events, but we have seen increases in some groups, as well, for that.

Just to summarize, these second-line medications for our data, it looks like there are some circumstances where they may be beneficial when PTSD symptoms worsen, with the very important caveat that this is observational data, not a clinical trial. And it seems to be that providers are using them in cases where symptoms are worsening. Importantly, it seems that the benefits were similar across the classes, but that there were very clear differences in weight gain and other metabolic risks with Mirtazapine

being the worst offender followed by antipsychotics and with Prazosin generally having the least impact on metabolic outcomes.

In terms of next steps, we're still doing some work with the data, but we're starting to present our findings locally and nationally. We're working with our patient partners to figure out how to translate what can often be pretty complex diagrams and results into information for patients and families and with our stakeholder partners who are from the National center for PTSD and VA Office of Mental Health Operations. We hope this work can inform clinical trials to compare effectiveness of this medication. And we're also interested in working with the data to try to generate. Again, we don't have a placebo group as we would in a trial, but we might be able to find patients who had an increase in symptoms, but rather than add another medication, a provider just continued to see them. And those might be our control patients to tell us, you know, that pattern we saw where symptoms did go back down to baseline in 3-4 months. Do we see that in patients where their medication regimen isn't changed. Lastly, to tailor information, I'm showing you the summary results. But within those, there were patients who definitely had much greater benefits. And also patients who had much greater metabolic harms. So we are analyzing and looking at gender, race, ethnicity, trauma, to try to figure out which patients are most likely to benefit so we can provide more specific information for patients and providers.

So I just want to thank our project team and also Dr. Atkins mentioned the QUERI. We have a QUERI at our VA which has been fabulous in collaborating with the complexities of VA data. So thank you very much.

[Applause]

>> Okay. Well I want to thank all four of the presenters. I think what was impressive to me was sort of how diverse these different projects were. And Dr. Atkins sort of filled us in about how to sort of think about the whole sort of system of research within an integrated, a very large integrated healthcare system. So we'll open it up now to questions and comments and I believe we've got a microphone over here. So, we've got a hand up. There we go.

>> Hi, my name is Erin Guy. I'm a clinical psychology Ph.D. student completing my internship at Hines VA. I just have a question for Dr. Cohen. After you viewed that participant's PTSD increase, were you also able to control for other mental health service utilization after that point. I'm just thinking if their mental health provider noticed an increase in symptoms, that they may also put in consults for other services at the VA.

>> Yes. That's a very important point. The influence of other mental health services. The results that I was trying to focus everybody on, on that right-most column, that is adjusted for the number of mental health visits, which we can identify using VA coding. But what will we haven't done and I think what we would like to do is try and drill down

more and look at what types of mental health interactions and particularly psychotherapy patients are getting. So one of our colleagues on the team has developed a way to identify evidence-based practice psychotherapy that's delivered within VA. So if we can evaluate that, we might be able to look more specifically at what patients are getting and the influence of that on response.

>> We've got one right here.

>> I just want to thank all of you on the panel for providing academic information. My name is Lenore Johnson. I'm a PCORI ambassador and a United States Navy veteran myself. I'm curious. I know the VA has been very helpful for receiving information on vets. But for a person like me who is on my husband's healthcare plan, are you getting results on the civilian side for those who don't necessarily use the VA for their resources and help?

>> Back within my previous life, when I was at the VA system, I remember there was a lot of talk about the VA data warehouse. I think Beth's project was sort of an impressive example of the capabilities of using a large data integrated warehouse. But there was talk about how could non-VA care be integrated into datasets that are based on VA care and what sort of progress has been made in that area in the last few years. I guess I'll direct my question to both Beth and David.

>> Yeah. And there may be two components of your question. A lot of our veterans do get non-VA care through Medicare. But we only, our research is largely focused on veterans who are getting some of their care from the VA. We don't actually have an easy way to do research on veterans who are completely outside of our system. So if your question was, you know, what are our options for understanding about veterans' care and outcomes outside of that delivered by the VA, that is a challenge. And one of the challenges is that veteran status isn't reliably captured. It's not necessarily captured by private healthcare providers. It's not captured regularly in Medicare. We're able to get Medicare data once we know that somebody is a veteran from our data. We can match that. But I couldn't go into a Medicare database and pull out all the veterans who are in there easily. Now, there is some interest in since we do know everybody who is a veteran. We have databases of everybody who is a veteran working with DoD. There are ways we could try to match that to other datasets that are outside the VA. But was part of your question also about the messaging? Were you also wondering are we doing, should we be doing a better job of getting our messaging about what we've learned about veterans to people outside of our health system?

>> Yeah. Because a person like me not connected to the VA system itself still looking for that connection and still receiving information.

>> Right. Obviously we do try to, you know, broadcast what we're learning about veterans fairly widely. Our websites are open to everybody. But obviously we could

do more. I mean we are going to be pushed to confront this more directly because under the Mission Act, we are now providing more options for veterans who we're currently caring for to go get care in the community from non-VA providers. And a big question for us is are those community providers, are they prepared to, do they know enough about veterans to give them good care? And how can we work with them to make sure they understand the important things about veterans, about specific veteran-specific conditions, so that they're going to give care that is equal to or better than what we can provide. And so that's something we will learn a lot more over the course of the next several years about how to work with people outside our system in terms of taking care of veterans. But thank you for pointing that out. It is a gap that we're quite aware of.

>> Maybe Beth could comment on that, some of those issues. And then Elisa, you might have something to add with your work with the Veteran Spouse Network.

>> Yeah, I can just say specifically for our study it would be wonderful to have that information about veterans treated in the community. We do have some information. If there is a service provided in the community that the VA is paying for, we have some information about it. But not on the level of what someone's symptoms are or their medications. At least for what I presented, for the hospitalizations and emergency room visits, if a patient doesn't have another source of insurance it would be covered by VA, and it was covered by VA, that's included in that information.

>> Yeah, I was just going to make similar comments to what they both made. With the Mission Act, I think there is potential where symptoms will be talking better to each other from VA databases and community ones because I hope the VA will want to know more about the quality of the care that they're sending out their veterans out to receive. I think they've always cared about it, but maybe we can get better data with this new integration. And for families, I would say we're not there yet. If we think about veteran family health, because the issue like veterans is there is not a lot of attention to asking that question about the individual patient in the community healthcare setting as to are you a veteran or do you have a family member that has served in the military. And I think once we all start including that question and then also training our healthcare providers in military culture and things to be aware of when treating a patient with that military history, that will improve our care of them.

>> I just want to add one point that the American Academy of Nursing has a campaign that they really are asking nurses to ask patients have you ever served. That is a campaign that is national. The other piece of that campaign that they're putting forward now is I served too for the kids. So for school nurses, for community workers, and for teachers to ask the child have you ever served, and it's I serve too. One person wears the uniform, but the whole family serves. If you're interested in that campaign, it is up on the American Academy of Nursing website, have you ever served campaign.

>> I think we got one right here.

>> If you look at marijuana use as a function of PTSD. I worked with veterans for 30 years, Vietnam veterans. It was not unusual for them to say they were self-medicated with marijuana. We started testing for marijuana in the urine. Take-home doses. Took away the take homes. He had so many he punched the wall at home, broke his hand, and we solved the problem by getting permission to prescribe him Marinol. His urines then were positive for THC and he got his take-homes back and was happy. But I'm just curious if you're looking at marijuana use as a function of PTSD and outcomes.

>> I can tell you that's something we're really interested in. I'm based in California where marijuana is now recreationally legal and the VA has a national policy now about being able to have open discussions now about marijuana use and also having it not necessarily interfere with their other treatment they're receiving. So I think that's a good step forward. I know anecdotally from other work that I do, not with patients, but many patients are using it. And we don't have evidence. I think that's a huge and important gap. It is something I'm personally interested in. Because as you mentioned it, it can be captured in routine urine screens that we do for other reasons. There could be potential to, again it's not a trial, but to just look at among patients with PTSD who do screen positive for marijuana use do they have different trajectories of symptoms. But I think there is a lot of interest to do more active work so we can have informed discussions with patients.

>> My interest is twofold on the question side. The first one is for Doctors Atkins and Borah. The second one is for Dr. Borah. The first one being how does PCORI assist with VA for removing or alleviating the negative aspect that VA has in the eyes of a lot of veterans on things such as if you have a formulary that is working from outside the system, but you try to bring it in and VA says no, these are not medications that are in the formulary, but these work just as well. Well, when you've gone through multiple years of trying to find the medications that actually do work and don't have the side effects, but you're told through VA that these are exactly the same, no these were actually eliminated years ago because of the side effects and the fact that they didn't work, how do we get around the negative contexts that a lot of veterans have because we had to go through that?

>> Yeah, I'll start with that question. The formulary process is something that's, you know, separate from research. They do have a process for looking at the evidence and trying to decide what to cover. They now are, I think, working to at least make sure there aren't discrepancies between DoD and VA so that service members who have been getting treatments while in DoD run into this obstacle when they move to VA. But I think you're talking about a slightly separate one if you're getting medicine outside the VA and now come into the VA for benefits and there are suddenly what you're hoping to get is not in the VA.

I think you're getting at a challenge about, which a lot of this conference has talked about is personalized medicine. So that two drugs may be good on average and the

formulary may decide to cover the one that's cheaper, but there may be individuals for whom that average doesn't apply and what's the right approach for that.

I mean, the VA does have processes for getting drugs that are not on the formulary if the clinicians, you know, think about that. Think it's appropriate. So I don't want to speak too much for individual personal decisions. I think our formulary process in general, you know, is an evidence-based process. I think it's served veterans pretty well. We pay half of what Medicare pays for medications, which I think is important in allowing. But I take your point that we are struggling with this issue of, you know, getting the right drug for the right person really involves personal details. And maybe as we learn more about those we can build that information into these kind of decisions. Right now, unfortunately, I think it is up to working with an individual provider to say this thing that you're providing me isn't right and is there a process to get the thing that seems to be working better?

>> Second question goes directly to Dr. Borah. I was very intrigued by the whole stance of taking care of the veteran spouses.

But the question that I have is it seems like so much of the focus these days has been on the folks coming back from Iraq and Afghanistan. The question is when you have a military spouse who has come in long after the military experience, what has been the research? What has been the real exposure? I was Vietnam-era vet. And my wife came in long, long, long after that was over. So her exposure has been just the stories of what I had gone through, which she real honestly gets very little of. She hasn't been involved in she was part of the process. Hers is very much after the fact. So how does --

>> That's a great question and something we didn't anticipate. And something we've actually had, of course we don't turn anyone away. But we have spouses that were there throughout the military service history experience. We have spouses that married the veteran after military service. Included we have spouses that were from Vietnam era. And they married them after Vietnam and they lived with their PTSD for 20 years and thought that was normal and just the way he is. And now they've realized with much more awareness and treatment options for PTSD, that it's not too late for him to get treatment and they can be supportive along that process. And they've also, funny, their veteran spouse has gotten the PTSD treatment and they say oh I have a new husband, this isn't the guy I married. I married the cranky Vietnam vet. So those are great outcomes. They have to adjust to this new person. But we had to adjust and revise our curriculum because we made the assumption incorrectly that all of our spouses in our peer-support group had been there during the whole military service history and could just understand and had that cultural background. But now we've had to adjust and include different discussion questions to incorporate and be more inclusive of all of those experiences. It's gotten a little bit more complicated but it helped us figure out how to serve them better. So I hope that answers your question.

>> Hi there. My name is Dave Hibler. And I have a question specifically for

Dr. Atkins, but I would be interested to hear from anyone on the panel. You spoke about implementation and dissemination of the VA and that needing to be improved. I was wondering if you could say how that is currently being undertaken and how you're looking to improve that?

>> We're taking several approaches. In the ten years I've been at VA, we've put an emphasis on trying to engage the people who are going to own the solutions we develop in practice. And we've started with the folks in Washington, like the people who run the Office of Mental Health and Suicide Prevention or rehabilitation services, surgery, things like that. We realize that that is important because they sort of set policy, but the rubber really meets the road out in the field in all the decisions that a medical center director or a network director or even the chief nurse or whatever make.

So we've been working to try to engage those people in the field more. Just so we understand what are the things that they care most about. Because the first rule of success is study something that somebody else cares about. Because if you're trying to convince them that the thing you care about they should care about that's swimming upstream. But if you started with I'm really, and finding out what they really care about.

The second is we I think can rightly claim that the VA is a leader in actually bringing science to implementation. Implementation is a process. It can be studied figuring out what a different approach is, matching those approaches to different situations. And I think we have funded research to try to understand what are better ways of implementing. How do you train people to be a facilitator to go out and teach people how to set up new programs? What kind of support do they need?

And then the QUERI program is a place that's actually building sort of resources to teach front-line providers about how do you stand up a new program. But I would say that we're still, you know, we've gone to the base camp of Everest. We've learned how to do things better and we've learned how to make sure we're asking things that worked. But it is sort of a culture shift. You know, researchers want to study what the idea that they really are interested in. And we just want to make sure that they're putting on the, stepping out of their shoes and saying "Okay, if I were not a researcher really devoted to this, but I were a medical center director who had a lot of stuff on her or his plate, how do I make that pitch that they should care about this?" Sometimes it's a matter of understanding resources. You know, are you trying to convince them to spend extra money on your problem? Are you just trying to get them to do stuff differently with the resources they have? You know, train their providers differently.

So we are building more of that implementation thinking early on in our projects and into our decisions about whether we should fund stuff. Because we don't want to fund things that don't go anywhere. You know? That just end up in a journal. Other thoughts from folks in the front lines?

>> I'm a primary care provider at the VA and I can say I feel like we, I'm very grateful

that that is part of the mission, because I think I'm constantly seeing initiatives rolled out and I think that a lot of VAs have academic affiliations and we have a lot of trainees and one wonderful thing I've seen is just how open people are to involving everyone from any level of training into implementation projects. And so we have a lot of ideas, you know, coming from all levels and multidisciplinary teams getting together to do implementation work, which I think is the way you make something successful. You know, there is a top-down commitment to it, but it's being done at all levels.

>> Okay. In the back.

>> Yes. I probably have a little bit of a different experience in a situation that I wanted to ask about. I fought very hard to get my husband into a VA hospital. He had a brain tumor. We have the finest cancer center in our city, I think, as any in the world. But when it came to physical therapy, it was a dark hole anywhere in our area. And he really needed very specialized physical therapy. So his surgeon said look it, I'll write a letter of recommendation. The VA hospital is right down the street from us. They turned us down. My husband was a colonel in the Air Force. Under the current pay system, we did not qualify. We were not destitute. But they had what we needed. I went and knocked on the door and went right into the physical therapy before. And I walked into a facility like I had never seen. Wood floors, every equipment imaginable. And there were two people in there and four physical therapists. That was pretty hard to swallow, I've got to tell you, I've got to tell you. And I thought to myself as they're looking to revamp this system, things that can be treated outside of the VA hospital, in the community, it makes sense to put that outside. But the very specialized training, how many people come back that need physical therapy, very serious physical therapy that you cannot get in the community? Trust me. I've been to every facility and I can't complain about Tricare for Life. He got amazing treatment. He lived for 17 months. He had treatments I can't begin to tell you how much one treatment cost. And Medicare and Tricare paid for everything. But I couldn't get that physical therapy. I could argue that brain tumor was service related, but I wasn't going to spend years doing that. And we didn't qualify for financial aspects. There is a little bit of a dark hole there.

>> I can't really speak to what's being contemplated in terms of financing stuff. But it seems like the solution there would be to allow for Tricare to pay for services within a VA, to make VA a Tricare a provider. It's kind of the opposite of what we usually hear complained about. You have to wait too long to get VA care so can you get care elsewhere. I would have to assume your experience is probably an exception where there is excess capacity that we could make available to more people. But it's worth writing the Secretary, suggest that is maybe a possibility. There's a lot of changes going on in terms of the future of the VA and how it's going to look. It may be open more like that.

>> Okay. I think this is going to have to be the last question.

>> It's got to be a good one then, huh? Is this information on My Healthy Vet website? Is it available there? What this research is doing? And also, does the VA use step therapy on medications because I am one of them that is happening to also.

>> I'm sorry. The first question is, is this information on the My Healthy Vet website. And I would say information on our research is on our websites. I think you're pointing that we could probably do a better job to make sure it's linked to the website that's aimed at patients, which is My Healthy Vet. And so that's something I will take back and see are we connecting all this stuff on our public website to the veterans. Because they're going in through My Healthy Vet. I do know we have some links, but we probably could improve them.

>> I am from Maine and none of these projects or anything are in Maine. So we don't know about it.

>> Yeah. So, that's something I will take back. And I think these groups are really important for us to figure out how do we get, how do veterans want to hear about our research and how can we communicate more effectively to them. I think that's something we haven't, we have been really used to communicating to our research community and not enough to our veteran community. So I'm happy to take any suggestions and you can e-mail me. It's just my first name dot last name at VA.gov. The last part of your question, were you talking about hyperbaric therapy?

>> Step therapy.

>> Can you be more specific?

>> Try and fail first before they do another type of procedure. Like in the medications are always generic and they don't work the same. With that said, where does a veteran go to get help if the generic is not working and my caregiver doesn't know where to go either? In the VA system?

>> Certainly there are areas where I think we have pretty good protocols, certainly in terms of pain. We've developed some and tested and researched step therapy to increase and start with the least toxic kind of therapies. Don't start with opioids and gradually move up through different.

>> It's not a pain medication. It's narcolepsy, which is a schedule two, though.

>> Okay. Thanks. I'll take that suggestion back.

>> Well, I want to thank everyone. I think this has been a very far-ranging discussion and really sort of outlines the many opportunities for learning and finding out about best approaches to care for the veteran population. So we look forward to following up on these ideas.

So thank you.

[Applause]