Multifaceted Educational Outreach to Improve PTSD Care of Rural Veterans

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SORH Regional Partnership Meeting June 14, 2018
1. Share background information about rural Veterans with PTSD

2. Discuss intervention we have used locally to improve PTSD care in rural areas

3. Provide information about National Center for PTSD resources available to support clinicians
The Rural Veteran Perspective

• Nearly ¼ of US Veterans, 4.8 million live in rural areas and almost 1 in 5 (18%) have at least one service-connected disability.

• When compared to VA-enrolled urban Veterans, rural enrolled Veterans:
  – Are older (50% are 65 or older)
  – Have less income (51% earn less than $35,000)
  – Have higher rates of PTSD, chronic pain, substance use
  – Have higher suicide rates
• **45K.** Nearly 45,000 lives lost to suicide in 2016. (1 in 12 minutes)

• Suicide rates are **higher in rural America** than in urban

• In Vermont, 35% higher than national average (using guns, higher than national average in all ages, esp. 70-74 yrs

• Gap between rates in rural and urban areas grew steadily from 1999 to 2015

• **Suicide is PREVENTABLE** – communities and individuals can make a difference.
Rural Provider Realities

- Face unique challenges
- Significant clinical complexity in their patients
- High turnover
- Rural hospital closings
- Professional isolation
- Chronic mental health service and provider shortages
The Impact on PTSD Care

• Access and utilization of evidence based psychotherapy is more limited in rural/geographically remote areas (Grubbs et al., 2017; Lindsay et al., 2015; Morland, 2013)

• Higher rates of guideline-discordant PTSD treatment in rural-dwelling Veterans (Bernardy et al., 2012)
  – Antipsychotics
  – Benzodiazepines
  – Concurrent sedatives

• Despite progress, there is still a large gap between the need for mental health services and the use of those services in rural areas
Exploring the Gap Between Guidelines and Practice in PTSD

• Diagnosis, assessment, and treatment of PTSD is a nuanced skill
• PTSD characterized by avoidance and stigma, making it more difficult to identify, engage in care, and treat
• Limited medication options/limited success
  – Sertraline*, paroxetine*, fluoxetine, venlafaxine
    *=FDA approved
• Symptom-focused treatment (i.e., insomnia) fails to address core issues of PTSD
• Trauma-focused psychotherapy is now first-line guideline recommended treatment for PTSD

www.healthquality.va.gov/guidelines/MH/PTSD
What we are doing to improve rural PTSD care

**ACADEMIC DETAILING**
- Key messages around evidence-based care of Veterans with PTSD
- Med overuse messages coupled with desired substitute practice

**PSYCHOTHERAPY TRAININGS**
- CBT for chronic pain, CBT for insomnia, Present Centered Therapy for PTSD, Eye Movement Desensitization and Reprocessing

**BARRIER RESOLUTION**
- Tools, services and networking to promote evidence-based PTSD treatment and de-implementation of harmful practices

**DIRECT-TO-CONSUMER MESSAGING**
- Infographic posters highlighting evidence-based treatments
- Direct mailing of health education to Veterans (EMPOWER, Tannenbaum 2014)
If we want prescribers to refer patients to safer, effective treatment options, those options have to be available!

With Rural Health support, trained
- 21 clinicians in Present-Centered Therapy
- 17 in CBT for chronic pain
- 15 in CBT for insomnia
- 7 in CBT for insomnia for groups
- 10 in EMDR
- 25 in Written Exposure Therapy (new 1st line treatment)
• Sleep disturbance common in PTSD

• Cognitive behavioral therapy for insomnia (CBT-I) is first-line and effective in people with PTSD (Qaseem 2016; Wu 2015)

• We sponsored two CBT-I trainings

• Impact: Therapists (n=10)
  – 80% offering CBT-I
  – 78% satisfied with results

• Impact: Prescribers (n=17)
  – How has CBT-I impacted your sleep medication prescribing?
  – 41% reported a decrease
FOCUS ON BENZODIAZEPINE HARMS

- Cognitive Impairment
- Alzheimer’s Disease
- Worse talk therapy outcomes
- Falls and Fractures
- Impaired driving
- Car accidents
- Mortality
  - All cause + unintentional overdose
- Anger, Fatigue, Irritability, Depressed mood
- Substance use risk
- Negative respiratory outcomes
- Reproductive risk
Positive impact on local Prescribing Trends

Number of Patients

Educational Intervention

- PRAZOSIN IN PTSD
- OFF-LABEL ANTI-PSYCHOTICS IN PTSD
- OPIOID + BENZODIAZEPINE
- BENZODIAZEPINES IN PTSD
• Ongoing provider education
• Ordering screen alert for antipsychotics
• New pharmacy and nursing review processes
• MS Assistant help to coordinate care
• Clarification of covering/discharging provider prescription expectations
• Standard antipsychotic patient education
• Partner to promote services: Move!, Nutrition
• Education on no more fasting labs!
Engaging Veterans in Their Care

If you are taking any of the following medications...

- Aripiprazole (Abilify)
- Asparine (Saphirin)
- Clozapine (Clozaril)
- Lopipride (Fanapt)
- Lurasidone (Latuda)
- Olanzapine (Zyprexa, Relprevv)
- Quetiapine (Seroquel)
- Paliperidone (Invega, Sustenna)
- Risperidone (Risperdal, Consta)
- Ziprasidone (Geodon)

Please be sure to see your healthcare provider regularly as there are benefits and side effects.

**Benefits:**
- Manage symptoms well
- Improve quality of life

**Potential Side Effects:**
- Weight gain
- High blood sugar
- High cholesterol
- Blood pressure change

What do I need to do?
Please work with your health care team to manage the side effects from your medication. Your help is very important.

It’s as easy as 1, 2, 3...
1. Get your weight checked at every visit
2. Check your blood pressure at least yearly
3. Do your blood tests for diabetes and cholesterol at least yearly

What other things can I do to stay healthy?
- Monitor your weight at home.
- If you need to lose weight:
  - Even small amounts of weight loss helps.
  - Lower your calorie intake and exercise more.
- If you smoke, use drugs or drink alcohol, consider if you need to stop or cut down.
- Take your prescribed medication for your physical and mental health.
- See your primary care provider to monitor your physical health.

When you have questions, ask your healthcare professional.
Your Personal Health Tracking Log is on the back of this sheet.

For more information on healthy living, go to My HealtheVet: www.myhealth.va.gov/MyHealthVet

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**Personal Health Tracker (Bring to Every Appointment)**

- Mental Health Provider: ______________________
- Primary Care Provider: ______________________

<table>
<thead>
<tr>
<th>Date</th>
<th>Antipsychotic Medication and Dose</th>
<th>Weight (Pounds)</th>
<th>Blood Pressure</th>
<th>Glucose</th>
</tr>
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</table>

**Blood Pressure**

- Fasting
- Hgb A1c
- Cholesterol
  - Total
  - LDL
  - HDL
  - Triglycerides

**Side effects to report to your healthcare provider:**

- Muscle pain or stiffness
- Restlessness or uncontrollable movement
- Loss of balance or difficulty walking
- Dizziness or fainting
- Excessive thirst and/or urination
- Changes in sexual functioning

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**Healthy Food Tastes Good**

**Exercise Feels Good**

**Let’s Get Up and Move**

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VA Academic Detailing Service

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VA Created Exellence in the Centry

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Benzodiazepines + sedative substances can result in unintentional fatal outcomes.

- 27% of Veterans who received opioids also received benzodiazepines
- Benzodiazepines commonly involved in opioid-related OD death (30.1%)
- Risk of OD death increases with increasing benzodiazepine daily dose

In our Veterans, 49% of opioid OD deaths have concurrent benzodiazepines prescribed

Modeled after **Memphis** and **Saginaw VA**: Teamed with AD, Amb Care, Primary Care, & Pharmacy to send 173 highest risk rural Veterans overdose and naloxone information.
What can we offer through AD?

- Re-evaluate treatment care plan with provider
- Look for overlap of sedative/hypnotics (opioids and benzodiazepines) and suggest taper strategies and/or naloxone kit
- Ask provider if checked PDMP
- Has the patient been offered an EBP? Address barriers to psychotherapies
- Review measurement-based care strategies
- Outreach to patient for missed appointments and regular contact/expressions of caring
- Weapons in the home? Safety plan?
IMPACT: ALL LOCAL OUD PATIENTS

% OUD Patients with a Naloxone Fill in the Previous Year

(405) White River Junction, VT

Fiscal Yr/Qtr

2016 2017 2018

5.2 8.6 10.3 10.9 12.0 10.4 21.2 23.2 28.1

(VA AD OEND Dashboard)
Focused on Benzodiazepines

- Facility support for BZD tapers
- Working since 2015 to launch BZD taper services with multiple unanticipated barriers
  - Worked with Primary Care Mental Health team to now offer this service
  - Developed an online Benzodiazepine tapering tool
  - Benzodiazepine Factsheet with interviews for our website
- Decided to use direct to consumer education and chronic disease management model
PTSD EMPOWER PROCESS

• Mail booklet with cover letter to PTSD patients on chronic benzodiazepines as identified by the AD PTSD dashboard

• Assess impact
  – Trend and analyze BZD and other sedative-hypnotic prescriptions
  – Lorazepam mg-equivalent reduction in those that received mailer vs didn’t
  – Survey/interview providers and Veterans on their opinion of the mailer, change in risk perception
Barriers for Rural Providers

- Bandwidth (barrier to telehealth)
- Available providers (for acute & chronic needs)
- Provider time
- Available psychotherapy options to refer patients to locally (EBPs)
- Patient buy-in
- Distance/Travel
- Consult/Follow-through tracking
- Care coordination between services
- Less on-site services available
Lessons Learned

• Rural providers and Veterans are an important population that deserve support but can be difficult to reach
• Need for flexible models of care delivery that meet patients where they are
• A multifaceted PTSD academic detailing intervention was associated with desirable trends in medication utilization in rural Veterans
• Enhancements such as psychotherapy trainings were associated with increased delivery of CBT-Insomnia and have been a positive experience for therapists
How can we close the gap in practice?

- Recognize the disparity of our treatment reach in rural areas
- Increase access and engagement by use of clinical video telehealth (CVT) technology
- Increase rural provider access to EBP training
- Use direct-to-consumer education such as EMPOWER to reach rural Veterans
- Tailor academic detailing and system solutions rural providers and Veterans when possible
- Develop community partnerships to improve rural care
RESOURCES
A new online tool to help patients learn about and compare evidence-based PTSD treatments

www.ptsd.va.gov.decisionaid
PTSD TREATMENT DECISION AID: THE CHOICE IS YOURS

Prolonged Exposure

What type of treatment is this?

Prolonged Exposure (PE) is one type of trauma-focused psychotherapy for PTSD. PE teaches you to gradually approach trauma-related memories, feelings, and situations that you have been avoiding since your trauma. By confronting these challenges, you can actually decrease your PTSD symptoms.

How does it work?

People with PTSD often try to avoid anything that reminds them of the trauma. This can help you feel better in the moment, but not in the long term. Avoiding these feelings and situations actually keeps you from recovering from PTSD. PE works by helping you face your fears. By talking about the details of the trauma and by confronting safe situations that you have been avoiding, you can decrease your PTSD symptoms and regain more control of your life.

What can I expect?

Your provider will start by giving you an overview of treatment and getting to know more about your past experiences. You will also learn a breathing technique to help you manage anxiety. Around your second session, you will work with your provider to make a list of people, places, or activities that you have tried to avoid since your trauma. Over the course of therapy, you will work through your list step-by-step, practicing in vivo exposure.

53

For every 100 people with PTSD who receive a trauma-focused psychotherapy such as PE, 53 will no longer have PTSD after about three months.

9

For every 100 people with PTSD who do not receive PTSD treatment, 9 will no longer have PTSD after about three months.

This means that you will gradually confront these situations. With time, you will find that you can feel comfortable in these situations — and you will not need to avoid them anymore. After a few sessions, you will begin to talk through the details of your trauma with your provider. This is called imaginal exposure. Talking about the trauma can help with emotions like fear, anger, and sadness. You will listen to recordings of your imaginal exposure between sessions. By confronting the details of the trauma in therapy, you will find that you have fewer unwanted memories at other times.

Is it effective?

Yes, trauma-focused psychotherapy (including Prolonged Exposure) is one of the most effective types of treatment for PTSD.

How long does treatment last?

PE usually takes 8-15 weekly sessions, so treatment lasts about 3 months. Sessions are 1.5 hours each. You may start to feel better after a few sessions. And the benefits of PE often last long after your final session with your provider.

What are the risks?

The risks of doing PE are mild to moderate discomfort when engaging in new activities and when talking about trauma-related memories. These feelings are usually brief and people tend to feel better as they keep doing PE. There is also a slight risk that someone could listen to a therapy session without your permission if the recording was not secure. You and your provider can discuss ways to secure your personal information related to this program. Most people who complete PE find that the benefits outweigh any initial discomfort.

Will I talk in detail about my trauma?

Yes, around your 3rd session, you will start talking in detail about your trauma. Your provider will guide you through it, keep track of your anxiety level as you talk, and make sure you take things at your own pace. You will listen to a recording of this part of your session at home between sessions.

Group or individual?

PE is an individual therapy. You will meet one-to-one with your provider for each session.

Will I have homework?

Yes, you will practice doing some of the things you have avoided since your trauma. You will start with activities that are manageable for you, and you will work up to activities that are more challenging. You will also listen to a recording of your therapy sessions, including your imaginal exposure recording. Practicing these skills between sessions helps you get the most out of PE.

How available is this in VA?

Almost all VA Medical Centers offer PE in their specialized PTSD programs and more than 2,000 VA providers are trained in PE. Smaller VA facilities that do not offer PE may be able to use video-conferencing to have you receive PE from a provider at another location.

See what Veterans have to say:

"Now that I have had PE, I can do the things that I've done before I went to Iraq. I can go to crowded places. I can drive a car. I can be around people, my friends and family."

Valentia Ovalle

"I had a problem believing that this therapy, me actually living the trauma over and over was going to help me... but all of it fit more and more and more, the therapy, it worked. I listen to it and you listen to it and eventually, you're controlling the memory versus it controlling you."

Arthur Jefferson

"I had to spend at least 30 minutes in a restaurant, which was, at first, it was really difficult, but now, I'm up to, at least, I can go and have dinner and not have to worry about getting out there in a sweat."

Curtis Cedarbaum

The PTSD Treatment Decision Aid is an online tool to help you learn about effective treatments and think about which one might be best for you.

Created May 12, 2017  www.ptsd.va.gov/decisionaid
One-side is patient education, the other is provider guidance!

**Benzodiazepine Risks**

Are You Aware of the Possible Risks from Taking Benzodiazepines?

There are more effective and less harmful treatments available for sleep, nightmares, PTSD, pain and anxiety.

**Possible Risks**

- Feeling tired or drifty
- Memory and thinking problems
- Depression, mood changes, irritability, anger
- Memory problems
- Unsteady walking
- Increased risk of falls, broken bone, or concussion
- Cough and sleep apnea may get worse
- Car accidents
- You can be arrested for Driving While Impaired
- Overdose—especially when combined with alcohol, strong pain medications (opioids), street drugs
- Birth defects
- Baby may need emergency care because of withdrawal symptoms

How ready are you to make a CHANGE?

**Discussing Benzodiazepine Discontinuation**

1. Assess patient’s willingness to discontinue or reduce the dose
   - Express concern
     - “I would like to take a minute to discuss my concerns about (benzodiazepine name).”
   - Provide education on potential risks
     - “Because of your [age or other risk factors], I am concerned that the use of (benzodiazepine name) may put you at increased risk for [relevant repercussion].”
   - Assess patient’s readiness to begin taper process
     - “What do you see as the possible benefits of stopping or reducing the dose? What concerns do you have about stopping? What can we do together to help address these concerns?”
     - If patient indicates no desire to change, provide information handout. “What would be a reason you might consider changing from (benzodiazepine name) to [name of recommended alternative]?”
   - Negotiate plan
     - “What changes are you willing to make to meet this goal?”
     - “Would you be willing to talk to one of my colleagues to learn about options to support your change?”

2. Agree on timing and discuss the symptoms that can occur with benzodiazepine taper
   - Inform patients
     - Withdrawal is only temporary and not all patients will have symptoms
     - Slowly tapering will decrease these symptoms
     - Report distressing symptoms and adjust the rate of taper accordingly

3. Provide written instructions for a structured medication taper. Be prepared to slow the taper if the patient reports significant withdrawal symptoms.

**Benzodiazepine Dosage Equivalents and Taper Schedules**

<table>
<thead>
<tr>
<th>Benzodiazepine</th>
<th>Approx. Dosage Equivalents</th>
<th>Elimination Half-life (hours)</th>
<th>Example taper: Lorazepam 4 mg bid (Convert to 40 mg diazepam daily)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chlordiazepoxide</td>
<td>25 mg</td>
<td>&gt;100 hr</td>
<td>Week 1: 35 mg/day&lt;br&gt;Week 2: 30 mg/day (25% of initial dose)</td>
</tr>
<tr>
<td>Diazepam</td>
<td>10 mg</td>
<td>&gt;100 hr</td>
<td>Week 2: 25 mg/day&lt;br&gt;Week 4: 20 mg/day (50% of initial dose)</td>
</tr>
<tr>
<td>Clonazepam</td>
<td>1 mg</td>
<td>20–50 hr</td>
<td>Weeks 5–6: Continue at 20 mg/day for 1 month</td>
</tr>
<tr>
<td>Lorazepam</td>
<td>2 mg</td>
<td>10–20 hr</td>
<td>Weeks 11–12: 10 mg/day&lt;br&gt;Weeks 13–14: 5 mg/day&lt;br&gt;Week 15: Discontinue</td>
</tr>
<tr>
<td>Alprazolam</td>
<td>1 mg</td>
<td>12–15 hr</td>
<td></td>
</tr>
<tr>
<td>Temazepam</td>
<td>15 mg</td>
<td>9–10 hr</td>
<td>Weeks 11–12: 10 mg/day&lt;br&gt;Weeks 13–14: 5 mg/day&lt;br&gt;Week 15: Discontinue</td>
</tr>
</tbody>
</table>

**Shorter taper (e.g., 3 months):** Reduce dose by 50% the first 4 weeks then maintain that dose for 1–3 months then reduce dose by 5% every 2 weeks.

**Longer taper (e.g., 6 months):** 10%–25% every 4 weeks.

Switching to a longer-acting benzodiazepine may be considered if clinically appropriate; in patient’s consider tapering the short-acting agent until withdrawal symptoms are seen then switch to a longer-acting agent. High dose alprazolam may require complete washout, such as gradual switch of diazepam or dosages before taper may be appropriate; other treatment modalities should be considered (e.g., cognitive行为 therapy) if clinically appropriate.

References:

PROMOTING CBT FOR INSOMNIA

How's your SLEEP?

9 out of 10 Veterans with PTSD have sleep problems
4 out of 10 Veterans have signs of insomnia

How does PTSD make sleep worse?
- Feeling "on guard" all the time
- Worrying or negative thinking
- Memories replaying in your head
- Nightmares disrupting sleep

Cognitive Behavioral Therapy for Insomnia is the #1 recommended treatment, not sleep medication.

CBT for Insomnia is a short talk therapy proven to work in:
- Veterans
- Depression
- TBI
- PTSD
- Pain

CBT for Insomnia vs. Sleep Medication

- How it works: Changes brain chemistry
- How it works: Modifies thoughts and habits that affect sleep
- Easy to use
- Side effects: falls, dizziness, dependence, foggy head, memory problems
- Less addictive and slow
- 70-80% achieve better sleep
- Side effects: nausea, fatigue, dizziness
- Therapy takes effort, lasts appointments

Ask your provider about a CBT for Insomnia referral today.

www.PTSV.va.gov

Scan for free VA mobile apps to help with CBT for Insomnia, PTSD, and mindfulness.

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