Reaching Rural Veterans: Applying Mind-Body Skills for Pain Using a Whole Health Telehealth Intervention (RAMP)

Diana Burgess, PhD, Center for Care Delivery and Outcomes Research (CCDOR), Minneapolis VA Health Care System; University of Minnesota

Roni Evans, DC, PhD, University of Minnesota

Katherine Hadlandsmyth, PhD, Center for Access & Delivery Research and Evaluation (CADRE), Iowa City VA Health Care System; University of Iowa

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RAMP

Poll Question #1

- What is your primary role in VA? (choose 1)
    - student, trainee, or fellow
    - clinician
    - researcher
    - administrator, manager or policy-maker
    - other

Today's talk

I. Introduction to the NIH HEAL Initiative, RAMP Study
II. Background: Chronic Pain in Veterans, Whole Person Health
III. Collaboration with Advisors
IV. RAMP Intervention
V. Questions

NIH HEAL Initiative - Prevention and Management of Chronic Pain in Rural Populations

- UG3/UH3 projects that accelerate implementation of effective non-opioid interventions for chronic pain management in rural and remote populations
- Partner with one or more rural healthcare system(s) to plan and implement the intervention
- Trials join HEAL “Pragmatic and Implementation Studies to Improve the Management of Pain and Reduce Opioid Prescribing” (PRISM) Program

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Rural Veterans: Applying Mind-Body Skills for Pain (RAMP)

Goal: To improve pain management and reduce opioid use among rural patients in the VA healthcare system

- The RAMP program is a cohesive, scalable multi-component CIH intervention that addresses Veterans' needs and overcomes existing barriers to pain care
- RAMP is designed to be implemented within the VA through its nationwide Whole Health System initiative
- We will collaborate with Veteran patients, VA health system advisors, and Veteran-serving community advisors

RAMP Study Overview

Phase 1 UG3 (2 years): Engagement activities including developing & working with multi-level advisory panels (n = 35-50) & pilot study (n = 40)

Phase 2 UH3 (3 years): Hybrid Type II Effectiveness Implementation Pragmatic Clinical Trial

1. Assess **effectiveness** of cohesive mind-body intervention delivered by Whole Health coaches via telehealth (RAMP), at improving pain and secondary outcomes among rural VA patients with chronic pain (n = 500)

2. **Implementation**. Work iteratively with multiple levels of advisors (patients, community advisors, VA healthcare system leaders and staff; n = 35-50) to co-develop, evaluate intervention implementation strategies used in the trial and adapt these strategies to scale up RAMP within the national VA healthcare system
   a. **Mixed-methods assessment** of facilitators/barriers, RAMP use, etc.
   b. **Co-creation** of plausible implementation strategies to scale up RAMP
   c. **Budget impact analysis**

RAMP

Rural America is disproportionately affected by chronic pain

- Higher rates of both chronic pain and high-impact chronic pain (Dahlhamer, 2016)
  - Urban: 19% (7% high impact)
  - Rural: 27% (11% high impact)
- Higher incidence of chronic joint and low back pain & physical limitations (Jones, 2009)
- More likely to be prescribed opioids & less likely to use non-opioid interventions (Garcia, 2019; Prunuske, 2014)

Rural/Urban disparities in pain & pain management exist in VA

- The Veterans Healthcare Administration (VA) serves 2.7 million rural Veterans
- Veterans have increased risk of chronic pain & greater pain prevalence & severity (Nahin, 2017)
- Rural Veterans
  - Less likely to receive comprehensive and specialty pain care (Hadlandsmyth, 2022; Arout, 2017)
  - Lower use of self-management for pain (Eaton, 2018)

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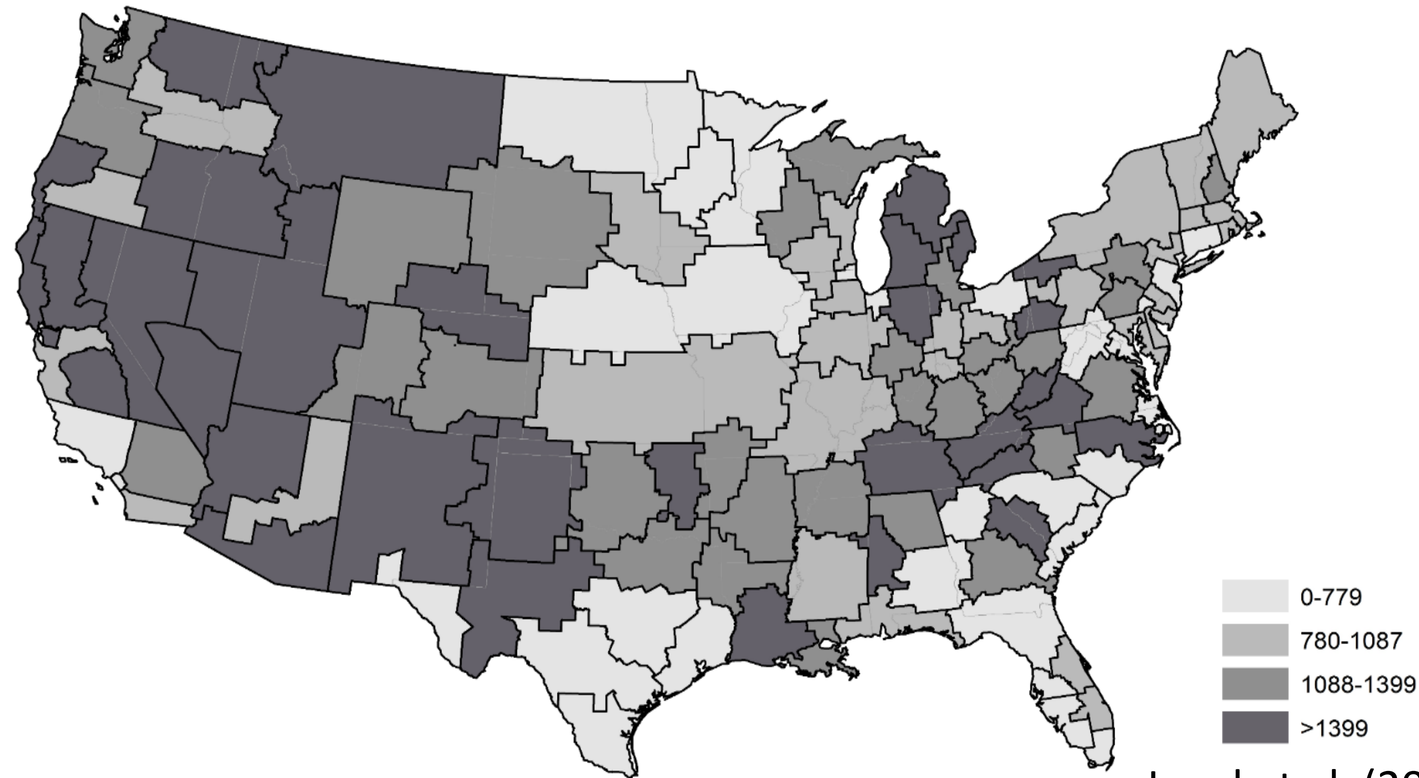
Rural VA patients are more likely to receive opioid medications



Lund et al. (2019) *Military Medicine*

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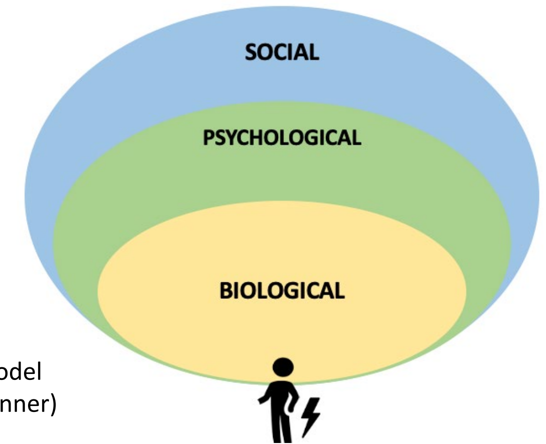
Chronic pain

- Complex ‘biopsychosocial’ (BPS) phenomenon
  - Greater intersection of BPS factors in Veterans (coping, depression and anxiety, trauma, social support, income, education)
  - A condition that affects the whole person
- Growing recognition that pain requires ‘management’ versus ‘cure’
- Emphasis on adaptive or resilient pain behaviors = ‘helpful pain behaviors’
  - More self-management…
    - Less use of substances
    - Less fear avoidance
    - More movement, physical activity
    - More social interaction
    - Greater emotional regulation



Dynamic Biopsychosocial Model
(Lehman, Engel, Bronfenbrenner)

Complementary & Integrative Health (CIH) Self-Management for Whole Health

- Growing body of research to support multiple complementary and integrative self-management modalities for improving pain and other BPS outcomes
  - Psychological, mind-body, physical exercise & activity, lifestyle advice, pain education
  - No one approach 'best'
  - Desire for integration of multiple approaches, greater access among Veterans
- Increased calls for interventions that integrate multiple modalities, cohesively, to address intersecting BPS (whole person) needs

VA and Whole Health

- VA's Office of Patient Centered Care and Cultural Transformation has expanded the CIH services over the last decade, supported by 2016 Comprehensive Addiction and Recovery Act
  - Approved CIH approaches covered by Veterans Medical Benefits package: acupuncture, biofeedback, clinical hypnosis, guided imagery, massage therapy, meditation, tai chi/qi gong, yoga
- VA is a national leader in advancing CIH through its Whole Health model of care
- Nearly 1/3 of VA patients with pain engage in some Whole Health services

CIH for pain remains underutilized, especially for rural Veterans

- Multi-level barriers to widespread implementation of CIH in VA
  - Lack of awareness and knowledge among clinicians and patients
  - Need for clinician referral
  - Support to successfully engage in CIH self-management
  - Demand for CIH providers often outstrips supply
  - Lack of availability of CIH/Whole Health pain care services outside of main VA medical centers

RAMP Advisor Input

Community Advisors
- Local Veteran Service Organizations (VSOs)
- National VSOs serving diverse Veterans
- Veteran Leaders

VA Healthcare System
- National VA Program Office Leaders
- Leaders, Staff: VISN, VA Medical Centers, Community-Based Outpatient Clinics (CBOCs)

VA & Non-VA Patients
- Veteran engagement panels
- Community engagement panels
- Participants in previous trials

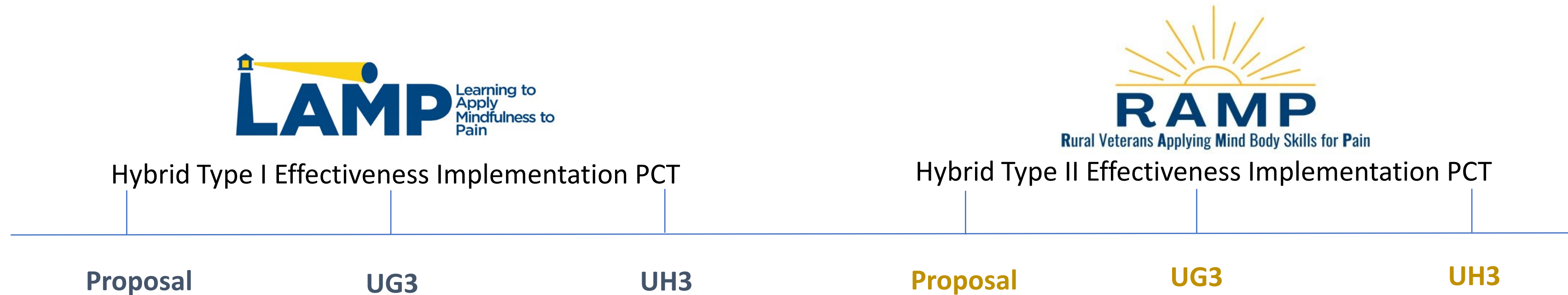
VA & Non-VA Scientists

VA & Non-VA Practitioners

RE-AIM/PRISM

GLASGOW RE, ET AL. RE-AIM PLANNING AND EVALUATION FRAMEWORK: ADAPTING TO NEW SCIENCE AND PRACTICE WITH A 20-YEAR REVIEW. *FRONT PUBLIC HEALTH*. 2019;7:64.

Iterative input from advisors, critical to RAMP intervention & study design



Example: Key informant interviews identified barriers & facilitators to implementing LAMP via telehealth, using VA Whole Health coaches (LAMP, UH3)

Barriers

- Confusion, uncertainty, lack of awareness about the Whole Health coaches; lack of centralization and clear delineation of the role; are coaches allowed to deliver intervention for pain?
- Structures and resources to support Whole Health are rapidly changing
- High levels of burnout and overload -> some resistance to new programs & "top-down" mandates

Facilitators

- Strong support from National Leadership; local champions, support for telehealth, aligned with facility leader goals

How this informed RAMP

- Need multi-level advisor involvement, early and often
- Collaborate with advisors to co-create and test tailored implementation strategies

RAMP Current Engagement Plan

GOAL: Gain a better understanding of rural VA needs

Patient Advisors (n=15-20)

- RAMP Engagement Panel and other ongoing Veteran Engagement Panels

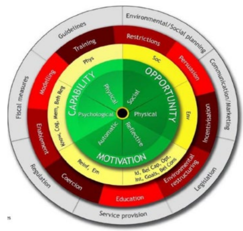
Community Advisors (n=10-15)

- Non-VA Community Organizations (VFWs, American Legions, national organizations serving marginalized groups, etc.)

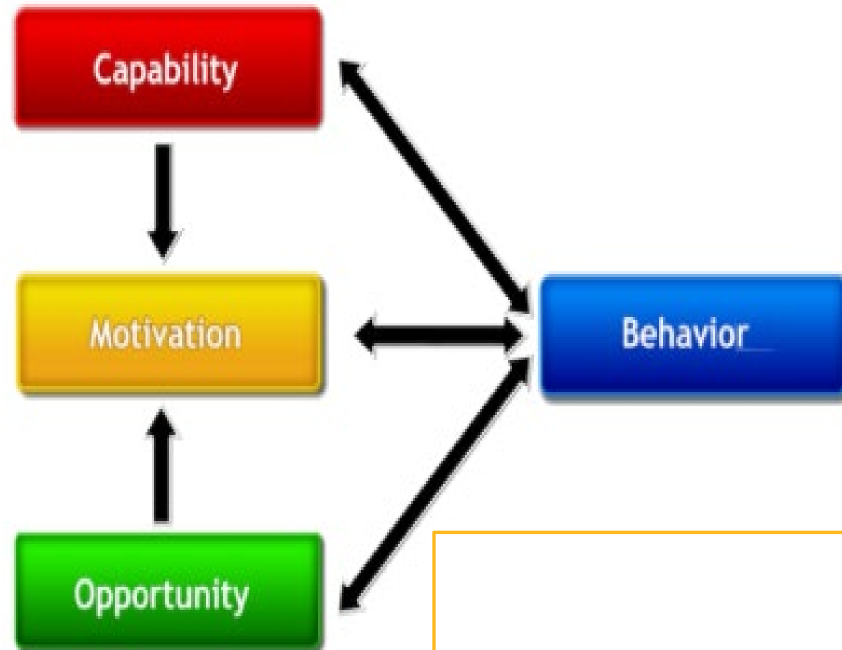
VA Health Care System Advisors (n=10-15)

- National VA Program Office Leaders
- VA Medical Center Leaders & Staff
- VA Community Based Outpatient Clinics

RAMP Intervention Underlying Model



Michie et al (2014). *The Behavior Change Wheel*



Helpful Pain Self-Management Behaviors

- Non-drug self-management
- Stress, emotional regulation
- Physical activity
- Social interaction

Main Goal of RAMP Intervention

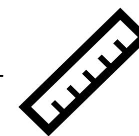
To provide rural VA patients the **opportunities** and resources, to enhance their **capabilities** and **motivations** to engage in helpful pain self-management behaviors

*Capitalize on the existing VA Whole Health Initiative's opportunities and resources

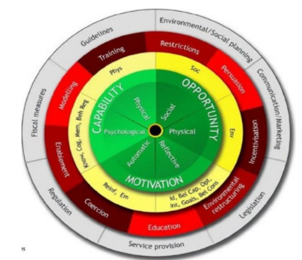
RAMP Intervention Design Process

1. What are the target behaviors?
2. What do Rural Veterans with pain need? What do program facilitators need?
3. What are the appropriate intervention strategies (that can work in the VA)?
4. What content, behavior change techniques should be included?
5. What formats of delivery should be used?

Puts RE-AIM/PRISM into action at the intervention level
Has, and will continue to involve our key advisors



- ✓ Affordable
- ✓ Practical
- ✓ Effective
- ✓ Acceptable
- ✓ Safe
- ✓ Equitable



Michie et al (2014). *The Behavior Change Wheel.*

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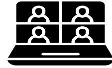
Group Mind-Body Program

Telehealth Sessions 

First Session:
- 1 x 60 min, 1:1 with WH Coach
- Focus: Personal Health Inventory For Pain Self-Management

Group Sessions:
- 11 x 90 min
- Facilitated by WH Coach
  - Group discussions
  - Viewing of pre-recorded expert led videos
  - Practice (mind-body strategies, physical exercises)
  - Home practice

Opportunities

Core Elements
- Environment, Resources
- Education
- Skills Training
- Enablement
- Persuasion
- Incentivization

Enhance Rural Veterans'…

Capabilities

Motivations

Helpful Pain Self-Management Behaviors

Congruent with VA Whole Health Initiative

Core Intervention Elements

Environment, Resources	Education	Skills Training	Enablement	Persuasion	Incentivization
To address physical and social opportunity and resource needs	To address capability needs (e.g., knowledge of BPS nature of pain, mind-body connection, self-management, etc.)	To address specific capability needs (e.g., mind-body, exercise, & wellbeing self-management skills)	To address motivational needs by enhancing possibilities, reducing barriers	To address motivational needs by inducing +/- feelings with communication to stimulate action	To address motivational needs by creating an expectation of a reward

Behavior change techniques

Workbooks, digital recordings; 1:1 initial session w/ WH Coach; weekly group sessions with other Veterans	Evidence based information, consequences, prompts/cues	Instructions, demonstrations, practice, feedback, graded tasks, behavioral experiments, self-monitoring, behavioral substitution, habit formation, body changes	Social support, goal setting (behavior), problem solving, action planning	Focus on past successes, framing/reframing	Behavioral contract, self-monitoring of behavior, feedback on behavior, feedback on outcome of behavior, social reward, rewarding completion

Communication techniques

Active listening, motivational techniques

Relational Alliance Principles

Congruence, connectedness, expectations, individualization, partnership, roles & responsibilities

Trauma-Informed Principles

Safety, Choice, Collaboration, Trustworthiness, Empowerment

Topic Videos (Education)

Evidence based information about pain, whole person (BPS) wellbeing

- Program Intro, What is Pain (BPS/Whole Person)
- Pain & Mind-Body Connection
- Pain & Kindness
- Pain & Wellbeing
- Moving with Pain
- Pain & Pacing
- Pain, Thoughts & Feelings
- Pain & Sleep
- Pain & Social Wellbeing
- Looking Forward

Mind-Body Videos (Training)

Instructions, practice in mind-body skills, activities

- Relaxed Breathing
- Mindful Meditation
- Guided Imagery
- Progressive Muscle Relaxation
- Shifting Thoughts & Attitudes Activity
- Pleasant Activity Planning
- Set Back Planning
- Mini-Practices

Physical Exercise Videos (Training)

Instructions, practice in exercises of core muscle groups, with emphasis on body awareness

- Postural exercises
- Strength, muscle coordination, stabilization exercises
- Stretch exercises

*All videos put on website AND summarized in workbook, with instructions and pictures

Next Steps (UG3 Milestones)

- Community-based relationships developed; patient, community and VA advisor panels established
- Multi-level advisor perspectives of barriers/facilitators to RAMP program implementation, including reach, perceived effectiveness, potential for adoption, implementation and maintenance (n = 35-50)
- Experimental intervention (Pilot Study)
  - 40 rural Veterans, at least 35% female, 35% racial ethnic minorities
  - 75% satisfied with RAMP program; 75% attend recommended # of sessions (≥7/12); Facilitators deliver 90% of session activities 90% of time
  - >80% complete post-treatment data collection (13 weeks)

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Questions/Comments?

Diana Burgess, PhD (diana.burgess@va.gov)

Katie Hadlandsmyth, PhD (katherine.hadlandsmyth@va.gov)

Roni Evans, DC, PhD (evans972@umn.edu)