Cyberseminar Transcript

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Session: Implementing Web-Based Interventions at VA: Case Studies in Diabetes Prevention and Cognitive Behavioral Therapy for Women Veterans

Presenter: Julian Brunner, MPH; Alison Hamilton, PhD, MPH

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Moderator: Hi everyone, and welcome to Using Data and Information Systems in Partnered Research, a Cyberseminar series hosted by VIReC, the VA Information Resource Center. A huge thank you to CIDER for providing technical and promotional support. This series focuses on VA data use in both quality improvement and operations research partnerships. This includes QUERI projects and partnered evaluation initiatives. This slide shows the series schedule. Sessions are typically held on the third Tuesday of every month at 12 p.m. Eastern. You can find more information about this series and other VIReC Cyberseminars on VIReC’s website, and you can catch up on previous sessions on HSR&D’s VIReC Cyberseminar archive. For those of you just joining us right now, slides are available to download. This is a screenshot of a sample e-mail you should have received today before the session, and in it you will find the link to download the slides.

Today’s presentation is from the EMPOWER QUERI. EMPOWER stands for Enhancing Mental and Physical Health of Women through Engagement and Retention. This session is titled Implementing Web-Based Interventions at VA: Case Studies in Diabetes Prevention and Cognitive Behavioral Therapy for Women Veterans. It will be presented by Julian Brunner and Dr. Alison Hamilton. Julian is a health statistician and qualitative researcher at HSR&D’s Center for the Study of Healthcare Innovation, Implementation, and Policy. He studies health IT, access to care, and the implementation of complex interventions. He is currently a PhD candidate in UCLA’s Department of Health Policy and Management. Julian is joined by Dr. Alison Hamilton. She is the associate director of Implementation Science at the Center, and she is the director of the EMPOWER QUERI. Her work focuses on using implementation science to improve quality of care for women Veterans. Thank you both so much for joining us today.

Dr. Alison Hamilton: Thank you. Great. Are we all set?

Unknown speaker: I think so.

Dr. Alison Hamilton: Okay. Thank you so much, everyone, for joining us today. This is Alison Hamilton speaking. And thank you to Hira and Heidi and everyone at VIReC and CIDER and everywhere else for making these webinars happen. It’s really my pleasure to just introduce us, introduce the session and Julian, who is going to be walking you through a couple case studies. We do just want to acknowledge our funding from QUERI and also the Women’s Health Research Network from HSR&D and our wonderful team of investigators. Next slide, Julian.

And the usual disclaimer that our views don’t necessarily reflect the position or policy of the Department of Veteran Affairs or the U.S. government.

So today, as I mentioned, we’re going to be presenting a couple of case studies of implementing web-based interventions. These are both projects that are done within the context of the EMPOWER QUERI. We’re going to talk about an online version of the Diabetes Prevention Program and also a computer-assisted cognitive behavioral therapy that we’re using in a study of implementing care management, tailored care management for women Veterans.

First we just want to get to know a little bit about who is in our audience, so we’re going to do a poll question. So first if we could just learn a little bit about your role in the VA.

CIDER Staff: And our options here are research investigator or PI; data manager, analyst, or programmer; project coordinator; clinical or operations staff; or other. And if you choose other, if you could take a second and type in in the Q&A function what that role is. We would love to hear that. For everyone, I'm giving you just a few more moments to respond, and then I'm going to close the poll out, and we’ll go through the results. Okay, it looks like we’re slowing down here, so I'm going to close that. And what we’re seeing is 24% of the audience saying research investigator or PI; 15% data manager, analyst, or programmer; 15% project coordinator; 30% clinical or operations staff; and 15% other. And in that other category, we have health behavior coordinator and primary care. Thank you everyone.

Dr. Alison Hamilton: Okay, thank you. And then I think we have one more question, which is has development or evaluation of health IT interventions been a part of your job? Has it been a big part, a small part, or has it not been a part of your job thus far?

Moderator: And again we’ll give everyone a few moments to respond before we close the poll out and go through the results. And it looks like we have slowed down there, so I'm going to close that out. And what we’re seeing is 27% of the audience saying yes, a big part; 30% saying yes, a small part; and 43% no, it hasn’t. Thank you everyone.

Dr. Alison Hamilton: Thank you, and I am going to turn it over to Julian. Thank you very much.

Julian Brunner: Thank you. It sounds like we’re kind of evenly distributed across health IT experience. Alison, was there anything else you wanted to share with kind of the context of EMPOWER as a whole?

Dr. Alison Hamilton: I mean I think the most important things for us in EMPOWER are to use care models and test and implement care models that are patient centered and involve women having choices as to how they want to get their care with the emphasis, as you heard in the name of our program, on engagement and retention. So our idea is the more options women have, hopefully the more likely they will be able to engage in something that’s satisfying and feasible and appealing to them and that that might help them to remain in care and get the benefits from care that they need. So that’s a thread that kind of runs through our entire program. You’ll hear about two of the three projects related to diabetes and mental health. And then we have another study led by Bevanne Bean-Mayberry and Melissa Farmer about reducing cardiovascular risk, which we won’t be talking as much about today but a subject of other Cyberseminars. And happy to hear from anyone; contact information will be at the end if anyone has questions about the studies in more detail or needs any other information.

Julian Brunner: Great. Thank you very much.

Dr. Alison Hamilton: Thank you.

Julian Brunner: All right, so I'm actually jumping back a couple slides to just the names of the cases we’re looking at, and you’ll kind of notice that they’re both web based in a sense but in pretty different ways. So the online version of the Diabetes Prevention Program is directly patient facing, and it’s meant for patients to use at home. So that’s probably what most folks think of when you think of kind of a web-based tool. And then the computer-assisted cognitive behavioral therapy is meant to be used in clinic, but it's actually accessed via a browser, which makes it much more of a kind of stand-alone module than a lot of the IT we usually look at in clinic, but it’s also web based. Really, we’re thinking of any type of somewhat separate module of health IT that plays some role in a clinic. And kind of, in reflecting on some of what we’ve learned in the implementation of these cases, we’ve noticed some things in common and just some interesting things we wanted to share.

All right, so before I start talking about just kind of the individual things we’ve noticed and wanted to tell you about, I always think it’s worthwhile any time you’re talking about a health IT implementation, it's worth remembering that you don’t have to think of everything de novo, that there are useful frameworks that can help you anticipate some challenges and that can organize your thinking and how to preempt the challenges. And we’re not actually organizing today’s talk about, around any of these existing frameworks just because I think a comprehensive inventory of every aspect of implementation would be probably kind of dull to listen to, but it’s just to keep these in mind in preparing any kind of implementation like this.

So there are frameworks that are specific to implementation or disseminating innovations that aren’t IT specific at all but end up covering a lot of the main considerations in implementing IT. And then there are ones that are really IT specific but not necessarily related to healthcare. So there’s the Technology Acceptance Model. There’s kind of the whole discipline of user-centered design that comes into play a lot when you’re looking at these types of tools. And there are frameworks that try to draw from both of those areas and look at implementation of health IT in a healthcare setting. So the sociotechnical model is a good example of that. So again, we’re not using this framework as an organizing feature here, but it’s good to know that those exist.

Okay, so across the two cases, there were just some conceptual commonalities in the types of things we thought were important or challenging or surprising in the implementation process. So just kind of broadly, I'm going to talk mostly about the process of introducing the application and training people on it. The partnerships and sometimes contracts you set up with whoever has designed the tool because you’ll see in the health IT literature a lot of the thinking and development and design and implementation kind of assumes that you’ve made a tool from scratch, homegrown, and now you want to do something with it. So these cases were really useful ways to look at how you can spread tools that have already been developed and how to adapt them. There’s also always the issue of integrating whatever you’re making with the systems that are already there, and we thought the process of collecting and using feedback from users was also really important.

Okay, so the first case is the online version of the Diabetes Prevention Program, and we have Dr. Moin on the line as well to answer questions at the end too. All right, so just the background on DPP, there’s a lot of strong evidence for it starting with the highly publicized trial in 2002 and a lot of implementation since then including several that use digital tools, which have tended to have similar efficacy. And I'm not actually going to report any findings in this talk. It’s really just trying to share some of the experience of implementing.

So to describe what DPP is, what the Diabetes Prevention Program is, for people at VA, probably the easiest way to think about it is in contrast to MOVE. So there are a lot of things it has in common. It’s also lifestyle intervention, but it’s a little bit more narrowly focused and structured. So it’s 16 core sessions over the course of six months with standardized goals, and each session builds on the last. And kind of a key feature of the program is that there are meant to be cohesive groups with one instructor that follows you across the group, and it’s also specific to patients with prediabetes as opposed to other programs that take all comers.

And in the study we offer patients the choice of in-person or an online version of the program. And given the focus on women’s health in this project, this was really suitable because there were just a lot of women who weren’t able to attend in-person sessions where a weekly in-person group session just wasn’t possible. And so what that consisted of, when you try to re-create this online, is human coaching, not just kind of a set of online tools but with real people on the other end, trying to replicate that group but online, and then some other kind of digital tools incorporated.

So these are just images from the company that runs this online Diabetes Prevention Program, Omada, just kind of what the human coaching looks like. So it’s an individual who is following your data who is kind of aware of your specific goals and in direct contact with you. So that’s kind of one piece of the accountability. The other piece is the online group where they try to replicate some of that camradery and accountability by having messaging with the other people in the group. There are little indicators of progress that you’re making. And then they have this online bank of learning modules that, again, try to build on one another. They’re not just kind of stand-alone sessions.

And one thing that seems to be really popular is they’ve integrated wireless scales, so it sends data back to the company to make it easier to track. They connect to other apps on your smartphone, and you can use it mostly on the phone if you like.

So that was just kind of the introduction of what the program is meant to do and how it works, so now I want to talk through some of the lessons and implementation and just the process of implementation. So first the process of introducing it. So we sent letters directly to patients, but in order to do that, we kind of queried within the EHR who has prediabetes, and there’s actually a paper linked at the end of the talk on how that query was constructed. Confirmed that with their PCP and sent them a letter. If they didn’t reply from the letter, we called them to follow up. And anyone who opted in and confirmed their eligibility and gave them a choice of the in-person program or online. And actually this is where the kind of tech piece comes in. In order to overcome, so since it’s a third-party company, we were actually constrained in the information that the VA was able to send to them about patients, which kind of makes sense. So instead of figuring out how to get permission to send any personal information that the VA has to another company, we gave patients a code, sent them to the website, and said okay, enter your own information online. That way you don’t have to send anything from the EHR. We use this code so we know how to link back to your record at the VA.

And then the other important thing in training is this help desk model. So a lot of the time when you kind of make an IT tool from scratch, you have to figure out how to, you usually don’t have the resources to staff an 800 number or a help desk. You have to kind of make stagnant training materials and hope that that does the job. But when you have a company devoted to it that has the resources and skill, they can staff a help desk. And actually I think in a previous iteration of this project when patients had trouble with their digital scale, they would send technicians to the home and that sort of thing. So again, just at this scale, that’s one of the advantages.

Okay, I'm actually going a little bit out of order here, and you’ll see why in a minute, but another key piece of implementation is figuring out how to collect and use good feedback. So try to look at feedback from patients. Actually in a previous DPP trial, interviews with patients showed the strong preferences about avoiding cumbersome data entry. So if there was another app you have on your phone where you’re already putting in information about your dietary habits or exercise or anything like that, it’s nice to avoid having to put anything like that in again into a different app, so they, in response, tried to build an interface between other applications on the phone so you don’t have to put in things multiple times.

Some of the important input from providers we got was that in other groups if you don’t have a women-only group within the VA, you often face a real challenge in recruiting women to the group. So whenever possible, we tried to create women-only groups.

And then this starts to get a little bit meta, but most of what I'm telling you today in the seminar actually comes from these periodic reflections we did with the people implementing each of the programs in the EMPOWER QUERI. So there’s actually a paper in press about this and a link to an abstract at the end. But basically we sat down with each person leading a program, each kind of implementer, and recorded conversations with them and a qualitative researcher and transcribed those conversations along the way of implementation. So we have a record of the things that are really important in making an implementation successful and kind of the adaptations we make to interventions and just all the stuff that’s really hard to remember after the fact or hard to capture in another way.

Okay, so this is, again, the sort of thing you might not think about if you’re just making a homegrown tool. Once you start collaborating and deploying or building on tools that other groups have developed or that private companies are selling, the nature of those partnerships has huge implications. So this slide is basically a couple examples of the importance of finding a vendor that you can treat as a partner and the importance of that relationship. So our relationship with the vendor started when the company was really pretty small, and they were willing to kind of work with us on a really granular level on things we needed. As it grew and kind of different people took over responsibility for different parts of the program, for example, we had really wanted to have women-only groups. That ended up not being the case for a while because we realized it hadn’t been codified in the contract. We had just kind of requested that, and it was kind of an uncodified agreement. And some of the data that we had been really happy to get from the company initially, as they grew, they started worrying more about sharing. But because we built a strong relationship with the vendor and really tried to treat them as a partner and share data back with them that they found really useful, we were able to overcome those barriers, and they created women-only groups again and shared some of the data we needed.

Okay, so again, you’re going to have to pay attention to integrating with whatever system is in place. And again, the kind of linking thread between these two programs is that they sit outside of CPRS, and that’s part of what makes them a little bit more nimble and easier to implement and to adapt because you don’t have to think of every implication of putting it within a closed a system, but that always raises the question of how many stand-alone modules do you want in your healthcare system and do you want, what information do you want at the providers’ fingertips?

So basically if you’re generating all of this really important information that’s not necessarily healthcare information but is kind of information about health, how much of it do you want to feed into CPRS or just make available to providers? And when you’re trying to figure out, that starts to turn to questions of providers’ capacity to take in and integrate lots of information, time within a patient visit to discuss any of that information, kind of just what the appropriate role is of the provider in coordinating or overseeing patients’ progress in a stand-alone program, and generally just different styles of practice and preferences across providers.

So that’s all I had to share so far about the Diabetes Prevention Program, and we’ll take questions about it after we talk through the second case.

So the other one we’re going to look at is this tool for doing CBT, cognitive behavioral therapy, in clinic. Okay, so like the other one, there’s a lot of evidence in support of this intervention. This is a tool that was originally developed at the University of Washington in Seattle called the Coordinated Anxiety Learning and Management, CALM, so it’s especially designed for anxiety disorders and to some extent comorbid depression but really centered on anxiety. And it was subsequently adapted for use within the VA by this group at the VA in Little Rock, Arkansas, and they let us use that program in our own study with women Veterans. So it’s this really nice kind of progression from development outside the VA, having it adapted within the VA, and then further looking at its implementation and application for women Veterans. And with each kind of step of that, you have suddenly different patient population and just different needs and a different practice context.

So this is just kind of a first picture of what the tool looks like. Like I mentioned, it’s web based, so you get to it through a browser crucially at a VA computer, so it still sits within the VA firewall, but you don’t have to figure out at each site how it’s going to interact with the rest of the system. And the idea is a care manager in the clinic can use this tool to do in-person CBT with the patient. It has assessments and videos and things that kind of function like worksheets, and it kind of walks you through the cognitive behavioral therapy.

But of course it’s not just that tool that we wanted to look at. It’s really the work of the care manager enabled in part by this tool that we’re really interested in, so kind of that overall environment where we're doing collaborative care for women Veterans. So it’s the work of the care manager that if the patient opts for cognitive behavioral therapy, it’s intended to make that easier to do. But again, it’s a choice of the patient, and it’s kind of embedded within this whole set of, or I guess, it’s really a workflow in kind of IT speak. But some of the features of that are this kind of light decision support in helping you do CBT.

Okay, so again, that was kind of the background of the program, and now I want to talk through some of the process of implementing. And we’re trying to emphasize kind of the commonalities across projects here, so again, we thought the introduction and training process was really important. The model we’re exploring to start is for a single care manager at a site to be the main person who uses the computerized tool. And we’ve only implemented at one site so far, so we haven’t experienced too much of the scaling up part of this yet. But just the process of training at our first site has been really instructive and it's sort of the different kind of thinking and different process when your direct users are employees rather than patients. And when it’s just one or two people at a given location you can be a lot more hands-on. So the introduction to the care manager using it right now consisted of direct coaching in advance and some kind of just-in-time coaching, so kind of the help desk model, along with just having some time to explore the contents of the tool. So even that process has been helping us understand the training process better and will help us in the next site.

Now it’s kind of hard to overstate this, a huge enabler of this project was our partnership with the Little Rock VA to use the program that had already been adapted for VA that already meets VA’s IT security requirements. And like I mentioned, you get to it through a browser, so it makes the local configuration a lot easier. So this is really the piece of this project that made it happen a lot more quickly than a lot of other IT projects. So in the project we’re not discussing as much on today’s call, we’ve been held up a lot by that local configuration and the committees that need to approve new pieces of EHR. Now if you start to look at kind of stewardship of what goes into an electronic health record system and stewardship of providers’ and patients’ time, you understand how important that process is, that it can really slow down this implementation or development. So when it’s stand-alone, that makes it a lot easier. Similarly, in contrast to the Diabetes Prevention Program, which required a formal contract, that process also slowed things down a lot. So the ability to just have a partnership within VA to use a tool that already existed within VA just helped speed things along a lot.

And then again, there’s this question of integrating with existing systems. So whenever there is any type of overlap with an existing tool, what do you do? One example of this we saw in CALM, the tool we are using for CBT, one of the key things that the system features is a series of assessments that you can do on the computer itself or you can print it. But if you do it on the computer, it stores it and you can kind of track progress. And some of those assessments were the same assessment tools that another module, the Behavioral Health Lab, BHL, that some sites use. So when you’re faced with that, you don’t want to have a patient fill out the same assessment multiple times, in which case you have to figure out where you’re going to put that information and which one is primary. And then even before you think about kind of the technical barriers to transferring that information from one place to the other, you just have to decide kind of which one is going to be primary.

And just as I was describing with the other case, you’re generating all this really interesting and potentially useful information because you’re just creating a lot of data. You’re talking to the patient and setting goals and getting all this richness, but then, so in neither case have we tried to push information and further crowd the patient record. But once you have the data, it begs that question. And that’s I think an exciting future direction for this type of research is to start considering, okay, if there are small artifacts of information that get generated from these kind of stand-alone modules, what is it that you want to extract from them and either share with the provider or a patient in a way that they can share with other providers and family and other tools.

All right, so this is the final set of slides, talking about the process we use to get feedback from users for the CBT tool. So we’ve been conducting interviews with patients. I think it’s every third patient we ask to interview. Again, the periodic reflections with the care manager who is using it and with Dr. Lang who has been leading the implementation. And from those conversations, we have been finding just all sorts of little things that could help with the program’s usability, making sure you can tell how long the video is going to be before you click on it, finding out just how the menus are working. But a lot of the most interesting things we’re discovering are less about the program itself and more about how it fits into the clinic workflow and how it functions for a particular patient population. So for some patients with more severe needs, especially younger Veterans recently separated from the military, it also functions more as a bridge or a waypoint to other care. And then there’s a group of patients, especially older patients, some of whom have less severe mental health problems, that CBT and this tool have been a really good fit.

Another thing we’ve heard is probably kind of pretty easy to picture, if you don’t have a computer that’s intended for multiple people to gather around, it can be difficult and uncomfortable to use it that way. So an exciting part of this tool is that it’s meant to be used collaboratively. It’s not something that you just hand over to a patient who has a lot else going on their life and say, okay, yeah, try this. And it’s not something that a care manager or someone in the clinic is just looking at and distracting them from facing and talking to the patient. It’s something that you sit down and use together, which is really neat, but you have to figure out how are you going to configure the room and the computer to make that doable.

And then our last real content slide of this talk, we’ll close on this issue because I think it’s fitting and kind of a common and core issue in health IT is the issue of flexibility and structure. So one of the interesting things we’re seeing so far is that for a given patient, there are some parts of the program that are more relevant than others. So I guess it’s customizable, but it’s hard to tailor it enough to be a perfect fit for everyone. So the care manager said that there are individual pieces from the program that she uses, but she doesn’t typically follow it sequentially, and when you do that, when you kind of pick and choose from the resources that it has, it’s actually pretty cumbersome because it’s designed to be used in a lot more linear way. And I think that was especially striking because it’s such a common challenge in health IT and these types of tools, just the tradeoff between designing a system that’s highly structured that guides you through every step versus making kind of a resource bank that gives you less support and structure but more flexibility. So as we try it in new settings with different levels of experience, we’ll see how it adapts.

And that’s really all I had to share from a me talking at you point of view, but we can take questions, and before we do that, I wanted to check in with Dr. Lang and Dr. Moin to see if there was anything you guys wanted to add.

Dr. Ariel Lang: No, I think you represented things nicely, Julian. This is Ariel Lang. I'm happy to answer any questions. However, I'm on the CBT product side of things.

Julian Brunner: Great. Thank you.

Moderator: Okay, we do have a few questions in from the audience, so I’ll get started with those. Julian and Alison, thank you so much for your presentation. The first question: I think this refers to the first case study. The audience member can correct me if I'm wrong, but the question is, is there any data to suggest one modality is more effective than another?

Julian Brunner: My answer will be stay tuned, but Alison, do you want to elaborate on that?

Dr. Alison Hamilton: I would actually defer to Dr. Moin for that if she is still on because she knows this area the best of all of us. Tannaz, do you have any initial thoughts on that? Okay, I'm not, I think, okay, you there?

Dr. Tannaz Moin: Yeah, I'm here. Can you guys hear me?

Dr. Alison Hamilton: Yeah.

Julian Brunner: We can.

Dr. Alison Hamilton: We can.

Dr. Tannaz Moin: Okay, good. Yeah, no, I think that’s a great question. With reference to weight loss interventions, it’s sort of an overarching umbrella. I think there is a fair amount of literature suggesting that remotely delivered interventions are effective if not as effective as online. With respect to DPP, the Diabetes Prevention Program, which is a, I would say a pretty intensive lifestyle change program with a specified number of sessions annually and so on, we really don’t have any head-to-head comparisons in the general literature. We have one prior VA sort of demonstration project that was done, and that paper is sort of currently under review showing that the online DPP performs similarly in terms of weight loss as compared to the in-person program. So hopefully those results will be published in the next couple of weeks. And within EMPOWER, where we did the gender-specific groups that Julian was talking about, we’re seeing sort of, again, comparable. It’s much smaller numbers of participants so that the study wasn’t really powered to look at weight loss differences. But one important metric is adherence or participation in the program and actually sort of completion of modules or sessions, and we know that tends to be much higher with online. And it’s not a surprising result because the online is much more flexible and convenient to the participants’ needs, so they can do it at 1 a.m. in the morning if they want to or 2 p.m. in the afternoon. And there generally tends to be more opportunities to attend these. The way this particular online DPP intervention is delivered, there are weekly modules. So there are actually 52 opportunities in a year to sort of meet higher adherence metrics. So I'll stop there, and I hope that answers the question.

Moderator: All right. Thank you. I’ll move on to the next question. What is the present status of the Omada DPP contract with VA? It was demonstrated out of a policy office, but this effective program has yet to be implemented in VA despite one in four Veterans having a diabetes diagnosis and many more likely having prediabetes. This seems like a failure to implement into routine practice.

Dr. Tannaz Moin: So this is Tannaz Moin again. I think, if it’s okay with Dr. Hamilton and Julian, I can take a stab at answering [unintelligible 41:49].

Dr. Alison Hamilton: Yeah, would you [unintelligible 41:49].

Dr. Tannaz Moin: Okay, so contracts, I have to say, and Dr. Hamilton and Julian have heard me say this many times, as has Dr. Lang, are I think the bane of our existence. So the prior study that I alluded to, the VA DPP trial which I had the pleasure of working on with Dr. Caroline Richardson and Ms. Laura Damschroder out of Ann Arbor VA, was really sort of a demonstration where we were partnering with NCP. Based on that study, we then sort of went on to think about the tailoring for women Veterans. And the EMPOWER study is really, this is a quality improvement initiative, so we are I think moving along the translation as we go from sort of the work I did with Laura and Caroline to the work I'm doing now within EMPOWER. But yes, contracts are difficult, and from a national perspective there isn’t sort of a national initiative currently to sort of implement Omada across the VAs. MOVE is our sort of national weight loss standard of care program. And there is a tele-MOVE, there’s telephone-delivered MOVE, and obviously in-person MOVE. And so I think the ideal would be that maybe we think about either a MOVE version that’s delivered online if there’s interest in sort of building our own within VA or thinking about doing things more broadly. But that would take several operations partners or partnerships in the VA and also VA sites who are interested. So if there is anybody on the call that’s interested, please feel free to e-mail me. And I think this is something we would like to see sort of more broadly disseminated.

Moderator: Great. Someone mentioned that there is a MOVE coach app available on iOS and soon for Android.

Dr. Tannaz Moin: Yes. And that app is, from what I understand, is actually pretty widely available, and it’s something that the Veteran could really do completely on their own, and it’s great. And it also could be used to supplement things that they’re doing either one on one, sort of referrals with nutrition or otherwise in the VA or at the MOVE program, but absolutely. And that app is available.

Moderator: All right. Thank you. I only have one more question from the audience, so if anyone else has any questions you would like to ask, please send those in. I believe this question refers to the second case study. What level of expertise were the care managers? Nurses, PhDs, social workers, PIs, site coordinators?

Dr. Ariel Lang: This is Dr. Lang. So the current case manager is a nurse, which has actually worked beautifully because most of the care management team for our PC-MHI is frontline nurses, so she has moved into that role quite smoothly. CALM more broadly was designed for use by a variety of disciplines in primary care, so nurses, social workers, psychologists, whoever else might be in the primary care setting and readily available can be trained. That’s part of the idea of having a program that does so much to guide the therapist in terms of working with someone is that it allows her someone with relatively less background in CBT to still deliver the manually-based care.

Moderator: All right. Thank you. We do not have any more questions from the audience. Julian, Alison, do any of you want to make any closing remarks before we end the session?

Dr. Alison Hamilton: This is Alison. I would just say thank you all for attending. As Julian said, stay tuned. We’re in the process of learning a lot in these projects and just trying to dig into the role of IT supportive intervention and looking at a variety of implementation outcomes. So we’re really excited at these developments and just trying to push the envelope in terms of what we can do and what we can learn and what are the implications for tailoring and adapting interventions. So thank you all very much for coming. And Julian, thank you for leading the presentation. Any closing remarks from you?

Julian Brunner: Not really. I was also going to say stay tuned, and in the meantime check out the resources we’ve posted at the end.

Moderator: All right. Thank you both so much. To the audience, if you do have additional questions, you can contact the presenters directly. You can tune in for the next session in VIReC’s Partnered Research Cyberseminar series on Tuesday, June 19th, at 12 p.m. Eastern. Dr. Zach Landis-Lewis from the University of Michigan will be here to present on Designing Performance Feedback about Goals of Care Conversations in VA CLCs and HBPC sites. You can also join us for VIReC’s next session in the Corporate Data Warehouse series, Querying Meta Views. This session is scheduled for tomorrow, Wednesday, May 23rd, at 11 a.m. Eastern, and it will be presented by Dr. Margaret Gonsoulin. We hope to see you there.

[ END OF AUDIO ]