Cyberseminar Transcript

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Session: Evaluation of a Peer Coach-Led Intervention to Improve Pain Symptoms (ECLIPSE): Results from a Study of Peer Supported Pain Self-Management for Veterans with Chronic Pain

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Dr. Marianne Matthias: Thank you all for coming. This is a Cyberseminar on the Evaluation of a Peer Coach-Led Intervention to Improve Pain Symptoms. Results from a Study of Peer Supported Pain Self-Management, I think management was the word missing from that prior slide. So before we get started, I have a few poll questions that I’m going to turn over to Maria to ask. So. Here’s the first one.

Maria: Okay, the poll is open. And the question is, what is your role in research? Is it a clinician investigator, non-clinician investigator, data manager, analyst or programmer, project coordinator or research assistant, clinician or other? And if you please put the other information into Q&A. And the audience is responding. And I’ll give them just a few more moments to finish answering the question. And it’s starting to slow down. So I am about to close the poll. And the responses we have are 18% responded A, clinician investigator, 13% responded non-clinician investigator, 5% responded as data manager, 15% responded as D, project coordinator, 30% put in E, clinician non-research, 13% said other. And some of the, we did not get any responses about other, oh we did get one response as program manager at DoD funding agency. Okay.

Dr. Marianne Matthias: All right. Last question.

Maria: Hold on one second. It’s just about to open. The next question is open now. How many years of experience do you have working with the VA? One year or less, more than one, less than three years. The next one is at least three less than seven, at least seven less than 10, 10 years or more. And the responses are coming in. And we’ll just give it a few more moments and let everybody respond. And it has slowed down, so I’m going to close that poll. And the responses are, 17% are one year or less, 18% for more than one less than three, 29% for at least three less than seven, 8% for at least seven less than 10, 23% 10 years or more. And 0% have responded, have never worked. Okay, back to you Marianne.

Dr. Marianne Matthias: All right. Thank you, Maria. Just start with some disclosures that these are my views, and they do not necessarily represent the Department of Veterans Affairs, or the US Government. And I have no conflicts of interest.

And then just some acknowledgements for the ECLIPSE study team. You can see the names of the Co-Investigators listed here, as well as the rest of the study team that this project would not have been possible without. And the funding is from VA Health Services Research and Development.

So to start with a little background, probably many if not all of the audience know that chronic pain is prevalent and does affect about 65% of Veterans. And also chronic pain requires effective consistent self-management. And self-management is defined as the ability to manage the symptoms, treatment, physical as well as psychosocial consequences as well as life-style changes that are inherent in living with a chronic condition. And self-management includes a number of things. Treatment adherence, behavioral change, adapting certain roles, managing negative emotions, and coping skills. And self-management is widely recognized mainly by the VA and the National Academy of Medicine as critical part pain management.

And what we’ve learned from a lot of the work we’ve done over the years is that self-management requires support. So patients have identified barriers to self-management as not getting support from other people, not having any kind of encouragement to keep up with the activities. And that they feel without the support that they’re just not very motivated to maintain their activities. They, on the other hand, described facilitators support as having someone to help troubleshoot when certain self-management activities don’t help, to perhaps help them find other activities that might be more helpful, to listen, just to hear them when they talk about their pain and their frustrations with self-management and other things related to pain. And also just very simply to encourage them to keep going. Especially when they do feel frustrated.

So in these other studies we’ve done where we learned this about Veterans. These studies had a nurse care manager who was providing self-care management information and support. But unfortunately—as most of you know—it’s not always feasible outside of a research study to have a nurse to provide that kind of support with clinics being busy and nurses having other responsibilities. So this presents a big barrier to implementation.

So peer coaches are a potential solution to that barrier. Because they can provide support and a lot of the same benefits as a nurse. They may not have the same expertise, but they do have the expertise of living with pain themselves. And being able to share what’s worked for them and what hasn’t worked. And so given that they’re able to provide encouragement and motivation and to listen, because they understand what it’s like to have chronic pain. And the advantage of this too is there’s much greater implementation potential to use peers in this type of support role. Because obviously there are more patients with pain than there are nurses. And also it has a potential to be this self-perpetuating model as patients who are given peer coaches, then become masters of self-management and then they go, and they become coaches themselves and help other Veterans. And peer support has been shown to be effective in other contexts requiring self-management. And in the VA specifically there’s work in diabetes and mental healthcare.

So this is a model that we developed based on our early work with pain self-management support. And you see that typically when we think about self-management, we think about the things in this upper left quadrant in the box labeled strategies that list some but not all of pain self-management strategies. But really what we’ve found from our work over the years is that self-management really is a lot more than that. And it’s also finding what works because the same thing doesn’t work for everybody. It’s having somebody to help you feel accountable so that you actually do what you’re committing to do for your daily self-management. And it’s the motivation and support that I mentioned earlier. Encouragement to stick with it. Having somebody to listen. And so previously as I said we found that the nurse care manager had filled this role. But then we expanded this to the idea that well maybe peers could do this and do a good job with this.

So from that we did a pilot called improving pain using peer-reinforced self-management strategies, or IMPPRESS. And this is a VA QUERI funded rapid response project. So it was way back when QUERI was funding these RRPs. And we had 20 Veteran peer coaches who had participated in a prior intervention with chronic pain self-management that had taken place at our facility. So we had we were able to find people that had some self-management experience. And then 20 Veterans with chronic musculoskeletal pain persisting at least 6 months, and they had to have at least moderate pain severity. And this was a pilot test. So we did a simple pre-test, post-test design.

So we had 4-month intervention period, this is only a 12 months study. Each coach was paired with two Veterans. And peer coaches were asked to do things like help their Veterans set goals and then follow-up on those goals. Discuss relevant parts of the pain self-management manual, and I’ll talk about the manual in a little bit. And then they were asked to provide encouragement, share their personal experiences, and engage in social talk where appropriate. And in addition peer coaches received regular supervision calls from a psychologist who was working on the study.

So for IMPRRESS we had our primary outcomes as pain intensity and interference. And we used the PROMIS pain and interference measures. And the PEG, which is a 3-question version of the brief pain inventory. And we had a number of secondary outcomes including depression, anxiety, patient activation, et cetera.

So for the results of the pilot study, we had pretty high retention rates. Ninety percent with peer coaches, and 85% with the patients. All participants were male, that was a conscious decision because it’s such a small study. And we did believe based on previous work that matching on gender was a good strategy. So we just kept it simple and all participants were male. The ages are a typical age range for Veterans, ages 50 to 71, and you can see the prominent pain conditions listed below.

And the results, remember this is a very small sample. I’ll just direct you to the third column from the right, the effect size. And you can see that for a number of outcomes we had pretty encouraging effect sizes. And everything, all of the outcomes went in the expected direction. So in particular, the depression and self-efficacy and patient activation all had very good affect sizes. So we were encouraged by the pilot study results.

And of course there were limitations to the pilot study. It was a pre-test, post-test design, as I said, and also all male Veterans, as I said. We had a shorter intervention period. And as you saw, just a very small sample size. There were some advantages of this in the sense that we had, we were able to be more selective with our peer coaches. So we were able to keep coaches that we thought would be good coaches. And then this also allowed more personalized attention from study staff in terms of making sure that the coaches were doing what they were supposed to do. And helping them troubleshoot if problems arose and things like that.

So then we had, based on our encouraging pilot results, the follow-up study. The ECLIPSE study that this is about. So this was a 4-year randomized control trial, as I said, funded by VA HSR&D.

And the ECLIPSE Aims, it was a hybrid type 1, meaning that we were looking for feasibility for implementation at the same time that we were looking for effectiveness. So the first aim, the primary aim was to look at the impact of the intervention on pain intensity and function. So that was our primary outcome. And then our second aim involved looking at secondary outcomes, and you can see those in red. And then our third aim was the pre-implementation aim which was qualitative work to explore facilitators and barriers to implementation.

So just a brief overview. This was a 6-month peer coaching self-management intervention. And it was compared to a control group, and the control group was offered a 2-hour class in pain self-management. And eligibility criteria just increased they had to have musculoskeletal pain for at least 3 months. At least moderate, 5 or greater pain severity. And of course, they needed to be willing to engage phone or in-person contact with another person. And there are some of exclusion criteria listed as well.

So peer coaches, where did we get them? They were first as with IMPRRESS the pilot study, they were participants in past pain self-management studies. We also identified peer coaches based on recommendations of primary care providers. And then later in the trial, we had a few ECLIPSE intervention completers who really seemed to benefit from the intervention who went on to be peer coaches. And the coaches had musculoskeletal pain diagnosis, but they didn’t have to have a minimum pain to be in the study. And I should add too, that the peer coaches the way we design this study, were also study participants. So they were coaching but they were also considered participants in the study. So we really had 2 groups. We had the peer coaches, and then the Veterans whom they coached. So we recruited coaches in waves as needed, because we obviously couldn’t recruit all Veterans at once. So we would recruit a group of coaches usually 4 to 8, just varied depending on our needs and who got at the time. And then we would conduct a 2 to 3 hour in-person training session with them. And training peer coaches were assigned at least one Veteran to work with. We let them choose how many Veterans they could work with, and we found in the end almost half chose to work with just one. And there were a few outliers that worked with many, many over the course of longer than one 6-month period.

And we had a lot of methods in place to monitor our peer coaches. So after the training, they offered monthly booster sessions which is designed really to reinforce skills, answer any questions that came up, and troubleshoot problems. And in some ways, these were almost more helpful than the initial training, because the initial training was a little bit abstract. And once they’ve actually gotten into coaching, then they have questions come up that are accessed about things that are actually happening with their coaching. And in addition to these monthly sessions, there were regular one-on-one check in calls from one of the peer coach supervisors on the study to make sure everything was going okay, also to make sure they were calling or contacting the Veterans. And then the study also did check in calls with the Veterans to ensure that their coaches were contacting them. And to identify any issues that might come up.

So we matched patients and coaches on gender. As I mentioned earlier. And to the best of our ability pain locations. It depended on the pool of peer coaches we had and who was being recruited at the time as a Veteran participant. But usually most of our participants had more than one pain location. So it worked really well to be able to match them on pain location. They were asked to meet or talk 2 times a month, or at least 2 times a month for a total of 12 sessions over a period of 6 months. And they were given the option to choose phone or in-person because we really wanted to make this as accessible to them as possible. And we did however encourage them to meet in person the first time. So they knew each other a little bit. And then we had, the sessions were guided by a manual on pain self-management that was derived from some previous studies. And everybody, the coaches and the Veterans were given this manual, they weren’t asked to just read through this manual. Coaches were really it was emphasized that they should be flexible and if there’s a section of the manual that corresponds to a particular problem their Veteran’s having the day, they talked then they should feel free to discuss that part of the manual. And we also encouraged them to discuss, as coaches, their own experience with pain management and challenges and how they overcame them. Of course to the extent that they were comfortable doing this. And then goal setting was a big part of what we designed sessions to be around, and that was covered extensively in the peer coach training.

And just to give you a sense of what was in the manual, the left-hand column self-management knowledge outlines the different sections that were in the manual and that the Veteran participants were given. And the section that the peer coaches were given. The peer coaches had an additional section on the righthand column, how to be a peer coach. And this was really, we developed this in the pilot study and refined it for ECLIPSE, and it was based largely on Dan O'Brien-Mazza who was the director of peer support services for VA mental health services. He was really helpful with getting the study designed and started. And he shared the VA peer specialist manual. So a lot of this context came from that.

So we had outcome measures at baseline, 6 and 9 months. And we gave both patients and the peer coaches the outcome measures. So we did not pay the peer coaches to be peer coaches. We did not pay them by the session. And this was a conscious decision that I’ll talk about a little bit later. But we did have them take the same assessments on the same schedule as the patients and then they were compensated. You know the gift card for doing that. And we did this because we wanted to have a way to compensate them without actually paying them. But then also we did want to ascertain the effect of peer coaching on coaches because there’s really not a lot of work that’s been done with that. So our primary outcome was the brief pain inventory total score. And that’s a 0 to 10 scale with subscales of pain interference and pain intensity. And then the secondary outcomes you can see are listed here.

So just quick statistical information. We were powered to detect a point 45 effect size on the primary outcome. And we used an intent to treat approach. And with also had site exploratory analyses planned including intervention dose to see if the dose of the intervention had any affect on outcomes.

So we ended up with 215 enrolled. Two did withdraw after consent but before including their baseline, so that left 213. And 119 were randomized to the intervention and 94 to control. But it’s not even because in our power calculations we accounted for nesting of patients within coaches. So we accounted for an interclass correlation among patients who were assigned the same coach. So that’s why we needed more in the intervention group than the control group, because there’s no nesting in the control group. And everything was balanced between groups. On baseline characteristics our randomization worked. And our demographics you can see below, a mean age 56. Most were male and most were White.

So the results. Primary BPI total at 6 months. We went from 5.8 on the BPI to 5.6. And both groups started at the same place. And both groups ended at the same place. So clearly, there was no effect. And then at 9 months, similarly, so they started at 5.8, and both groups improved by 9 months. And those improvements were statistically significant. However, if you look at the difference of differences there’s no difference. So they both improved, but the intervention group did not do better than the control group.

So what happened? Well and again, actually not much happened. But again, why? So there are a number of reasons why we think this happened. And one big one was, adherence was low despite all of the efforts of the study team. So I described a little bit about the phone calls. There were regular phone calls to patients, regular phone calls to peer coaches. But at the end of the day, you can’t force anybody to do anything. So they signed up for the study, and many were very good at making their meetings. But not everybody was. And so of the data, of the patients we have data on with a number of contacts, because those were self-reported, very few had the prescribed 12 or more meetings with peer coaches. And over half actually met 5 or fewer times. So they just, they signed up for the study, but for whatever reason many of them did not adhere to the recommendations of how often they should be. And we did do some exploratory analyses with dose. And those didn’t really yield anything either.

So why was adherence so low? Was it because of the coaches? We asked, you know, should we have paid the coaches? A number of other successful peer coaching models, including in the VA, for example diabetes, have offered some form of stipend or salary. We did make a conscious decision not to pay them because we wanted this model, we wanted to test a model that would be as implementable as possible. And so a volunteer model could be easily implemented because you would need to find someone to supervise the peer coaches but that would be all. And so it would be a much more minimal burden on existing clinic staff. So as many of you know, I’m sure the VA does have peer specialists that are paid VA employees, why didn’t we use them? Well we couldn’t at the time of ECLIPSE. VA peer specialists were not available outside of mental healthcare at that time, although now they have been expanding. So that would have been a completely different model, and it could have been something we might have tested but not at that time. So that was kind of what we were thinking until we started reading the qualitative data. Is maybe it was because we relied on the volunteer model of peer coaches. But the picture is a little bit more complicated than that.

So from the, we interviewed peer coaches and Veterans, and Veteran engagement was a huge barrier identified by the peer coaches. Peer coaches described they couldn’t reach their Veterans, or their Veterans wouldn’t return their phone calls. In many cases there was a focus from their Veterans on socializing rather than going through the self-management content. And Veterans just in many cases just did not want to talk about goals. And so our coaches met a lot of resistance there.

Here are just some examples of what our peer coaches said about Veteran engagement. I won't read all of these to you, but one said they were just not into their program. Another said, they thought that they were just in it for the gift card. And another said, I don’t even get calls back anymore. And then there’s a couple of quotes on here focusing on that the social activity without wanting to go into the pain management content.

Our coaches did identify other barriers to, I mentioned goals a minute ago. Goals were like dirty words, one peer coach said about one of his Veterans. And another said, they just didn’t want to set goals. And then another said, I don't think they were interested in changing, it was more about complaining. And then also the phone context for some seemed to pose a barrier. There’s a balance between trying to find the most effective way for people to meet, and a way that facilitates [inaudible 0:27:43] as possible, but also a way that is engaging for people. And for some, the phone did not seem to be engaging.

Veterans also did identify some similar barriers. One Veteran just admitted that they didn’t return phone calls. Another Veteran didn’t like the phone. And then talking about the social conversation. So some of these ideas were corroborated in the Veteran interviews as well.

However, there are some upsides to this. We did find that there were people in the qualitative data did identify facilitators and benefits to peer coaching. So many mentioned how talking to fellow Veterans was really valuable. And then those who felt they had a good peer coach talked about how their peer coaches listened. Their peer coach was attentive, offered good advice, and was not judgmental.

So some facilitators that Veterans identified were easier to talk to Veterans about Veteran’s things. And then another said that their peer coach was well versed in how to get me where I thought that I wanted to be. And then another, he wasn’t pushy, he was an active listener, and he focused on me. So there’s some examples of some good experience that some of the Veterans had.

And then benefits were identified. People didn’t feel alone in their pain. They did like having someone to be accountable to for self-management activities, similar to what we found with the nurses. And similar again, someone to listen to them. And also just the peer coaches provided optimism and hope for some people.

So some quotes from Veterans identifying these benefits. One said, I enjoyed feeling that other people had the same issues. Another one said, if you’re like me, and you’re single and you live by yourself, there’s not anybody to keep bugging you. So really talking about the pushing and the motivation. And at the bottom, this Veteran says, I can see a little ray of hope. And I try to focus on that and not think of all the negatives that go along with my pain. Before it was like, doom and gloom. So these are some benefits that the Veterans identified.

And coaches themselves also identified some benefits to being a coach. Friendship and another said being a peer coach helped me stay active socially. Another said that being a peer coach helped with his own pain self-management. So I started practicing what I preach, and I was feeling better. And then there was also this idea of just peer coaches feeling rewarded by the work they were doing. So the best part is when you’re talking to them and they say, man I like talking to you. And you give them some ideas. And you call back and say hey, some of that stuff works, it’s just pleasant.

So in summary, the negatives were that there was very low adherence and engagement on the part of many participants. And there was difficulty focusing on the curriculum for some. And those who use the phone appeared to have extra challenges. And then of course, we did not see measurable changes in pain or secondary outcomes. There were positives, though, and patients and coaches identified encouragement and motivation. The social contact and the friendship. Learning new ideas for pain management, and then having someone to talk to and listen to them.

So the bottom line, peer coaching for pain self-management did not produce measurable changes and outcomes. But even so, peer coaching did appear to help some people just not in our measures. It didn’t show up in our measures. So then the question is, is peer coaching worth another try? Or is it not a model that is going to be viable?

So what could help peer coaching work better in pain management? One thing that would probably be helpful based on our experience is to not have peer coaches deliver so much content or curriculum. Instead a model where a clinical or research team member provides the content for pain self-management either individually or in a group format, and then using the peer coaches in a supplementary fashion to encourage and reinforce messages from that team member. So really, they’re in an encouragement and reinforcement role and they’re not tasked with helping people set goals and things like that that are a little bit challenging and as we learn, can often lead to a lot of resistance. Another thing that could be done in the future is now that VA peer specialists have expanded, use those in this type of context. Using peer specialists would allow, it would use peers with more training and higher accountability that are required to go through a certain amount of training. And it would also because of that provide more control over the structure and frequency of meeting instead of leaving the pairs on their own to arrange them. And then because peer specialists are hired employees, and they work with a lot of different Veterans, there would be fewer peers to manage, so that makes it easier to track peers in terms of what they’re doing, and are they doing what they’re being asked to do. Another thought is a shorter intervention period. We didn’t really, this is not from our data, but I just suspect that 6 months may be a little bit too long. And maybe something like 3 months might be a little bit more manageable and might not seem as much of a commitment for people.

So the next [inaudible 0:34:23] exploratory analyses. And we’re still working on analyzing the qualitative data—some of which I shared with you today.

And just, if you’re interested here’s a list of the publications so far from the study. And I think this slide will be available. So you can take a look at this later.

And so thank you for your time, and I’m ready for questions.

Dr. Robin Masheb: Thank you Dr. Matthias, this was a wonderful presentation. This is Robin Masheb. My apologies for joining late to the call. This is wonderful. You have some questions about what would you have done differently? But you did a wonderful job at the end of addressing those things. So if people have some other questions, please feel free to write them in. And can start with one that we have, and a couple maybe that I have, did you do some sort of fidelity checks on your clinicians for this study?

Dr. Marianne Matthias: We did a Veteran or patient self-report, a coach self-report, and then we had recorded some interactions as well, and coded those. And similar to what I said about adherence, there was some variability in fidelity. And so some coaches were quite good, and others were not as good.

Dr. Robin Masheb: Did you have some sort of checklist that you did when you recorded the sessions and?

Dr. Marianne Matthias: We did, yes.

Dr. Robin Masheb: I don't know, did you have a chance to analyze that and maybe what percentage?

Dr. Marianne Matthias: We’ve analyzed it, we haven’t analyzed it extensively, no. So I can’t really speak to, it’s been a while since I’ve looked at that data. So I can’t really speak to specifics about it. But there was some variability in the degree of fidelity. Basically we had some really good coaches, and then we had coaches that weren’t so good. And I think that’s a key difference with the pilot where we had 10 coaches, and retained 9, and because we had so few we were really able to be very selective about who was a coach, and about just following them throughout the intervention, making sure that they were doing okay. And once we got into a large-scale randomized trial with a lot of people, it became harder to find those good coaches. So I think that’s an inherent problem with this model. Testing this model with purely volunteerism was kind of a high-risk high-reward enterprise. Because there were, I was a little bit worried from the start about oh, we’re putting a lot on the peer coaches, can they do it? But then the rewards of implementation potential were really enticing and made it worth testing. And clearly the HSR&D thought so too because they funded it. And it was, I think it was worth testing. And I wish it had turned out differently, but I think we learned a lot from it. And I think we learned that some kind of hybrid approach probably with peer coaches is likely to be a more productive approach. And I see in the chat, Bob Kerns has typed about the intensity of the intervention might not lead to meaningful benefits. And I think that’s a good point. I think that again, using peer coaches in a supplementary role, maybe in conjunction with other multimodal approaches is probably the best place to go from here. In terms of utilizing peer coaches in the context of pain self-management. And I think that that, so an especially now this ability to leverage VA peer specialists were there’s more quality control over who’s the peers are and what they’re doing. Because they’re VA employees and they’re hired, and fewer of them so it’s just more, it’s just easier to manage. And so I think that those are some important things that could make this type of approach with peer more effective for pain management.

Dr. Robin Masheb: We are experiencing background noise. So if everybody can make sure that they’re on mute, that would be very, very helpful. Another finding that I thought was\_

Dr. Robert Kerns: Excuse me, Robin.

Dr. Robin Masheb: \_really interesting from your follow-up interviews and somebody had written in about this was discovering that the Veterans didn’t like the word goals or setting goals. [inaudible 0:40:01]

Rob: Robin, Bob Kerns is trying to jump in.

Dr. Marianne Matthias: I think Bob was trying to say something.

Dr. Robert Kerns: Yes, do you mind?

Dr. Robin Masheb: Go ahead, Bob.

Dr. Marianne Matthias: No, no. Not at all.

Dr. Robert Kerns: I want to pick up on my question in the chat box, and then Marianne’s response. I think your exactly right, Marianne, even from where to push VA [inaudible 0:40:31] was very well done, intensive, trial that Kurt Kroenke and Matt Bair had done, you know much more intensive interventions targeting similar population produced maybe at best moderate improvements in patient relevant outcomes for pain. Pain relevant outcomes. And so I do think that the idea of using peer supports to try to sustain benefits further for more intensive interventions may be an opportunity. But I do, I know I can’t speak for VA policy, but I think the proliferation and acceptance of peer support specialists in the VA pose a great opportunity here. So you wouldn’t want to throw the baby out with the bathwater. I do think that you’re on, you’re a leading investigator, Marianne, in this area. And I think that you’re, I want to just reinforce you in terms of this kind of work, the design of your study, and now the future directions as you describe, seem right on target to me.

Dr. Marianne Matthias: Thanks Bob, I appreciate that. Yeah, I think that there still is promise for this model. I’m glad we tested it the way we did, because I think I would always wonder, would this work? Especially because it did work on a small scale. So I think it’s good that we know that this probably isn’t a viable approach going forward. Especially on a broad scale. But I think, I’m by training originally a qualitative researcher, so I always like looking at the qualitative data. And I think that it does give us insight into the idea that despite our quantitative outcome measures, this was a value for many people in this study. And I think that as a tool to augment some of these, especially these multimodal approaches now that are becoming so much more commonly deployed in the VA and elsewhere, you know these are non-pharmacological treatments that require a lot of patient commitment and time. And take maybe a little bit longer to work than a meditation. And so I think having support, not just from a healthcare provider who doesn’t have the time or resources to offer intense support anyway, but having support from somebody like a peer as people are trying to explore these multimodal approaches and make them work for them could be very valuable. Especially when we know that these non-pharmacological treatments are still underutilized.

Dr. Robin Masheb: I think you made some really important points that I just want to elevate given that I’m a psychologist who does clinical trials with cognitive behavior therapy, that I think there’s just a proliferation today about using these skills and that they can be used kind of by anyone and any setting. And we don’t know whether that’s the case. And I think that’s really interesting that you found that this worked when you kind of used a small tightly controlled sample. But then when you tried to expand it on a larger level it didn’t work. And I do think it is really important that we do trials and publish results even though there’s a negative finding. Because then it does leave open the question of well why can’t we just have some peer coaches go ahead and do this, and that would be such an easier way to disseminate it. So yeah, I thank you for those comments, and really appreciate you mentioning that and providing a context for your findings which I think are really important. I’ll just go back to some more detailed questions that I had started before. Somebody noted, and I thought that this was really interesting to that in your qualitative research you found that the Veterans didn’t like setting goals. That’s something that I often find with homework and the language of homework. I think for a lot of people it harkens back to school, maybe not doing well in school, feeling a certain amount of pressure. I was wondering if you had any thoughts about ways you could change that. I don't know whether it’s just the language or doing it a different way. The other word that people brought up, I’m not sure whether you found this in your qualitative research, but actually calling peer coaches, coaches. I don't know whether you had a sense whether that was received or unfavorably received.

Dr. Marianne Matthias: Yeah, that’s funny that you ask that, because we actually struggled with what to call them. And I think in IMPRRESS the pilot, I think we just called them peers. And then we talked about peer mentors, peer coaches, just peers. In VA they’re called peer specialists, but we didn’t want to use that language because that’s very specific to a position at the VA. So I think we decided on coaches because the idea of coaching is, you’re encouraging someone. And you’re not doing it for them, but you’re guiding them and encouraging them. And I think in some of our qualitative data with the work with the nurse care manager, some of our Veterans had compared the nurse to a coach as well. So it was something we thought about. We didn’t specifically ask any of the participants in ECLIPSE about that terminology. So I don't know, I haven’t thoroughly analyzed the qualitative data yet. I’ve shown you parts of it, but I haven’t dug in as deeply. So there may be something in there that emerged, but we didn’t specifically ask about that. And then regarding goals, I mean that’s a tough one, right? Because so much of self-management centers around goals. And I do think number one that’s where it makes a lot of sense to use the peer as an adjunct and then have somebody else with more training and motivational interviewing and things like that to be able to work on goals with patients. So I think that taking that away from the peer coaches and then just using the peer coaches as a way to reinforce and encourage is probably one approach. As far as how to get around the whole goals being a dirty word, that I don't really have an answer to except put it in the hands of somebody who has experience with that.

Dr. Robin Masheb: I’m also really curious, we have one of our attendees wrote in, how you handled the situation of health disclosure on the part of your peer coaches? You know it’s a really interesting thing that most professional clinicians are taught to be you know very limited in how much you disclose, that sessions are about your patient or client, and it should be focused on that. And here you have a situation where you’re trying to kind of capitalize on the relationship and evening out some of that imbalance of the relationship. But you also have these things that your coach is supposed to achieve during the session. So how much do you use that relationship? How much do you limit that relationship with that something that you struggled with over the course of this trial?

Dr. Marianne Matthias: Yeah. That’s a really insightful question. There is some work in the literature on peer coaching about this, and about the difficulty, not always a difficulty but it can be, but the challenge of navigating these lines that you just articulated. The peer coaches are often referred to as parrot professionals. So they’re not professional clinicians, but they’re not just patients either. Although in our model that was focused on strictly volunteer model and in cases where sometimes people just coached one other person it was closer to being, to having more equipoise in that relationship. But what we really wanted to do was leverage that. Leverage the commonality. Like the quote I showed you, it’s good to talk to a Veteran about Veteran things. And I think that’s come up in other work in the VA with peer coaching diabetes specifically. This idea of just having somebody that Veterans have unique experiences, and to have somebody else to share that with is I think perceived as really valuable. So I think it was something that we really wanted to leverage. Issues of disclosure per se didn’t really come up, but in the qualitative interviews with the peer coaches there were a couple of coaches who did mention the need to set boundaries in terms of like when they could talk to their assigned Veteran, how long they could talk to their assigned Veteran. And some of these people who were participants—as I’m sure isn’t surprising to people listening—were lonely. And so they really I think in some cases, I get the impression from the qualitative data, that maybe they were, and maybe this is part of the engagement issue too, they were maybe not looking for better ways to manage their pain, but maybe they were looking ways to alleviate loneliness. So that could be part of what was happening. So that did come up, the issue of boundaries in terms of time and when the relationship ends when the coaching ends and things like that. But just, as far as the last thing I’ll say about disclosure is we did tell the peer coaches in the training and the booster sessions share but share what you’re comfortable with. You should not feel like you need to share anything that you don’t want to tell the other person. But I think, you know most people especially Veterans we interacted with do enjoy sharing. And so I think that that was probably for most people an advantage. And it’s something that we, Michele Heisler who was a co-investigator on this study and has done peer work with diabetes in Ann Arbor, when she and I were talking in planning this study, that was one of the things that she really emphasized was having these shared Veteran experiences are, you know peer support might work better in the VA than in your local community health center, because even if you haven’t, even if two Veterans haven’t met, they have this bond that other people can’t share.

Dr. Robin Masheb: It’s very interesting. Related to this, could you talk a little bit about what the supervision was like and how you handled situations where maybe your coaches weren’t adhering to the protocol and any techniques you use to improve the fidelity of what they were doing and how that went?

Dr. Marianne Matthias: Yeah, so I think the booster sessions were a big part of it because as I said before, the initial training is valuable and important but it’s a little bit abstract. So once you start actually coaching someone it feels more relevant, some of the things you’re taking about. So the regular booster sessions were part of it. They did get individual calls more early on, and then tapered off later into the intervention as long as we were sure that they were meeting and talking. That happened on both ends. So the two people who were supervising the peer coaches, called the peer coaches but then the research assistant and project manager were calling the Veterans to make sure that they were being contacted. And then if they weren’t then we contacted the peer coach. And sometimes that went well, and they said yes, I have it on my list, or I will add it to my list, and I will call them. And there were times where we ran into, a peer coach a few times was called multiple times and said, you need to call your Veteran. Oh yeah, I’m going to do it, I’m going to do it. And it never happened. So I think again, that comes down to being able to be less selective about who was a peer coach when you have to recruit a whole lot of people for a randomized control trial. Because that wasn’t an issue in a pilot where we could be really selective. So I think you know people sign up for the same, they sign up to peer coaches, they have all the best intentions, they really want to help their fellow Veteran. But life gets in the way. I mean we had, there are some extreme examples of this that caused some peer coaches to withdraw. One peer coach his wife was diagnosed with cancer, so he withdrew. You know so things like that happen as well. So I think life gets in the way a lot of times. And I think we saw that\_ [silence 0:55:33 – 0:55:46]

Dr. Robin Masheb: Hello? I think I lost the sound.

Dr. Marianne Matthias: I’m here. Can you hear me?

Dr. Robin Masheb: Okay, yes.

Dr. Robert Kerns: We can hear you, Robin.

Dr. Robin Masheb: Oh, okay. So we have just two minutes and I need to wrap up in a minute. But maybe in like 45 seconds, could you just mention how you handled other conditions other than pain? Things like PTSD, depression, anxiety. And was it dealt with? Did you make referrals? Did you just take all comers?

Dr. Marianne Matthias: Yeah, well we did exclude if there was extreme, obviously on suicidal ideation which most studies do. But active suicidal ideation. But if they’d had a psychiatric hospitalization in the past 6 months they were excluded. I didn’t go into a lot of details about exclusion criteria. But then we made sure that the peer coaches were aware, they had multiple phone numbers of study team members to contact if they had any concerns or any issues with their Veterans that they were coaching. In addition, just in terms of comorbidities more broadly, we did specifically tell the peer coaches not to give medical advice. Not to give them advice on either pain medications or other kinds of medications and stick to self-management, stick to encouragement. So we were very explicit about that because we didn’t want to get into that territory because that’s not what they’re qualified to do.

Dr. Robin Masheb: Thank you so much. This was an amazing presentation. Thank you to our audience for participating today and writing in with some great questions. It made for an interesting discussion. If everybody can hold on for a minute or two to complete the feedback form, it helps us to provide you with great programming. If you’re interested in downloading the PowerPoint slides from today, you can go to the reminder email you received and there will be a link. Slides from all of our past sessions can be found by searching on VA Cyberseminars’ archive. And we hope that we’ll see you at our next Cyberseminar which will take place on Tuesday November 3rd at 11 AM Eastern Central time. And thank you again for participating in this HSR&D Cyberseminar.

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