WEBVTT

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00:00:00.030 --> 00:00:01.180

Anne Roubal: Me. It works.

2

00:00:02.770 --> 00:00:25.579

Anne Roubal: I'll start again since the recording is in progress. Thank you. So thank you for coming to the Webinar today from the Arc Academy. My name is Ann Robel. I am the project director of the Arc Academy, and I'm really happy to and excited to present this webinar today from bottlenecks to breakthroughs, innovations in behavioral health integration. This is the 1st in our series.

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00:00:26.048 --> 00:00:30.839

Anne Roubal: And so there'll be more coming more webinars coming out through here

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00:00:30.990 --> 00:00:37.139

Anne Roubal: through us. But we're really excited today to have Doctors Anna Ratzliff and Dr. Carrie Stevens on

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00:00:37.700 --> 00:00:45.729

Anne Roubal: on to tell us some of their really important research and work that they've been doing in the last few years.

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00:00:53.770 --> 00:01:09.840

Anne Roubal: So I'm going to just quickly. I know a lot of people are on here because they already know what integrated behavioral health is and they want to. We want to get to our speakers. But I know there's a few new people and new faces. So we just want to give a quick overview here of what is integrated behavioral health as well as what we do at the Academy.

7

00:01:10.395 --> 00:01:12.469

Anne Roubal: And so integrated behavioral health

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00:01:12.630 --> 00:01:24.669

Anne Roubal: is a team of primary care physicians and behavioral health clinicians who work together to really improve the care of patients. And you can see on the left there. This is our lexicon from the Arc Academy.

9

00:01:25.620 --> 00:01:41.920

Anne Roubal: and you can see in the green there's clinical functions, and then in the blue, you can see some organizational supports and community functions. And when all of these work together really well, we get really good, integrated behavioral health care, and that

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00:01:42.060 --> 00:01:47.290

Anne Roubal: results and improved patient care, lower costs others.

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00:01:47.660 --> 00:01:54.050

Anne Roubal: improvements such as better health outcomes, lower mental health rates, and better care for them.

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00:01:55.500 --> 00:01:59.759

Anne Roubal: as well as more effective healthcare utilization overall.

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00:02:11.730 --> 00:02:18.250

Anne Roubal: I'm waiting for my slides to catch up here. There's just a slight delay. Okay? So there we go. Why is integrated behavioral health

14

00:02:18.400 --> 00:02:36.480

Anne Roubal: challenging to implement so integrated behavioral health care is great and it works really well. But there's a lot of reasons that it's challenging to implement. And that's sort of what our 2 speakers are going to talk about today. Some of those reasons that we've come found to overcome some of these barriers.

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00:02:36.960 --> 00:02:43.159

Anne Roubal: So there's numerous barriers. I wrote numerous here, and we limited it to 5 on the slide. There's a lot more

16

00:02:43.310 --> 00:03:00.760

Anne Roubal: as well, but often we hear people say that. You know, it's really tough for financing and payment models that on our lines to integrated behavioral health care, it's often easier to just refer a patient out versus actually building integrated care or doing it. Well, there's stigma associated with that as well as workforce shortages.

17

00:03:01.660 --> 00:03:14.710

Anne Roubal: We hear a lot that there's a shortage of primary care providers. And so why would how are we going to train primary care providers who are also doing integrated behavioral health care when there's already just a shortage of primary care overall.

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00:03:14.850 --> 00:03:24.950

Anne Roubal: And so within this space, we're all doing our best to improve and bring out integrated behavioral health care, but acknowledging that there's all these forces that make it challenging to do so.

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00:03:26.800 --> 00:03:30.969

Anne Roubal: And so where did we come in? We're the Integration Academy.

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00:03:31.250 --> 00:03:42.260

Anne Roubal: and we are sponsored by arc or funded by arc, we provide a slew of resources and toolkits. This shows you our website at the bottom.

21

00:03:42.440 --> 00:03:56.899

Anne Roubal: which I know is how you all registered for this website or webinar. So I hope that you take a little bit of time or took a little bit of time to play around on our website. If you haven't been there before, we have lots of toolkits, other resources issue briefs on specific topics.

22

00:03:57.558 --> 00:04:09.489

Anne Roubal: tools and resources. Really, for all levels of providers, patients, facilities trying to start integrated healthcare. Or if they're already starting it, resources on specific things.

23

00:04:10.780 --> 00:04:16.019

Anne Roubal: And we provide a lot of that for behavioral integrated healthcare as well as Moud.

24

00:04:16.329 --> 00:04:33.539

Anne Roubal: And we update this regularly at least once a month. There's an update on our carousel, which is what you're seeing there. Which means there's a new story or a new resource that we're highlighting. We do a lot of partnerships with other agencies and other organizations working in behavioral health care. And so we're always

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00:04:33.770 --> 00:04:50.499

Anne Roubal: looking for new ideas. So if you go to our website and you think that there's a tool missing or a resource missing. We're happy to hear from you, or if you just think we should, could you? Do you have any tools about this? We're happy to hear from you, or if you love something that we've done, we're also happy to hear

26

00:04:50.740 --> 00:05:13.759

Anne Roubal: things that are useful. And so we really do hope you find some time to spend on our website. And we also do these webinars like we're hosting today as a resource as well as visit many conferences. So you'll see us around some of those presenting some of the resources that we provide and check back because we have a lot of exciting stuff coming up this summer, including other webinars

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00:05:13.860 --> 00:05:19.559

Anne Roubal: as well as some updated toolkits and really exciting issue briefs coming out.

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00:05:34.190 --> 00:05:37.204

Anne Roubal: So we're gonna transfer over to the webinar. Now,

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00:05:37.820 --> 00:05:50.700

Anne Roubal: I'll provide a brief speaker introduction, and then our 2 speakers will give their presentations. Each will have about 30Â min, and then we'll do an open question and answer forum. So please submit your questions through either the

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00:05:53.061 --> 00:05:58.400

Anne Roubal: question, the chat function box or the Q&A, and we'll work on our side to organize those

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00:05:59.150 --> 00:06:04.699

Anne Roubal: and hold them for the end after both speakers have talked, but so that we can ask questions for both speakers.

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00:06:04.860 --> 00:06:19.139

Anne Roubal: But please ask your question in the moment, as you're thinking about it, and we'll keep a rolling list of those the Pi on the project. Garrett Moran will also join me on that time to help filter those questions, so you'll hear his voice a little later as well.

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00:06:21.435 --> 00:06:25.370

Anne Roubal: And then and then we'll wrap up so that will take us through the webinar time.

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00:06:31.360 --> 00:06:32.340

Anne Roubal: Sorry.

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00:06:33.260 --> 00:06:37.900

Anne Roubal: There we come. There's a slight delay on the slides. I don't but

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00:06:38.220 --> 00:06:52.369

Anne Roubal: I'm really excited, as I said, to start this Webinar series off with Dr. Anna Ratzliff and Dr. Carrie Stevens. They've done a lot of work in integrated behavioral health. Dr. Ratzliff's going to talk to us about the Nih heal funded champ study.

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00:06:52.510 --> 00:07:08.309

Anne Roubal: Excuse me trial. And then Carrie Stevens is going to talk to us about some digital tools in implementing that in the workforce. Their research is really exciting. I've gotten a sneak preview, but I'm really excited for you all to hear about the work that they've done.

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00:07:09.610 --> 00:07:17.280

Anne Roubal: So I'm gonna introduce each one a little bit before each section here.

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00:07:17.620 --> 00:07:23.649

Anne Roubal: So when Dr. Ratzlaff is done, then I'll introduce Dr. Carrie Stevens a little bit more as well.

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00:07:24.290 --> 00:07:49.010

Anne Roubal: So Dr. Ratzliff is a professor, psychiatrist and national expert on collaborative care and specifically on training teams to implement and deliver mental health treatment in primary care settings. And she's going to present to us today on Nih heal funded collaborating to heal addiction and mental health in primary care. The Champ Trial addressing dual diagnosis, mental health disorders and opioid use disorders in primary care.

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00:07:49.180 --> 00:07:53.450

Anne Roubal: So I'll transfer it over to Dr. Ratzloth. Thank you for being here today.

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00:07:59.170 --> 00:08:19.240

Anna Ratzliff (she/her): All right. I think I'm good. You couldn't. And I will just see if I can advance my slides. Okay, perfect. So really nice to be here. Thank you for the invitation. I am at the University of Washington, and I'm really excited to talk about these data because they're pretty hot off the presses, so

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00:08:19.240 --> 00:08:42.720

Anna Ratzliff (she/her): we will go ahead, and before I jump into the details of the study, and I will talk about both the results as well as some of the implementation experiences of the teams that participated. I just want to make sure to acknowledge all of the people who supported this work. We had an Mpi. Team that's listed here, as well as numerous groups involved

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00:08:42.720 --> 00:08:50.790

Anna Ratzliff (she/her): and really driving the work that I'll be presenting, as well as acknowledging the funding from the National Institutes of Mental Health.

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00:08:52.830 --> 00:09:16.910

Anna Ratzliff (she/her): So this study was really part of a large initiative called the Heal Initiative. And so I just wanted to acknowledge that this was one of a number of studies that were funded during this period of time from basically 2019 to 2024 that were really focused on trying to both understand and manage pain and also improving the treatment for opioid misuse and addiction.

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00:09:20.260 --> 00:09:41.949

Anna Ratzliff (she/her): trying to make sure the slides advance. Okay, there it goes. Okay. So this was really the state of the world around opioid use disorders during the time that this project was initiated. And you can see on this slide that one of the big concerns that people had was that there were a lot of people dying every year from opioid overdoses.

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00:09:41.950 --> 00:09:53.280

Anna Ratzliff (she/her): So the goal of this study was really to see what are effective strategies to engage people who are at risk for death from overdose, especially those who have an opioid use disorder.

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00:09:54.370 --> 00:10:01.130

Anna Ratzliff (she/her): and there were a couple of big ideas that we were incorporated into this trial. The 1st was that

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00:10:01.130 --> 00:10:26.050

Anna Ratzliff (she/her): when we can actually get people onto medications for opioid use disorder. It really helps retain them in treatment, and that basically almost every day that someone is in treatment and not using it lowers their risk for overdose. So that was a really important concept. And one of the goals of this study was to see, how can we actually keep people more supported in staying, engaged in medication for

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00:10:26.180 --> 00:10:29.070

Anna Ratzliff (she/her): opioid use, disorder or mou D.

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00:10:29.840 --> 00:10:58.299

Anna Ratzliff (she/her): The other big concept was that this was really a trial looking at co-occurring disorders. So one of the big ideas was that we know that collaborative care model which is a model of integration, is effective for treating mental health disorders in primary care settings. So I'm going to briefly review what the collaborative care model is. I know there's an audience here who many of you will probably know about these trials, but I want to make sure

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00:10:58.300 --> 00:11:22.840

Anna Ratzliff (she/her): it's really clear what we were testing in our study before I present the results. So the model of collaborative care that we were really adapting was based off of the work of Dr. Jurgen Unitzer, and these were trials that were published in the early 2 thousands. The basic concept of collaborative care is that you're taking that relationship between the primary care provider and the patient

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00:11:22.840 --> 00:11:44.060

Anna Ratzliff (she/her): and really adding in additional team members and a structured approach to mental health treatment in primary care settings, basically utilizing the ideas in chronic care management. So in this case, you're adding in someone who's a behavioral health care manager. That person has 2 functions, both to help

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00:11:44.170 --> 00:11:58.100

Anna Ratzliff (she/her): coordinate care of the entire team and also to be able to deliver brief behavioral interventions to that patient right there in primary care, setting where they're already coming ideally and have an established relationship with the primary care provider

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00:11:58.100 --> 00:12:19.019

Anna Ratzliff (she/her): and a psychiatric consultant, and in this case the psychiatric consultant often is not seeing patients in person, but is rather providing support and indirect consultation to the team through a process called the Systematic Caseload Review, where they meet weekly with the care manager, talk about each patient and help with both diagnosis and treatments.

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00:12:19.020 --> 00:12:30.320

Anna Ratzliff (she/her): offering patients that whole range of treatments right there in primary care. So either brief behavioral interventions from the behavioral health care manager or medications prescribed by the primary care provider.

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00:12:30.320 --> 00:12:48.840

Anna Ratzliff (she/her): So some of the tools and resources that the team really uses to provide these care include a registry to track the population of patients that have been identified as needing mental health treatment, active treatment with evidence-based approaches, and that full range, both medications and brief behavioral interventions.

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00:12:48.990 --> 00:13:00.679

Anna Ratzliff (she/her): and the regular use of measures to track response to treatment over time. So those are some of the core features of the collaborative care model that we were going to adapt for this study.

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00:13:04.930 --> 00:13:06.530

Anna Ratzliff (she/her): trying to move it forward.

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00:13:11.880 --> 00:13:13.580

Anna Ratzliff (she/her): Not sure.

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00:13:14.820 --> 00:13:34.630

Anna Ratzliff (she/her): It's working. There we go. Oops skipped over one. Okay, so I just wanted to say that the evidence base for the collaborative care model is well established with now over 100 randomized controlled trials, showing that this works for various conditions which I'll show in the next slide. It also has been shown that this model of care improves

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00:13:34.710 --> 00:13:47.920

Anna Ratzliff (she/her): really across the quintuple aim. So improve access for population health outcomes reduces total cost of care has been associated with provider satisfaction, patient satisfaction.

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00:13:47.920 --> 00:14:04.789

Anna Ratzliff (she/her): and has been shown to have equivalent or better outcomes across a wide range of different populations. The data showed on this slide was actually from that original impact trial and showed that at every site that implemented collaborative care patients with depression in this case

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00:14:04.790 --> 00:14:17.950

Anna Ratzliff (she/her): had better outcomes when using collaborative care compared to usual care. So this is a model that has robust evidence, but really hadn't been tested for co-occurring disorders, which is what we'll get into talking about in the next few slides.

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00:14:18.580 --> 00:14:28.039

Anna Ratzliff (she/her): It has been shown, though, to be effective across a range of different conditions, including some. A couple of papers looking at substance use disorders.

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00:14:29.160 --> 00:14:53.340

Anna Ratzliff (she/her): Okay, so what did we actually do in this trial? What we did as the University of Washington is, we really wanted to test adaptation of the collaborative care team to address co-occurring disorders. So this is a slide that really describes the team and the functions in the intervention arm of the trial.

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00:14:53.340 --> 00:15:18.289

Anna Ratzliff (she/her): So in this case we adapted that role of the primary care provider to be able to prescribe both medications for mental health disorders, but also medications for Oud. Again remembering that that's 1 of the most effective treatments we have to really save lives in opioid use disorder. We had the care managers trained up to be able to coordinate care for both those disorders, including behavioral activation for opioid use.

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00:15:18.290 --> 00:15:23.410

Anna Ratzliff (she/her): disorder that was adapted to really be certain to help support those patients.

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00:15:23.410 --> 00:15:40.270

Anna Ratzliff (she/her): And then the psychiatric consultant, being able to support the team in the work of addressing both mental health disorders. In this case it was anxiety, depression, and Ptsd as well as opioid use disorder. So we used all those same key principles that I've already described.

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00:15:40.270 --> 00:15:57.690

Anna Ratzliff (she/her): And then the measures that were used in the study were, whatever the appropriate mental health measure was depending on the diagnosis, and a new 4 item, opioid treatment response inventory that we really created for this study to be able to track response to the Moud treatment.

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00:15:59.750 --> 00:16:26.929

Anna Ratzliff (she/her): So this is the basic design of the study. It was a multi-site cluster, randomized trial. We had pairs of clinics from the States that you see here on this figure. All of them were a matched pair of clinics in the same organization, and they were randomized to either provide collaborative care for both mental health disorders and oud, or provide collaborative care for mental health disorders

72

00:16:27.040 --> 00:16:42.509

Anna Ratzliff (she/her): on its own, with the opioid use disorder being treated, however, they normally would have done it in the clinic before the trial. So in some cases that was referring out in some cases that might still be a Pcp. Prescribing that Moud.

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00:16:42.600 --> 00:16:59.199

Anna Ratzliff (she/her): all of the clinics, had to be willing to have a provider that was willing to prescribe medications for opioid use. Disorder had to have a behavioral health care manager and a psychiatric consultant, so really had to have those foundational pieces in place to deliver collaborative care.

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00:17:00.660 --> 00:17:29.659

Anna Ratzliff (she/her): And we had 24 clinics that enrolled patients. Okay, so study aims, we had 3 major areas that we were interested in studying as part of this trial. The 1st was, does systematic screening for opioid use disorder, help us identify more people with Oud. So that was a real question. We were curious if universal screening would make a difference in being able to recruit patients for this trial, and also be able to offer patients access to treatment.

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00:17:29.840 --> 00:17:57.900

Anna Ratzliff (she/her): Then the main question was, is collaborative care for oud and mental health disorders more effective for patients with co-occurring disorders than if we were just delivering collaborative care for the mental health disorders. Only. So we'll talk a bit about those data as well. And then what kind of sustainment supports helps maintain this high quality, collaborative care for co-occurring disorders once the trial's over.

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00:17:59.390 --> 00:18:27.720

Anna Ratzliff (she/her): So for aim one, these results are actually already published, and the answer to the question is that we did not find that systematic screening, for Oud helped us identify more people with Oud. So this was a little bit of a surprising finding. Essentially what we did is we had the clinics basically say, Who's your population of patients? How many of them in the 6 months prior to initiating screening.

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00:18:27.720 --> 00:18:35.669

Anna Ratzliff (she/her): had a new diagnosis of Oud, and then we looked after the initiation of screening was put in place, you know.

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00:18:35.680 --> 00:18:49.010

Anna Ratzliff (she/her): Look at your population of patients. How many new diagnoses of opioid use disorder are there after we have routine screening in place. So what you can see on this is that

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00:18:49.160 --> 00:19:16.869

Anna Ratzliff (she/her): there was, you know, some of the clinics actually had a negative number, so fewer people were actually identified afterwards, and that the median pre post increase was only 1.5 patients. So it was a really small number and not a meaningful number. So we really concluded that while all patients had the goal of implementing. This. Most also had some barriers around this

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00:19:16.880 --> 00:19:25.080

Anna Ratzliff (she/her): and that. We really didn't see in this case that the that the use of regular screening

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00:19:25.170 --> 00:19:37.549

Anna Ratzliff (she/her): had any impact, and probably not enough benefit to outweigh the costs just in terms of time and effort that the clinics put into it, at least in the, in the study sites that were included in this trial.

82

00:19:39.340 --> 00:20:00.609

Anna Ratzliff (she/her): We were really interested in learning a little bit more about why that might be. And so one of the things that we did is actually interviewed a lot of the clinics. So we had a formative evaluation throughout this entire trial, and these are some of the experiences of the people that were participating. I think everyone

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00:20:00.610 --> 00:20:18.410

Anna Ratzliff (she/her): was a little surprised, I think, when we 1st started, people were like, we're going to have a million people showing up that now have a new diagnosis of Moud. And they really, we didn't really find that. So I think that a lot of people really felt like they were surprised.

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00:20:18.740 --> 00:20:27.769

Anna Ratzliff (she/her): That it it, you know, you had to screen a lot of patients before you maybe found a patient that needed attention, and a lot of times they felt like

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00:20:28.960 --> 00:20:36.890

Anna Ratzliff (she/her): They were going to find undiagnosed as oud, but actually they generally knew in their practices who were the patients that had this diagnosis and maybe needed help.

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00:20:39.100 --> 00:20:44.851

Anna Ratzliff (she/her): Okay, I'm sorry. These slides are kind of slow and advancing. I'm trying to do it. There.

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00:20:47.830 --> 00:21:12.889

Anna Ratzliff (she/her): I can't. Okay, there we go. Oops. Now, I skipped too fast. Okay. So aim to was focused on the question of, does the collaborative care team, if focusing on co-occurring disorders actually more effective than if you focus on the patient's mental health disorder needs only. So for this, we recruited 254 patients.

88

00:21:12.890 --> 00:21:25.890

Anna Ratzliff (she/her): We had really good follow-up engagement with patients. So these were the survey completions. So we were really pleased with how we were able to retain patients over the 6 months of the trial

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00:21:25.890 --> 00:21:46.809

Anna Ratzliff (she/her): and our primary outcomes that we were looking at is the number of days of non-prescribed opioid use again, really saying even a couple of days might mean a big difference in people's survival. Given the lethality of overdoses in opioid use disorder, and then we also were looking at mental health functioning.

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00:21:48.120 --> 00:22:13.089

Anna Ratzliff (she/her): These are a few of the key demographics. These were largely middle aged group of patients. I think it's important to know, and I'll highlight that most of the patients actually that ended up being included in the study were on medications for opioid use. Disorder. At the beginning we were surprised about this. We actually thought we would be initiating a lot of Moud. So this was actually a slightly

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00:22:13.090 --> 00:22:24.349

Anna Ratzliff (she/her): different patient population than we anticipated recruiting, but they all had mental health symptoms burden at the beginning of the trial. So we're eligible for that.

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00:22:26.250 --> 00:22:50.039

Anna Ratzliff (she/her): So these are the results. These are new data. They're under review right now for publication. So you're getting a bit of a preview. But this is the main outcome, and you can see that there was a small difference, but it was statistically significant between the control and the intervention at both 3 and 6 months, showing that there was less

93

00:22:50.320 --> 00:23:14.760

Anna Ratzliff (she/her): use in the population that received the intervention. Again, that collaborative care that was really modified to address both their opioid use, disorder and their mental health disorders. And even though these numbers are small again, remembering that this is a very lethal disorder when not treated, these are clinically meaningful data, we believe as well.

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00:23:14.930 --> 00:23:42.139

Anna Ratzliff (she/her): I'm going to show just a couple other views of these results. Just because I think there's some interesting data here to consider. You know, you can look at that also, as the number of patients with any use in the last 30 day window. And you can see that another way of looking at this is that our intervention lowered the total number of people that we're using in the intervention group compared to the control.

95

00:23:42.880 --> 00:24:01.119

Anna Ratzliff (she/her): And you can also see that the number of patients with no opioid use at baseline, who returned to use was actually also lower. So this seems to be really that the collaborative care intervention was really helpful in patients maintaining their engagement in their Moud treatment.

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00:24:04.420 --> 00:24:06.379

Anna Ratzliff (she/her): Okay? Trying to move forward again

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00:24:12.710 --> 00:24:15.634

Anna Ratzliff (she/her): if it goes. Sorry. I've tried to move the slide forward.

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00:24:17.330 --> 00:24:18.140

Anna Ratzliff (she/her): Okay.

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00:24:18.570 --> 00:24:38.630

Anna Ratzliff (she/her): all right. Great. So this, however, we did not find a difference between the 2 groups in the mental health functioning of patients. So what we found is that both groups basically had pretty good, small, modest improvements in their mental health functioning.

100

00:24:38.870 --> 00:24:50.709

Anna Ratzliff (she/her): And you know, in some ways I'm not super surprised in these results, because we know that collaborative care, even collaborative care on its own, is effective for treating mental health disorders.

101

00:24:50.850 --> 00:25:07.630

Anna Ratzliff (she/her): You know it was interesting to me that that perhaps the addressing the Oud did not have as much impact on these results as we would have expected. So these are all. That's 1 of the reasons why science is important is that you learn new things

102

00:25:09.190 --> 00:25:34.150

Anna Ratzliff (she/her): in the last couple of slides for my presentation. I'll just talk a little bit about some of the experiences of the teams that were involved in delivering this care. Some of the things that they found challenging, and some of the ways in which they addressed those barriers. So I think the 1st thing that's really important to note is that it was really challenging to keep these patients engaged in treatment.

103

00:25:34.180 --> 00:25:58.930

Anna Ratzliff (she/her): you know, it was really hard to find patients, and then it was hard to keep them engaged to actually initiate treatment, or we ended up under recruiting for this study, and I think part of it just was both fewer patients than we expected, being taken care of in primary care, but also real challenges, and actually, even if a patient was identified, getting them engaged

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00:25:58.930 --> 00:26:07.789

Anna Ratzliff (she/her): in care, and that there was some sense that perhaps stigma, you know, both in the in the community as well as in the clinic systems.

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00:26:08.226 --> 00:26:11.720

Anna Ratzliff (she/her): might be contributing to some of these challenges.

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00:26:14.360 --> 00:26:20.999

Anna Ratzliff (she/her): Another thing that really came up was just the the challenges around the structure of primary care.

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00:26:21.390 --> 00:26:45.070

Anna Ratzliff (she/her): the study started in 2019. So you can understand that most of the trial was actually conducted during the pandemic and primary care, really struggled at times to be able to have the kind of access open that they hoped to have to be able to rapidly meet the needs of these patients. So if somebody was identified on a Tuesday.

108

00:26:45.070 --> 00:26:58.799

Anna Ratzliff (she/her): it might be hard to find an appointment with that primary care provider in a timely enough way to actually get them started on treatment or really be able to address their treatment needs.

109

00:26:58.800 --> 00:27:27.849

Anna Ratzliff (she/her): and that some of that appointment. Scheduling processes were really thought to make it more challenging to actually get patients into treatment as quickly as people would have ideally wanted, and that some of that was also driven just with the reality that in primary care it's a very productivity. Driven environment and the sort of longer appointment times are more complex care needs of these patients

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00:27:27.890 --> 00:27:34.910

Anna Ratzliff (she/her): was intention with the needs for clinics to be productive and seeing a lot of patients.

111

00:27:36.710 --> 00:28:01.139

Anna Ratzliff (she/her): Oh, we also found that some of the training that we provided was really really important, and that people needed a lot of support around becoming comfortable, really, both making a diagnosis of Oud and also having those conversations with patients when that screening came up positive.

112

00:28:01.190 --> 00:28:23.339

Anna Ratzliff (she/her): and that the patients were really complex, and that a lot of the people were saying that the mentoring and support that they got during the trial was really helpful in sort of, you know, kind of getting over that barrier of being comfortable engaging in this work regularly as part of their primary care practice.

113

00:28:25.510 --> 00:28:50.289

Anna Ratzliff (she/her): and I think that even with that there were some providers in some of the practices that were still concerned, or, you know, had hesitation about getting engaged in this work. You know, I think people calling this sort of not necessarily resistance, but overwhelm and sort of struggling with the idea of taking on another complex patient, I think could

114

00:28:50.290 --> 00:29:08.500

Anna Ratzliff (she/her): be helpful, was one of the challenges in that, you know, over 65% of the clinicians actually perceived that providing this care was really time consuming. And just if you're a busy primary care provider that can really feel like a major barrier in wanting to engage in this work.

115

00:29:08.590 --> 00:29:14.320

Anna Ratzliff (she/her): and that we also found lots of people who were really deeply connected.

116

00:29:14.640 --> 00:29:33.700

Anna Ratzliff (she/her): committed to their patients and connected to their communities and wanting to offer these services in their clinic and really focused on, we're just going to make it work, even though it is really challenging. So you saw sort of that whole range of attitudes when you when you looked at the clinic team members.

117

00:29:35.590 --> 00:29:57.269

Anna Ratzliff (she/her): So the 3rd aim is what kind of sustainment makes high quality. Collaborative care for co-occurring disorders helps maintain that, and due to our challenges with recruitment, we really didn't get to meaningfully engage in this aim during this trial, but we did, towards the end of the study, engage in assessing the

118

00:29:57.270 --> 00:30:16.190

Anna Ratzliff (she/her): teams that were involved, commitment to sustainment, and and really what barriers they perceived or challenges they perceived and and provided some support around addressing those. So I think it was, even though all those challenges that I just described came up. I think people felt like

119

00:30:16.190 --> 00:30:28.800

Anna Ratzliff (she/her): when they did have a patient and were able to engage them, that that was really meaningful work, and that they really wanted to maintain that capacity. And most of the time what that looked like is.

120

00:30:28.800 --> 00:30:55.309

Anna Ratzliff (she/her): it was really that they had a collaborative care team that was addressing mental health disorders generally, and now could have that capacity to take on a patient with Oud when needed. So this wasn't that they built a whole separate capacity for these patients, but really broaden the scope of what their collaborative care team could really address in their primary care setting, and

121

00:30:55.340 --> 00:31:11.389

Anna Ratzliff (she/her): I think that they really that was that commitment to sustaining this was really driven by the comments that you see here, which is, that the interventions provided were beneficial and lifesaving, and that there was really a commitment to patient care in that in that way.

122

00:31:12.606 --> 00:31:14.239

Anna Ratzliff (she/her): Some of the things that

123

00:31:14.340 --> 00:31:31.429

Anna Ratzliff (she/her): clinics really identified as needs for sustainment included, continuing to stay clear on their vision for why they were doing this work, continuing to maintain access to the collaborative care that could include opioid use disorder treatment.

124

00:31:31.430 --> 00:31:54.889

Anna Ratzliff (she/her): that there's a lot of questions on how to maintain clinical skills, especially because one of the things that we found is that there was a smaller number of patients than we really expected in general. This was like between one and 5 patients on a person's caseload of collaborative care patients and so maintaining all the skills and comfort in really addressing the needs of patients with Oud

125

00:31:54.890 --> 00:32:20.199

Anna Ratzliff (she/her): was challenging because there just wasn't a lot of opportunity to iterate and work with patients consistently with those needs. And then, of course, and this was mentioned at the beginning. How do we pay for this care. Most of the clinic systems ended up were either billing or we're trying to work towards billing for their collaborative care team in general and and including these patients in that strategy.

126

00:32:21.650 --> 00:32:48.320

Anna Ratzliff (she/her): I'll just mention a couple of limitations. I mentioned this, but I think it's important to acknowledge that we really do have to consider these results in the context that most of the patients in both arms actually were already on Moud. So it's interesting to think about. We don't know if these same results would be generalizable to patients that didn't start out on medications for opioid use disorder.

127

00:32:48.320 --> 00:32:58.499

Anna Ratzliff (she/her): And I think that's really some of the future directions that we see would be important in this work is, do we see similar results with patients that are newly identified

128

00:32:58.580 --> 00:33:04.030

Anna Ratzliff (she/her): with opioid use disorder and might need that access to to the medications.

129

00:33:04.490 --> 00:33:33.039

Anna Ratzliff (she/her): And I think I will stop there. I did include all the published paper references in our slide deck. So I think that the slides get put up later, if you need that. But these are some of the publications that have already come out of this trial, and, as I said, the main outcomes paper is currently under review. So I look forward to answering questions during the question. Answer section

130

00:33:34.720 --> 00:33:36.199

Anna Ratzliff (she/her): can hand it over.

131

00:33:36.200 --> 00:33:38.019

Anne Roubal: Being stuck at Rutzel.

132

00:33:38.530 --> 00:34:00.090

Anne Roubal: So we are going to hear from Carrie Stevens next. That was fantastic. I should pause for a second and say that. And then I also want to remind people to throw their questions in the chat, because we will take those after Dr. Stevens's presentation. So we can sort of do a round robins style. So Dr. Carrie A. Stevens is a practicing clinical psychologist in primary care.

133

00:34:00.510 --> 00:34:21.369

Anne Roubal: clinical research, informaticist and vice chair of research at the University of Washington Department of Family Medicine, and she's going to share with us many challenges facing primary care for meeting the needs of mental behavioral health, as well as how some digital apps and solutions can increase quality of care and address the human bottleneck. Thank you, Dr. Stevens.

134

00:34:22.080 --> 00:34:42.960

Kari A. Stephens: Thank you, Dr. Rubel, and thank you, Dr. Ratzliff, for a great update on that big trial. I know I've gotten to your interim results. So that was fun to get to see where you guys are winding up at the end of it. So thank you to the Academy for inviting me to come. I've got lots of things to share with you today. I'm also a practicing psychologist in an integrated behavioral health

135

00:34:42.980 --> 00:35:08.100

Kari A. Stephens: team within primary care which I absolutely love doing Tuesday afternoons. So I get to be a clinician. But most of my time is spent being a researcher, and I'm going to see if I can try to master the delay in the slides that Dr. Ratzlip was talking about, and figure out exactly how we hit this advance going forward. But if you hear me pausing, it might be because I'm waiting for slides to move forward. So

136

00:35:10.440 --> 00:35:11.390

Kari A. Stephens: here we go.

137

00:35:17.130 --> 00:35:36.280

Kari A. Stephens: So learning objectives today, I want to touch on a few different things, and I've got kind of a packed set of slides, but I've tried to scale back, which is hard for me to do so. I might go through a few things a little bit quickly, but as Dr. Ratzliff said, I think that we're expecting the slides to get shared out with where I provide a lot of references to things if folks want to learn more.

138

00:35:36.280 --> 00:35:56.289

Kari A. Stephens: But by the end of this talk I've got 2 sort of main goals for you all, which is 1st of all to have you all walk away, being able to describe some of the challenges that we have in primary care to meet these complex mental and behavioral health needs as well as how are we measuring in the level of integration within these practices? What are some advances we've been making recently

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00:35:56.290 --> 00:36:00.890

Kari A. Stephens: related to that. And then I also want to help you. Oh, it actually advanced

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00:36:01.210 --> 00:36:22.890

Kari A. Stephens: quickly. Oh, we're fixed now, great! And then I also want to describe some recent innovations that we've been working on in several different study contexts that we've done that both talk about how we're advancing the level of integration and behavioral health in very practice, centric ways. And what's going on with digital health solutions. And how might that fit into the picture of integration.

141

00:36:23.190 --> 00:36:30.369

Kari A. Stephens: So as we jump ahead, I'm going to kind of breeze through a couple of background things because Dr. Rubel and Dr. Ratzliff have have talked to you both

142

00:36:30.380 --> 00:36:52.819

Kari A. Stephens: have both talked to you all about some of these stark facts that we have, but you'll see on the left. This is a center for workforce studies study that the center within our department has done here at University of Washington, that really profiled nationally, the Behavioral health Provider shortage. And I just think it's worth noting right here, you know, when you look at rural counties versus urban counties on the left there.

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00:36:52.820 --> 00:37:02.039

Kari A. Stephens: There are huge shortages across all of our counties, and particularly in rural counties. So it is just really paramount that we figure out how to do this integration. Better.

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00:37:02.274 --> 00:37:04.619

Kari A. Stephens: For for the sake of all the suffering going on

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00:37:04.750 --> 00:37:19.250

Kari A. Stephens: amongst very real people and communities, and I think all of us have either been hit ourselves or have loved ones, people within our circles that we know that have been hit with both medical and physical health, chronic conditions that are pretty devastating for folks

146

00:37:19.310 --> 00:37:42.989

Kari A. Stephens: on the right side. You'll see that the Cdc is also showing just the steady increase, you know. And to Dr. Raslip's point, with the pandemic coming in, it's disrupted lots and lots of services, and you'll see here the trend going up across all age ranges within patient populations, with chronic conditions in general that are both medical and mental health related. So you know, the problem is increasing essentially.

147

00:37:42.990 --> 00:38:12.990

Kari A. Stephens: We also know that the occupational burnout of our primary care workforce is quite high. So the study on the left is a study we published where we looked at almost 700 folks. That account for every type of person that works in a primary care clinic within that sample across 42 clinics in over a dozen States in the United States, and the burnout is just really high. And you can see the different types of people that work within a primary care setting. And you can see the levels of burnout that we found. And this is just one little study that we did. But this is repeated amongst many burnout studies.

148

00:38:13.010 --> 00:38:19.240

Kari A. Stephens: The good news side of it is on the right side a study we didn't do but one that was published a couple years ago, or in 2023

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00:38:19.430 --> 00:38:47.560

Kari A. Stephens: does show that if we do team-based care in a multitude of ways, not just necessarily the ones that Dr. Ratzliff and I are talking about today. But in all kinds of ways, just team effectiveness within. These clinics actually help to really improve the provider's experience, lead to less burnout, and then potentially better retention of those providers where they intend to stay longer in those positions. So team-based care really, really important. And we need to figure out how to do that in whatever shape or form is the takeaway.

150

00:38:47.750 --> 00:39:14.609

Kari A. Stephens: We did a study also, nationally looking at what's the trend look like in terms of integrated behavioral health as one particular umbrella of how we do team-based care. So I'm going to jump into, what are we doing kind of in this space around measuring this, a 1st stab that we've taken at this was a study that we did in partnership with the American Board of Family Physicians of a sample of over 25,000 boarded family medicine

151

00:39:14.610 --> 00:39:31.910

Kari A. Stephens: docs and asked them. Do you work in a co-located way in some fashion with somebody who's doing behavioral health as a specialty? So it's exciting to see the blue coming forward on this map, where you can see that most States have some presence of that. But there's also huge geographic variation in that.

152

00:39:32.000 --> 00:39:56.539

Kari A. Stephens: Another thing you'll find in the study that I have below here as well is that that trend is increasing. And so we're at a point now where we were pretty close to half a couple of years ago. Of all clinics represented by folks getting boarded, and we had 100% response rate because it was part of their boarding activity to fill out the survey, are now working co-located with some kind of behavioral health provider, which is really exciting to see that trend increasing.

153

00:40:03.570 --> 00:40:04.910

Kari A. Stephens: and it was working.

154

00:40:13.930 --> 00:40:43.550

Kari A. Stephens: I'm going to kind of in parallel look at our slides so I can start at least speaking while we wait for the delay in the slides to come forward. See if that might help some. Okay. So the models of integrated behavioral health do differ potentially across. And you heard Dr. Ratzliff talking about collaborative care, which is that 3rd column of X's there, the column on the left. This is from a paper that we published a few years ago that I'll talk about in a couple of slides, which is a cross model framework that we developed that sort of stretches across all these different models of integration.

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00:40:43.600 --> 00:41:08.470

Kari A. Stephens: And you can see on the left different kinds of particular activities within practices that these models tend to address. I just want to make the point here that there are different forms of doing this in different ways and so measuring. This is really complicated. One of the things to know is that there are several different common ways to measure how integrated a practice is. There are 4 that kind of float to the top, as being

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00:41:08.470 --> 00:41:33.040

Kari A. Stephens: the most popular in terms of having been used, having been published in terms of folks using this as a self assessment tool that you can ask practices to fill out. So we've got the ipad at the very top, the Ppac, the Mihof, and then Arcs integration playbook, self-assessment checklist. These are 4 examples. But I will say, kind of broadly across them without going into lots of detail on each one

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00:41:33.040 --> 00:41:41.229

Kari A. Stephens: that they tend to lack a behavioral anchor, or really capture what practices actually do when they're doing integrated behavioral health.

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00:41:41.260 --> 00:41:50.890

Kari A. Stephens: Some of these measures, too, are very particular to only certain models of integrated care, and none of these particular ones have been psychometrically validated.

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00:41:51.060 --> 00:42:17.990

Kari A. Stephens: So one of the innovations that's come out in the last few years is the practice integration, profile or the pip. And I bring this up because I'm going to show how we used it in a large national pragmatic trial. And so I want to get you guys familiar with this particular tool, because it tended to address those weaknesses, or at least aimed to, and you can see on the right the different domains that it tries to capture and actually have behavioral anchors that help us understand what a practice is actually doing.

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00:42:17.990 --> 00:42:37.079

Kari A. Stephens: And I want to give homage that the pip really grew out of the lexicon for behavioral health and primary care integration that the Academy arc has helped support over the years, and it's a great resource to look at that really gives a deep in-depth set of definitions and descriptions of what integrated behavioral health is all about.

161

00:42:37.110 --> 00:42:50.330

Kari A. Stephens: And then the pip is really bringing that pragmatically forward as a measurement tool. That also has been psychometrically validated to be able to to really see what a site's self-assessment is of how integrated they are.

162

00:42:52.160 --> 00:43:19.850

Kari A. Stephens: The pip itself does have these 5 different categories, and you can see a little bit here around what each of them tend to measure. Clinical services are asking things like, Do you address certain types of diagnoses within the practice? And what kind of workspace you have? Practice? Workflow tends to look at different behavioral anchors around that flow between the behavioral health provider and the medical provider, and how well they're interacting and really joining together on the care.

163

00:43:19.910 --> 00:43:48.949

Kari A. Stephens: The patient engagement category is looking at what kind of strategies are being used within the practice to keep patients engaged in care and not lost to follow up, and then integration and sharing methods are really about, what kind of systems are you using together? Do you use the same electronic health record system? Are there communication strategies and shared treatment plans that are occurring across the team, and then case identification as well. What kind of screening are you doing what patients have unmet needs. Do you have registries in place to track these things.

164

00:43:48.970 --> 00:44:02.280

Kari A. Stephens: etc. And what you can see on the right. And I've also cited Dr. Mullen's webinar. He has a recorded publicly available webinar at the link below. That's actually really lovely overview where you can get more in-depth information about what I just talked about

165

00:44:02.280 --> 00:44:29.789

Kari A. Stephens: across all of these different measures, and how the pip fits in and look and see that they're now evolving from Pip version 1.0, which is what we used in the study, because Pip, 2.0 didn't quite exist yet. But essentially this is a quick description that they moved from the 6 domains did some more psychometric validation. The Pip one was also psychometrically validated, refined it, though, into the 5 domains, and really took the Workspace domain, which was the 6th one from version one, and pushed that

166

00:44:29.790 --> 00:44:45.040

Kari A. Stephens: into clinical services within the pip. 2. Because they just tended to hang better together rather than be separate subcategories. So I think at this point, if anybody is interested in using this going forward, really, the pip 2.0 is the more robust resource.

167

00:44:47.680 --> 00:45:09.670

Kari A. Stephens: another innovation that we've been working on. To try to measure integrated care is to actually bring the lexicon forward to create some pragmatic definitions of what is integrated behavioral health in terms of what it looks like. We took a mixed methods approach with this and published this a few years ago, working with actually a lot of collaborators who also built the Pip and others

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00:45:09.670 --> 00:45:33.399

Kari A. Stephens: to do a qualitative and quantitative joint methods, approach to really talk to experts and practitioners and various community engaged folks that were working with us on this large pragmatic trial, and then nationally, folks that were working in all kinds of settings from the Department of defense to federally qualified health centers, academic institutions, training environments, etc.

169

00:45:33.400 --> 00:45:55.420

Kari A. Stephens: And also interview within focus groups. What do we define? What do we call this based on Donna Beation's model of quality care which really is about having processes and having structures that add together to really lead to the positive outcomes that we're shooting for. So what you see here is just a high, level summary of the 5 different

170

00:45:55.420 --> 00:46:03.890

Kari A. Stephens: groupings of processes. Each bullet represents a unique process that's important to understand. If you're doing any kind of integrated behavioral health.

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00:46:03.890 --> 00:46:22.270

Kari A. Stephens: these are processes that we would expect to have some kind of presence. Now, of course, every practice doesn't have each and every one of these, nor does it necessarily have all the structures you see in that yellow column on the right, which are really about what kind of physical structures or financial etc. structures are really in place

172

00:46:22.690 --> 00:46:45.349

Kari A. Stephens: to allow for this sort of work to happen. So we also did a crosswalk, and you can see all that in the paper. I referenced below. If you want to learn more about this with the pip itself and looked and found that about 80% of the processes you see in these columns are represented and measured in that pip version one and 2, and then about 44% of the structures were also included in the pip.

173

00:46:46.920 --> 00:47:15.730

Kari A. Stephens: We took that cross-model framework and did a couple of things with it that, I think were pretty cool to see. On the left side we collaborated with Icsi on a Minnesota health collaborative that they were working on. And really they formulated this model into their call to action, where they were trying to define a gold standard across the State of Minnesota, and all of the health systems that treat about 70% of the population of the State. And they were really clamoring for

174

00:47:15.730 --> 00:47:45.169

Kari A. Stephens: what are they aiming at? What are they trying to create when it comes to advancing integrated behavioral health. And we were very humbled and excited that they thought that this cross model framework that we were working on could potentially fit that bill. And sure enough, it did. So. I'm going to call that a little bit of a real world pilot test to see that this really did have salience for real community based work that was going on just around quality improvement that was really key to help the populations of their communities. We also published another paper

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00:47:45.480 --> 00:47:59.429

Kari A. Stephens: that looked at the Mehoff, a measure that I mentioned before, that got used within that statewide effort that measured over 100 clinics using that particular measure of integration, and mapped that measure to the different

176

00:47:59.430 --> 00:48:17.159

Kari A. Stephens: processes and structures that are related to our cross-model framework. And what you're seeing. On the right side is a graphical illustration of latent classes that we found across those clinics. Essentially, each line is a group of mutually exclusive primary care clinics out of those 105 clinics

177

00:48:17.160 --> 00:48:35.259

Kari A. Stephens: that show you how fully integrated they are across the dimensions you see on the bottom. And I know the text is really small. So really, the takeaway here is we were trying to naturalistically see what our clinics tending to do around integrated behavioral health. Naturally, we know that we've published all of these wonderful models.

178

00:48:35.260 --> 00:48:50.380

Kari A. Stephens: We know that we have, you know, really lovely definitions of them. But we don't know what actually then evolves in the real world. So it was really fun to be able to apply these 2 things to see. There were sort of 4 groupings that tended to fall out, at least in the State of Minnesota as well.

179

00:48:53.480 --> 00:49:12.859

Kari A. Stephens: So one of the things we did from moving from ways in which we want to measure integration is really figure out how to meet practices where they're at. There is this giant umbrella of behavioral health that we're trying to impact. When we treat folks in primary care, in primary care, we see everything. We see the whole person, and we see from birth to death

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00:49:12.860 --> 00:49:28.000

Kari A. Stephens: every possible problem that could hit a person physically presents somehow in primary care. So when you look underneath this behavioral health umbrella, there are many different dimensions in which we have evidence-based behavioral health interventions that could help all of these different areas

181

00:49:28.000 --> 00:49:41.309

Kari A. Stephens: and practices are each sort of a family of their own. I'm in family medicine. So I really think, in terms of community and family quite a bit. And we really need to address each of these groups with the respect they deserve to sort of meet them where they're at.

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00:49:41.310 --> 00:50:06.239

Kari A. Stephens: So there's different ways in which we've spent time doing that one way is to try to put up free materials, for example, and really adapt a lot of the evidence behavioral skills training into pragmatic snippets of free training. Here's examples on the left of 3 of those that I did in collaboration with the Aim Center and other folks in Dr. Ratzliff's Department of Psychiatry and Behavioral Sciences at University of Washington, where I.

183

00:50:06.240 --> 00:50:34.269

Kari A. Stephens: I used to be faculty as well before I moved into family medicine, and on the right Dr. Ratzliff and I worked with Dr. Knitzer and Dr. Caton to put a book together. And this was really meant for a primary care target audience to understand better how to treat specific kinds of disorders in a step-by-step fashion. These are sort of, you know, ways in which we've done this for a long time, I think, moving forward, we're really interested in trying to figure out how to give something to the practice

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00:50:34.270 --> 00:50:43.630

Kari A. Stephens: on their own. That's a bit more robust to help them target something specific and improve their integration in a way that they chose in a way that they felt empowered and

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00:50:43.630 --> 00:51:07.960

Kari A. Stephens: enabled to do so. We pitched a project to Pcori, the patient-centered Outcomes Research Institute and got funded for an 18.5 million dollar pragmatic trial. To do this across the country. This was a 2 arm parallel superiority, pragmatic cluster, randomized trial, a mouthful for a really large trial that really tried to work in the real world and say, Here is a toolkit, essentially a lean

186

00:51:07.970 --> 00:51:25.740

Kari A. Stephens: management based toolkit that we want to test and see if we can actually improve integrated behavioral health within the clinics. And can we also improve patients with multiple of these chronic conditions that I just mentioned. And you can see on the right side the whole list of what these different chronic conditions were that we were targeting.

187

00:51:25.740 --> 00:51:38.920

Kari A. Stephens: and I'll talk a little bit in a future slide about what the requirements were to get into the study. But at the bottom the reference. Here is the protocol paper, so you can learn more about the study there. If you want to know more about exactly how we executed

188

00:51:39.670 --> 00:51:55.340

Kari A. Stephens: the intervention itself. If I sort of describe this toolkit to you. These were really again based on lean principles that come through manufacturing, for how you you try and try again until you really get there and make a difference and find that right size solution.

189

00:51:55.340 --> 00:52:20.269

Kari A. Stephens: And this also took advantage of quality improvement methods, including Pdsa cycles. So you see, on the left, there really are these 4 components within the toolkit, 4 different stages, if you will, that we worked through. So these kind of come sequentially in time with each practice. Where at 1st you really need to have leadership engagement within the clinic, we've really found over time through a lot of studies that if you don't have leadership engagement within clinic

190

00:52:20.270 --> 00:52:22.810

Kari A. Stephens: to make these kind of changes, you're sort of dead in the water.

191

00:52:22.810 --> 00:52:40.289

Kari A. Stephens: So you need to start there and then plan a planning phase of really scoping and figuring out the boundaries of the workflow and the redesign that you want to do based on these lean principles. So the toolkit really gives these sort of methods for how you go about doing that. But each clinic is going to discover their own answers in that phase.

192

00:52:40.290 --> 00:53:00.139

Kari A. Stephens: and then redesign that workflow in a next stage of the toolkit with recommended tactics that we also provided there were many of these tactics that they got to self choose. None of them were prescribed as required, and then implement those changes again through these Pdsa quality improvement cycles that you know most practices are somewhat familiar with.

193

00:53:00.220 --> 00:53:15.920

Kari A. Stephens: and I will say the practices loved this trial. We we got very high enrollment for those that we approached. You know, I think much because they knew that they could learn out of this toolkit lots of methods and strategies that they could reuse for other targeted activities. Not just the one we were asking for.

194

00:53:16.200 --> 00:53:39.920

Kari A. Stephens: A second part of this intervention was the education module that we had. There were 70 of these asynchronous modules for every single member of the primary care team. So, regardless of what your role was in the clinic, there were online materials for you to watch and look and learn about what is integrated behavioral health, because our belief really is that integration is done by the entire group of

195

00:53:40.020 --> 00:53:50.300

Kari A. Stephens: community-based folks within that clinic itself. It's not just done by kind of this person or that person or or it doesn't really fully kind of meet its fruition across the whole clinic.

196

00:53:50.430 --> 00:54:05.820

Kari A. Stephens: We also had interprofessional courses for all practice member roles. So anybody that was clinically practicing some courses that targeted different practice members in different ways that were individualized, and the the trainings range from 14 to I'm sorry. 4 to 14Â h.

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00:54:06.590 --> 00:54:33.880

Kari A. Stephens: The 3rd and last component that we had of this intervention was really a coaching aspect where we had both a lead management expert and an integrated behavioral health expert, and who was a psychologist, work together with each of the clinics that were in the intervention arm for up to 2 years. So for anybody that wants access to the toolkit itself, it is published online. And that's what you see on the right, if you want to be able to access it. So any clinic currently can now pull up this toolkit

198

00:54:34.080 --> 00:54:34.840

Kari A. Stephens: at will.

199

00:54:36.110 --> 00:54:43.029

Kari A. Stephens: There were 4 particular research questions that this study overall was trying to address. The 1st was using. This

200

00:54:43.170 --> 00:54:46.419

Kari A. Stephens: does using this toolkit actually help

201

00:54:46.490 --> 00:54:55.700

Kari A. Stephens: adults with multiple, chronic, medical and behavioral health conditions. And does it increase the level of integration in the practices? Those were kind of the 2 primary questions

202

00:54:55.700 --> 00:55:20.010

Kari A. Stephens: of the study. We also wanted to look at what factors support and impede successful integration and then costs, and some of that's already been published in 3 and 4, a primary outcomes paper was also published that, you see referenced below for one and 2. What I'm going to talk about today is hot off the press of a study I just published that actually looked at whether or not integration improved. Once we looked at the pragmatic nature of the way in which we implemented

203

00:55:20.010 --> 00:55:21.110

Kari A. Stephens: the toolkit

204

00:55:21.371 --> 00:55:28.420

Kari A. Stephens: so that's what I'm excited to share with you today. But there, there have been several studies at this point that have come out of this trial.

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00:55:31.000 --> 00:55:32.560

Kari A. Stephens: And we're waiting.

206

00:55:42.820 --> 00:56:08.559

Kari A. Stephens: Okay? And so, in terms of methods over this trial, we had 121 practices that that were invited. We had 43 randomized practices, in the end 22 control and 20 active practices, with one that withdrew and we had close to 20. Let's see 23, almost 3,000 patients as well.

207

00:56:08.560 --> 00:56:32.939

Kari A. Stephens: So you can see on the left our inclusion criteria really included practices that had at least one primary care provider, a co-located behavioral health provider that was at halftime or more a shared electronic health system, and they needed to be able to provide their Ehr data for the study, and then on the patient side, we only were looking at adults who were seen more than twice in the last 2 years to make sure that they were actually engaged in care within the clinic.

208

00:56:32.970 --> 00:56:49.500

Kari A. Stephens: and to be eligible, they they had to have either more than one chronic medical condition and a behavioral health condition or 3 chronic medical conditions. So they didn't necessarily have to have a behavioral health or mental health condition as long as they have 3 or more medical conditions.

209

00:56:50.330 --> 00:57:14.780

Kari A. Stephens: I'm not going to go, too in depth, because there's a lot of slides here to keep working through, but you can certainly read more in the paper about all of the analytic methods, but essentially we used a multi-level mixed effects model to look at both. The intervention outcomes related to improvement in practice, integration, and whether or not we actually improved patient outcomes. And then we adjusted for a few different things

210

00:57:14.840 --> 00:57:24.949

Kari A. Stephens: that you see on the left and the right, so essentially. Both of them were 3 level mixed model with these repeated measurements, and then nested, as you see here in the slides.

211

00:57:24.960 --> 00:57:52.189

Kari A. Stephens: So let me not spend too much time getting into the weeds on that, and just jump into where? Where were we looking at patients from here, and then get straight to the results, I think, which is, which is the most exciting part. So there were 42 practices, as I mentioned, across 12 States, and this study was done much like Dr. Ratzliff's. We did bridge over into the pandemic, although the majority of our study was done pre pandemic. But a lot of our final outcomes, unfortunately, came after the pandemic hit as well.

212

00:57:53.450 --> 00:58:19.169

Kari A. Stephens: We also to give you some description of who we included. We mostly had family medicine or mixed family and internal medicine practices throughout the study. The mean number of behavioral health providers at the site were about one and a half, and the mean number of primary care providers is about 6, and those are in ftes, not physical human bodies, but the amount of full-time equivalent people working in the practice in those roles

213

00:58:19.320 --> 00:58:40.139

Kari A. Stephens: in terms of patients we had, you know, about half of them were married. About a 3rd of them were disabled or unemployed. About 2 thirds had a household income of $50,000 or less, a little over half had a high school education or less, and these demographics overall were generally pretty representative of the health system regions in which we had recruited from.

214

00:58:40.370 --> 00:59:02.930

Kari A. Stephens: and then the mean number of total chronic conditions that our patients had. Most of them had over 4 in total, and over 80% of them had either had chronic pain, and over 80% of them also had hypertension, and then, you see, about half had depression all close to half had diabetes. 40 ish percent had arthritis. And then about a 3rd had anxiety as well.

215

00:59:04.490 --> 00:59:11.399

Kari A. Stephens: our patient, I'm sorry. Rather practice outcomes, as I mentioned earlier, was the the practice integration profile.

216

00:59:11.460 --> 00:59:36.429

Kari A. Stephens: The way that we used this particular measure was not to ask one person to rate that, but actually have 4 people at the practice do that, and then we averaged across without waiting any one opinion more than the other, and in particular the 4 people we asked each of the practices to capture this measure with was a medical primary care provider, a behavioral health provider, an administrator. It was suggested to use a clinic manager or somebody

217

00:59:36.430 --> 00:59:53.169

Kari A. Stephens: equivalent or appropriate on that level, and then someone of their choice that they thought was somebody who would have a worthwhile opinion, and we let folks know that you know oftentimes people respond to that questionnaire from their own lens. And so it's important to get these multiple perspectives to really get that measure

218

00:59:53.580 --> 00:59:55.120

Kari A. Stephens: best used.

219

00:59:56.050 --> 01:00:23.829

Kari A. Stephens: So results for those practice outcomes were very exciting for us as we did this nested modeling. And what we essentially found that you're seeing here is, if you look at that vertical black bar at the 0. Any lines that cross. That is not a significant result essentially, and what we were assuming and hoping to see in our hypotheses is that these numbers would shift to the right, which indicated improvement in integrated behavioral health at the clinic

220

01:00:23.830 --> 01:00:32.039

Kari A. Stephens: at the very top row. What you see is the total pip score. And then what you see below that for the pip version 1.0 are the 6 different

221

01:00:32.150 --> 01:00:56.689

Kari A. Stephens: subcategories essentially, that the pip measures. And so you know what you see are actually pretty pretty big increases that we think are meaningful within the practice for not just increasing the pip total overall, but across the majority of all of those subcategories that we were we were looking at. So it's pretty exciting, because this was actually, you know, pretty

222

01:00:56.690 --> 01:01:07.849

Kari A. Stephens: different kind of intervention that you see out there, much less prescriptive about exactly what practices need to do, but more empowering them to figure out themselves what they needed to do, and seeing those changes occur.

223

01:01:08.720 --> 01:01:38.259

Kari A. Stephens: The patient outcomes we measured across 3 different scales. We use the promise 29, which is a global set of actually several different function measures that are included, and you see those listed in the bullets there in that 1st box. But overall we were looking at physical function, fatigue, sleep, disturbance, social participation, your pain interference. As you can see, we had a lot of folks with chronic pain, and that's a very common plaguing issue within our primary care, population, depression and anxiety.

224

01:01:38.430 --> 01:02:05.979

Kari A. Stephens: And then, in addition, we sort of doubly measured because the promise 29 does include a depression and anxiety. Measure the Phq. 9 and the Gad. 7. And I'll just mention the Phq. 9, which measures depressive symptoms, is just very commonly used in practice for value-based contracting for general delivery of care, so we thought it was important to be able to have that measure as well and generally anxiety disorder. 7. Scale is similarly pretty well deployed out in primary care.

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01:02:06.670 --> 01:02:16.740

Kari A. Stephens: So, jumping to the same way to read this graph for the patient outcomes you're looking at that vertical black line and anything that crosses over that vertical black line

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01:02:16.740 --> 01:02:38.940

Kari A. Stephens: is showing you non-significant results. So in looking across all of these different measures of a patient population of close to about 3,000. And these 42 clinics. What you're seeing is that we really didn't find patient improvements per se. With them all. Crossing essentially, scores were not significantly different, except for a slight

227

01:02:38.940 --> 01:02:59.240

Kari A. Stephens: exception to that with anxiety. But I would say, I don't think it's clinically meaningful. It was such a tiny difference that you know, I'm not sure that that's really worth interpreting necessarily. So I think that you know our challenge that we had in looking at this is one of the pieces of data that I wish so much, of course, in retrospect that we had

228

01:02:59.240 --> 01:03:23.410

Kari A. Stephens: was what level of service delivery did all these patients have? So it's possible that some part of this cohort never went back to the clinic during our observation period. In other words, because the design of the trial was an intent to treat design. And we wanted to really look at that cleanly across. We weren't able to account in these analyses again, level of service utilization. So I think future studies really need to look at

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01:03:23.410 --> 01:03:30.250

Kari A. Stephens: those patient outcomes more closely in relationship to just the pragmatic delivery of who's actually accessing these services.

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01:03:32.180 --> 01:03:44.810

Kari A. Stephens: Okay, I will mention one last thing about this study, which is, and this is in the primary outcomes paper that Dr. Littenberg and Company, that we all published back in 2023.

231

01:03:44.980 --> 01:04:11.019

Kari A. Stephens: That higher integration, according to the pip, was associated with higher levels of patient outcomes in the clinics at Baseline. So this isn't necessarily associating anything with the intervention itself. But this is an interesting finding to see that association. Now we can't say that's causal per se. And there's lots of X factors that could potentially account for that. But I do think it's interesting to see again all of these that are not crossing that dotted line vertically.

232

01:04:11.020 --> 01:04:18.519

Kari A. Stephens: are significantly either higher or lower, if your pip score tends to be higher.

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01:04:18.520 --> 01:04:30.710

Kari A. Stephens: So again, correlation only. But we still need a lot more research work to understand. How does integrated behavioral health overall in these various different forms? It takes really relate to improved, patient outcomes.

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01:04:31.980 --> 01:04:35.058

Kari A. Stephens: So I promised, as I turned for my last

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01:04:36.290 --> 01:04:46.819

Kari A. Stephens: 13Â min. It looks like of this is to talk to you about digital behavioral apps. Where do digital therapeutics fit into this? How can they help when it comes to integration?

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01:04:46.930 --> 01:05:09.929

Kari A. Stephens: So let me 1st start with, we've just completed a feasibility study we presented last summer some of the results we haven't published the final paper for this yet, but I can share with you the poster that we nationally presented of some of the preliminary results. This was a feasibility study we conducted with a non. FDA approved. So a brand new hot off the press

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01:05:09.930 --> 01:05:33.310

Kari A. Stephens: digital health app. We don't know how well it could perform or not. But it was worth trying to test out to see. Is it feasible to actually ask patients in primary care who suffer with chronic pain to try out an app and see if an app that has intended to embed things like cognitive behavioral therapy and acceptance and commitment therapy into the way that a patient can daily interact with it.

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01:05:33.310 --> 01:05:36.210

Kari A. Stephens: actually improve pain, interference over time.

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01:05:36.390 --> 01:05:59.820

Kari A. Stephens: And so this was not a study that is an efficacy trial. It was not powered for that, so please interpret it only as far as you can. But what we did see was a trend. And essentially, if you look in the box that I've highlighted here in our table. There's a little negative 2 number in there that again, I know the text is fairly small, but essentially what you're seeing. Are we measured at baseline one month, 3 months and 6 months after using the app.

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01:05:59.820 --> 01:06:07.779

Kari A. Stephens: and you see a drop in the promise score, and a difference of 2 or more tends to be clinically meaningful, a meaningful difference.

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01:06:07.780 --> 01:06:32.440

Kari A. Stephens: And we did see a drop about a month after usage of the app, which also lines up with most apps, are only used for about a month, and I want to say I attended in our pain Clinic for many years. I think I'm a pretty good pain psychologist, if I don't say so myself on some level. But I don't think I'm that good. I don't think I necessarily get my patients better in a month. So I think it's exciting to see that people might experience kind of a real difference in drop

242

01:06:32.570 --> 01:06:51.409

Kari A. Stephens: with just using a mobile app potentially. But again, we have to be very cautious in how we interpret these very preliminary results. So my team's been excited to look at digital therapeutics overall, and I want to spend the rest of the time talking to you about what's going on in that field right now. We're seeing a lot in the news. We're seeing a lot about. AI. What does all this mean?

243

01:06:51.800 --> 01:07:18.439

Kari A. Stephens: Digital health apps? What do I mean by that? There's sort of 3 different boxes that I want us all to be thinking about. On the left hand side. We'll kind of start with the highest vetted types of digital health apps out there in general. And those are what we call digital diagnostics and digital therapeutics. These are approved by the FDA, so those are technical terms, digital diagnostics, digital therapeutics is a technical term that the FDA actually uses

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01:07:18.440 --> 01:07:26.070

Kari A. Stephens: to approve and say, we have vetted this as being safe. And we have vetted this as having efficacy data of high quality.

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01:07:26.110 --> 01:07:50.990

Kari A. Stephens: What they mean by digital is software as a device of some kind. And what's interesting is that more than 50% of these digital apps that the FDA has approved tend to be mental health related in some way. Others are also related to common behavioral issues like insomnia and chronic pain, and things like that as well. So behavioral interventions are often now getting represented in what FDA is approving.

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01:07:51.370 --> 01:08:16.780

Kari A. Stephens: A second category are health and wellness apps, and these are what I'm putting in yellow here. Use at your own risk, so to speak. So these are direct to consumer products. A lot of us have them on our phones like the calm app that I put on here as an example. A lot of us as providers do talk about some of these apps with our patients, even in clinical care, but these are not vetted per se, and they can change at any time, because, you know, these are all owned generally most of the time by for-profit companies.

247

01:08:16.859 --> 01:08:33.860

Kari A. Stephens: and they're not really supposed to be treatment necessarily, and therefore are not necessarily evidence-based. So we kind of need to be cautious about that to some degree, but it certainly has helped us extend tools in various ways, like progressive relaxation or activity tracking and things like that.

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01:08:34.029 --> 01:08:43.180

Kari A. Stephens: Then there's the 3rd category. And this is probably what you hear the most about in the media, which are these entertainment apps, you know, and a real question mark, I think, for all of us in health care. Are they causing harm.

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01:08:43.180 --> 01:09:04.989

Kari A. Stephens: you know, is Tiktok being shut down, sold. Who knows? You know what's going on there, and chat bots like character. AI are getting sued from very scary stuff, and when I was looking at this talk even just in the last month or so, and seeing what the latest was with the Characterai Company itself. It's actually a lawsuit now, because a child's died by suicide related to that company, and they're now being sued for an actual death.

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01:09:04.990 --> 01:09:16.179

Kari A. Stephens: whereas just a few months ago, when I looked at it. There were several lawsuits that were claiming harm to their children. So you know, these things are getting scary out there for sure, and warrant a lot of attention.

251

01:09:16.229 --> 01:09:32.870

Kari A. Stephens: So I thought for this talk I would include just a slide here on chat bots and throw out this question for us all. Are they good, or are they bad, and just give you a couple of things that have been published here so that you can kind of keep up on what's going on. Because I think for all of us this is moving faster than any of us can keep track of.

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01:09:32.870 --> 01:09:57.850

Kari A. Stephens: The American Psychological Association has published an article that's up at the top left, and it's really talking about the use of generic AI Chatbots for mental health support and the dangerous trend that's coming out of that. And so I think that's a great article to get you more clear on what the Ftc. The Federal Trade Commission is talking about in terms of risks there, and what the Apa says in terms of what they would recommend. You talk to patients about.

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01:09:57.850 --> 01:10:03.509

Kari A. Stephens: particularly parents of teens who are tending to increase more and more use of these types of things.

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01:10:03.660 --> 01:10:14.389

Kari A. Stephens: Reuters also published that particular lawsuit that I just mentioned about this family, who who very, very sadly lost their son to suicide.

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01:10:14.540 --> 01:10:41.069

Kari A. Stephens: On the right side you can see a little bit of the summary of what's being said about these Chatbots at a glance overall. So the FDA approving mental health Chatbots has not happened at this point. There is no AI Chatbot that has gotten through FDA. So let's just be really clear about that. These direct to consumer mental health. Chatbots are totally unregulated at this point.

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01:10:41.070 --> 01:11:07.199

Kari A. Stephens: and they obviously might not be grounded in psychological science. You might have heard about Wobot or Therabot are examples of those, and then, you know, direct to consumer entertainment. Chatbots are particularly dangerous, because they're sort of extremely unregulated claiming and feigning themselves as therapists, and again, particularly to kids or folks that are really suffering with mental illness, who are looking for a connection, you know quickly, that are so freely available. Now.

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01:11:08.210 --> 01:11:26.750

Kari A. Stephens: if you're having trouble finding digital therapeutics, you're not alone. So I've looked up a couple of resources to try to help us out to track on this. There is a group called the Digital Therapeutics Alliance. They're a nonprofit. They can't keep totally up to date, but I would say, you know I found them to be a fairly

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01:11:27.310 --> 01:11:35.530

Kari A. Stephens: good resource to to be a place to start, to go see what they're touting. They do not have a comprehensive product library, but the

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01:11:35.530 --> 01:11:59.109

Kari A. Stephens: the apps that they do have seem to be well aligned with what FDA has approved. And so it's kind of a quick way to get a summary of some of the more hot ones, particularly from the companies that are putting out multiple of these apps. And then, on the right side, the American Psychiatric Association has actually put together an initiative they call the appadvisor. And this is really just an educational tool. It's not a library of what these are, but it's a nice

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01:11:59.110 --> 01:12:12.880

Kari A. Stephens: page, that sort of helps educate people about. What should you look for if you're trying to determine if a mental health app is actually good to use. So it's a great resource for clinicians, certainly, and potentially for for the community as well.

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01:12:14.510 --> 01:12:37.779

Kari A. Stephens: So in general, FDA approved, digital therapeutics do a lot of things. And I thought, you know, I've been looking at a lot of these. We currently are getting signaled by the Nih that we might be receiving a large grant to actually study how we can integrate these digital apps into integrated behavioral health settings. So I'm very excited to potentially get that project launched. And so, as we've been looking and kind of

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01:12:37.780 --> 01:12:47.120

Kari A. Stephens: scouring, what are the apps are that are out there. I kind of put together. This is sort of Carrie's version of 6 bullets. Of what are the kinds of things we see? These apps do

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01:12:47.120 --> 01:12:57.829

Kari A. Stephens: so at the top. You see, a lot of them retrain things for us. They retrain our brain sort of how we think, but even retrain some of the neurology and interaction that our neurons are having across the brain.

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01:12:57.830 --> 01:13:02.370

Kari A. Stephens: They can help us do things to retrain our muscles and our nervous system.

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01:13:02.510 --> 01:13:12.470

Kari A. Stephens: A lot of them also offer psychotherapy and biofeedback in various digital formats, and some of those are through apps. Some of them are using virtual reality technologies and wearables.

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01:13:12.570 --> 01:13:36.590

Kari A. Stephens: Some of these are using integrated wearables to do things that I thought were pretty fun and creative, like interrupting Ptsd. Related nightmares before they escalate, so wearing an apple watch on your arm. This is not an apple watch. This is my regular watch, but you can wear one on your wrist while you sleep at night, and it will sort of be able to read your biometrics to know that you might be likely experiencing

267

01:13:36.640 --> 01:13:50.440

Kari A. Stephens: a nightmare as you train that apple watch to know what that looks like for you at night, and then it will give a bit of a sensational burst to wake you up. Enough that you don't fully wake, but it interrupts that nightmare from progressing.

268

01:13:50.480 --> 01:14:11.300

Kari A. Stephens: Then there are others that do a lot of adjunctive support for psychiatric medications that people might be taking for various issues. So, in other words, targeting populations that are taking medications and not necessarily responding as robustly as we would hope, and then being able to use these apps and actually seeing those results step up in improvement.

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01:14:11.300 --> 01:14:33.039

Kari A. Stephens: Some are helping promote lifestyle changes like being able to take medications more on a regular basis, that are more closely adherent to what providers are prescribing, and also potentially doing more movement in their life. I don't want to necessarily call that straight up exercise. It can be all kinds of movement from small to large, and also doing various kinds of tracking of behaviors in general.

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01:14:33.070 --> 01:14:44.250

Kari A. Stephens: and then there are also video games, for example, games out there that are helping people with Adhd, both for adults and kids improve their lives living with Adhd.

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01:14:44.250 --> 01:15:06.459

Kari A. Stephens: and of course more so. This is also a picture of what several of these look like. I just mentioned to you, Nightwear, which is in the purple at the bottom. That's that apple watch for potentially how you can get woken from nightmares. But there are several that you see here. Dr. Ratzlip just talked about late breaking research being done to help deliver Moud for opiate use, disorder.

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01:15:06.460 --> 01:15:20.360

Kari A. Stephens: reset, reset. O actually addresses trying to help people who are on various opioid replacement therapies, such as buprenorphine, be able to succeed better at being on those treatments for longer.

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01:15:20.360 --> 01:15:49.410

Kari A. Stephens: You see various things for diabetes management. Another chronic condition that affects lots and lots of people in the United States rejoin on the top left is one of those apps that's just emerging. That's helping link together 2 parts of our brain neurology essentially one. That's short term memory versus emotion, recognition and doing exercise on your phone to actually get those 2 parts of your brain lighting up together, which we know tend to separate and not interact when we're majorly depressed.

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01:15:49.410 --> 01:15:59.070

Kari A. Stephens: And then others like Ysa, that help people reach reach an AI that helps them get resources better in these arenas.

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01:16:00.070 --> 01:16:04.030

Kari A. Stephens: Oh, and then endeavor on the bottom right? Which are the video games I just mentioned.

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01:16:05.040 --> 01:16:26.259

Kari A. Stephens: All right. So as I wrap up here, I want to just leave you all with, there's huge opportunity, I think, for these digital therapeutics, because these lists are growing in terms of what the market is developing and what FDA now is starting to put forward that are worth our attention, you know, close to 7 billion dollars is predicted just for this year to be invested in this kind of market.

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01:16:26.260 --> 01:16:37.620

Kari A. Stephens: There are over 350,000 of these digital health apps at all those different levels that I talked about, but the vast majority of them have very few downloads in the world of apps. Right?

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01:16:37.620 --> 01:16:57.859

Kari A. Stephens: And then 3 quarters of adults do turn to their digital devices for health, related information, and a few years ago, so it's probably higher. Now, about 2 thirds of teens have used a health app of some kind. So our kids are definitely getting into this quite a bit, as phones have proliferated amongst the youth at kind of all household income levels as well.

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01:16:57.890 --> 01:17:15.719

Kari A. Stephens: But we still have a lot of reluctance of physicians to want to use these technologies, particularly around AI. And most of these apps do actually address mental and behavioral health conditions. So I think it's worth us paying a lot of attention to this and thinking about how we can get our workforce really ready to embrace this part of treatment potential.

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01:17:15.770 --> 01:17:26.780

Kari A. Stephens: then on the right side, I also thought it was worth mentioning. This is an article that recently came out in Nature, where they profiled. Over 800 of these digital health validation studies have been out there, but

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01:17:26.880 --> 01:17:42.799

Kari A. Stephens: almost half of them had less than 100 enrollees. So this is very, very new science, and we really need to be looking a lot more at what are the barriers to dissemination in various ways and get much higher samples, testing more robustly.

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01:17:43.860 --> 01:18:10.560

Kari A. Stephens: That said, there are 2 meta-analyses to be aware of that have come out recently in this last year on the left. This was a compilation of 143 studies of digital mental health interventions that have been tested for depression and anxiety, and they found by and large the vast majority of those studies found high acceptability. So that's also exciting. Patients really do find these kinds of interventions acceptable to use the meta analysis on the right is 28 studies

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01:18:10.560 --> 01:18:17.680

Kari A. Stephens: of the effects of digital therapeutics overall. And we do see that there's high potential coming out of this meta analysis for the improvement quality of life.

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01:18:17.680 --> 01:18:38.640

Kari A. Stephens: It seems to be growing potentially, exponentially. And there are very specific barriers and needs that have come out, that I think you know we've talked about that are very parallel with the same kind of barriers we have within integrated behavioral health, in addition to some, some new ones with these technologies that we really need to be thinking about what kind of science we need to innovate and reduce those barriers.

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01:18:40.160 --> 01:19:05.960

Kari A. Stephens: The last couple points I'll make. I know I'm out of time. Here is just looping us and circle back so that integrated behavioral health cross model framework that we had. Where did digital therapeutics fit into that model? And I've taken the liberty to highlight in purple a bunch of these different bullet points across processes as well as a bullet point across structures. To show you there's lots of places that we could see. Digital therapeutics potentially help improve the processes that we have

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01:19:05.960 --> 01:19:11.289

Kari A. Stephens: for clinics that are working hard to maintain and improve their integrated behavioral health.

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01:19:11.390 --> 01:19:26.429

Kari A. Stephens: So I think that's this is just again, potentially. If you walk away from this talk with one thing, that there's a lot of exciting potential to have better reach better access for all to the evidence-based treatments that that we've developed over this many years.

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01:19:28.300 --> 01:19:44.529

Kari A. Stephens: There is also a paper that I did not write, but is trying to actually look at. How do we get health apps into clinical practice? So it's really neat to at least find a paper. I couldn't find any others. But there was one paper that sort of lists. How would you go about doing that? So again, a place we really need to work.

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01:19:44.620 --> 01:20:01.189

Kari A. Stephens: So I'll leave us with this final word of just saying going forward. We have this giant umbrella of behavioral health that we're trying to address in primary care. We need to take practice centric approaches to that. It's very possible, I think, to do that in lots of ways, and we need to really be embracing AI and tech solutions despite how scary they are

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01:20:01.670 --> 01:20:07.080

Kari A. Stephens: alright. So thank you again. It's been a real privilege to get to be here, and I look forward to helping with any questions folks have.

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01:20:09.490 --> 01:20:26.449

Anne Roubal: Thank you, Dr. Stevens, and thank you, Dr. Russell, and and thank you for I think, on that positive note, because I was feeling a little scared, too, as we were chatting, so I don't know how everyone else was. We have a couple of questions in the chat, and we also have a couple of questions that came in before the webinar. So we're

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01:20:26.620 --> 01:20:46.500

Anne Roubal: I'll just raise those, and but people can continue. Participants can continue to put questions in the chat or in the Q. And a box. I know it's almost 4 30 on the east coast. So thank you all for joining us and hanging out, and if you can't hang out till the end of the Q. And A. That's totally fine. Thank you for joining for the presentations.

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01:20:46.840 --> 01:20:53.039

Anne Roubal: So 2 questions that came in through the chat were actually for Dr. Ratzliff. So I'll just start with those, so I don't forget them.

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01:20:53.610 --> 01:20:55.919

Anne Roubal: But the 1st one was about the

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01:20:56.100 --> 01:21:06.520

Anne Roubal: the clinics who were in your trial, and it was about their insurance makeup. And so I don't know if you wanted to talk a little bit about that, but particularly they asked about Medicaid population as well.

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01:21:06.520 --> 01:21:31.839

Anna Ratzliff (she/her): Yeah, it's a really important question, because, that often contributes to things like engagement and ability to regularly engage in care. So I put the link to our protocol paper in the question and answer section and I, you know, tell me if there's somewhere else I can put it. It is in the references. And that does include a really nice table that actually shows each of the clinics and what their payer mix was.

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01:21:32.160 --> 01:21:49.769

Anna Ratzliff (she/her): however, like the big picture answer, is it varied substantially? 3 of the systems were Fqhcs. 6 of the systems were private, not for profit, and those probably had a little more of a commercial payer, mix, or or, you know, commercial representation in their payer mix.

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01:21:49.770 --> 01:22:01.693

Anna Ratzliff (she/her): And then one was a publicly traded company. So they they were. All actually managed Medicare. So it it was variable.

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01:22:02.770 --> 01:22:26.089

Anna Ratzliff (she/her): and I think it's an important question. So those data are available. If you want to go look at them in some more details. I guess I'll say I didn't see a huge difference in some of the things that we talked about at least anecdotally when I was supporting the practices, and like which clinic system struggled more to get people involved. I think it was challenging in general to engage this patient population.

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01:22:28.490 --> 01:22:40.675

Anne Roubal: Thank you, and I'll ask the follow up question there, too, or I guess not follow up. But another question that was for you, which was in the QA. But I'll just read it out loud, in case not everyone can see it. So one of the core features of

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01:22:41.250 --> 01:23:00.610

Anne Roubal: The cocn model is that treatment is done in episodes of care and with the goal that once goals are achieved, this episode is completed. So if we're treating patients with Oud, and the goal is to maintain sobriety, abstinence, minimal use. Does that change the model to being on one that doesn't include episodes, but could be continuous.

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01:23:00.760 --> 01:23:03.180

Anna Ratzliff (she/her): Yeah, I think that's a really good question, I think.

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01:23:03.230 --> 01:23:22.419

Anna Ratzliff (she/her): for our particular patient population that was studied in the Champ model. Care was continued for 6 months and then stopped. So if the patient had completed their episode of care, and in general, because this was for co-occurring disorders, we were often treating.

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01:23:22.420 --> 01:23:42.179

Anna Ratzliff (she/her): Getting. People stay on a stable dose of Moud, and then having patients have reductions or remission of their mental health symptoms as sort of the goals of the episode of care. I didn't go into detail. There's like so many things I wanted to talk about, but I was trying to be thoughtful about the time.

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01:23:42.180 --> 01:23:57.520

Anna Ratzliff (she/her): So in this particular case, we really did conceptualize that as what we were defining the episode of care, I think that the sense is that, especially if you can get people engaged early and get them supported and get their mental health symptoms

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01:23:57.550 --> 01:24:04.578

Anna Ratzliff (she/her): addressed. We we were hopeful that they would actually be able to then move to maybe more of a sustainment

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01:24:05.020 --> 01:24:32.989

Anna Ratzliff (she/her): type model of their care, where they would probably be still being seen by that primary care provider in that primary care clinic to get their Moud so would still be getting treatment, but might not need the intensive services of the collaborative care team throughout, you know the rest of their life so really conceptualizing that still, as an episode of care, it's a great question, though we don't have data on it. So I mean, it would be maybe another future direction that would be really important is understanding.

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01:24:33.390 --> 01:24:40.670

Anna Ratzliff (she/her): you know. Are there other dimensions of how we define an episode of care that are important to have people maintain those gains that we saw in this trial.

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01:24:43.240 --> 01:25:06.540

Anne Roubal: Thank you for that answer. That's really helpful to conceptualize it. I'm gonna pause and ask Garrett, our pi on this project as well, if he has questions, because I'm gonna guess he might have some for Dr. Stevens, because he's all about the therapeutics and things recently. But I'll let you ask whatever questions are brewing, Garrett, and then we can go back to a couple of other questions that we got before the webinar.

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01:25:06.740 --> 01:25:22.879

Garrett Moran: Okay, thank you, Anna, and I see we are almost out of time, so I'll go very quickly. Dr. Stevens. I was curious what you had what you thought about the recent report from the Peterson Health Technology Institute, which seemed to provide some very encouraging news about the potential of apps.

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01:25:23.610 --> 01:25:24.270

Garrett Moran: Did you.

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01:25:25.576 --> 01:25:32.189

Kari A. Stephens: I you know I'm not an expert on what that report says per se. So do. Can you say a little bit more about some of the points.

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01:25:33.020 --> 01:25:39.750

Garrett Moran: Well, it just just briefly it looked at 3 different categories, apps that are

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01:25:40.530 --> 01:25:54.593

Garrett Moran: to support ongoing in person therapy versus apps that are used independently, and then just sort of wellness apps, and generally had positive things to say about each of them, and and

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01:25:55.180 --> 01:26:01.764

Garrett Moran: positive returns on investment for the the 1st 2 categories. So that that was

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01:26:02.510 --> 01:26:09.539

Garrett Moran: And actually, I I think we need to talk offline because I got a lot of topics. I'd love to talk with you about, but.

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01:26:09.540 --> 01:26:25.690

Kari A. Stephens: I would be happy to do that. I I can say generally, so I'm I'm sorry I'm not. I need to to look closely at that and see what they say. I can tell you. My own knowledge base about that is, I think that's right. That assessment of those especially 1st 2 categories. I think we started out doing a lot of digital

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01:26:25.690 --> 01:26:50.340

Kari A. Stephens: solutions to try to advance care. That's actually happening where we call it sort of having a human avatar, someone that you're seeing that's helping you do that. There was a great example of one at down in Southern California, a great psychologist who was working on campus with students and really frustrated that they were turning away all of these young people from care because they just didn't have capacity, built a piece of software that said, Let's give these students who are coming in for mental health care

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01:26:50.340 --> 01:26:52.119

Kari A. Stephens: homework. And

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01:26:52.120 --> 01:27:16.709

Kari A. Stephens: they went from seeing one patient for the 50Â min hour to 4, and they did 15Â min visits, and they were using the app outside of it and got really great results in 4 times capacity to reach folks, and that was years ago. So I think we also seen over time. You need sort of that human avatar, but we're starting to figure out a little more of this independent piece of work, and I really do wonder if we can help push it out through primary care where we touch most

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01:27:16.710 --> 01:27:23.100

Kari A. Stephens: people, we could sort of have a proxy of that human avatar that doesn't have to be as heavy as that example I just gave you. So

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01:27:23.100 --> 01:27:31.520

Kari A. Stephens: I think that's right. There's a lot of potential. But we really have to figure out the safety issues and how to uniformly advise each other on what to recommend to patients.

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01:27:31.990 --> 01:27:34.790

Garrett Moran: Great. Thank you, Annie. I'll let you.

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01:27:34.950 --> 01:27:57.413

Anne Roubal: Yeah, I'll do. I'll yeah. I'll do one more question. I know we're hanging on. But I think it's sort of related to that. I was a question we got before the webinar that someone had submitted. But thinking about these, the implications of these devices for graduate medical education and and training behavioral health professionals. So I'm just you touched on it a little bit, I think, in some of the papers, but I was sort of curious if you might want to highlight some of the opportunities there.

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01:27:57.660 --> 01:28:20.799

Kari A. Stephens: Yeah, that's a whole other arena that's exciting. So you know, I think that there's some establishment of some software solutions that again for profit companies have been doing, one of which grew out of the University of Washington from a colleague of both Dr. Rathless and mine. That's really trying to promote a digital AI solution to looking at motivational interviewing training is kind of where they seated and started a lot of work through

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01:28:20.800 --> 01:28:44.140

Kari A. Stephens: r, 1 grants from the Nih that are pretty promising, and some of that technology now, and not just from that company. But, you know, across the board with Llms now really moving forward in the AI world. Large language models Llms. I should say. I think I said. Lm, think about M. And M's with it being lunchtime. But anyway, large language models that are making this so much better and easier

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01:28:44.310 --> 01:29:09.289

Kari A. Stephens: that there have been some pilot pieces of work done, including some folks in my department, trying to see if we can put together a tool to train family physicians, how to get coached by an AI about how to talk to patients better, for example. So it would listen into that whole private session, and then give direct feedback privately to the provider to say you did really good with this part, but maybe not this part so much, or you could have followed up with that. So I do think those things are going to be emerging in education.

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01:29:09.290 --> 01:29:23.519

Kari A. Stephens: and it's certainly aligned with acgme requirements that we have within our family Medicine Residency program to have our behavioral scientists actually help assist training family physicians how to have that bedside manner, so to speak, with patients, for example.

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01:29:23.520 --> 01:29:31.940

Kari A. Stephens: lots of potential applications in education, I think. But I would say, I know we're out of time. But, Dr. Ratz, if you might have some ideas there because you do a lot more education than I do.

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01:29:33.270 --> 01:29:50.559

Anna Ratzliff (she/her): Yeah, I mean, I think there's a lot of interest, and could, instead of you know, the AI be the therapist, could they be the patient so that we can really practice being the therapist or the treating provider. And I think there's a lot of interest in that, and that maybe that is a really important

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01:29:50.620 --> 01:29:54.849

Anna Ratzliff (she/her): strategy to think about training in many

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01:29:54.880 --> 01:30:24.870

Anna Ratzliff (she/her): other worlds. We do simulators before we do real, live, human kind of activities like flying and things like that. And maybe we should be doing that for behavioral health, too. So lots of interest there. And we could probably have a whole. You could probably have a whole topic on training which I think is actually really, really important. I mean, Dr. Stevens talked about that being a big part of her intervention in the study she she designed. It became a huge factor in the trial that I was talking about. And I think it's a really important topic to be thinking about around integrated behavioral health.

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01:30:27.250 --> 01:30:28.070

Anne Roubal: Well.

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01:30:28.070 --> 01:30:50.189

Anne Roubal: thank you, Dr. Ratzel. Thank you again, Dr. Stevens. Both of those. These presentations were fantastic. I just moved to our final slide. Thank you everyone for attending as well, and we will post these on our website, the slide deck and the recording as well. So feel free to share it and reach out. Here's our QR codes if you want to.

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01:30:50.190 --> 01:30:59.269

Anne Roubal: But you can also visit our website as well. So thank you so much. And I wish you all a happy rest of your Wednesday, wherever you are. Thank you.