Adrian Hernandez:

Hey, this is Adrian Hernandez and welcome to the NIH Collaboratory Grand Rounds podcast. We're here to give you some extra time with our speaker and ask them of the tough and interesting questions you want to hear most. If you haven't already, we hope you'll watch the full Grand Rounds webinar recording to learn more. All of our Grand Rounds content can be found at rethinkingclinicaltrials.org. Thanks for joining.

Hi, I'm Adrian Hernandez, one of the moderators for Collaboratory Grand Rounds, and today we're here with Julie Fritz who'll be reflecting on the BeatPain Utah pragmatic clinical trial partnering with community health centers within sociotechnical framework. So Julie, thanks for doing this for us.

Julie Fritz:

Thanks. Thanks for having me and for the opportunity to present at Grand Rounds.

Adrian Hernandez:

Tell us a little bit about the background here. You all have been dealing with some of the challenges with pain management. How did you get to this idea?

Julie Fritz:

So BeatPain Utah is working with community health centers in the state of Utah and trying to address evidence practice gaps that are really prevalent in pain management in that setting where access to non-pharmacologic options is really challenging based on geographic barriers, financial barriers, and many things. And that really is the motivation for our project, is trying to provide a telehealth solution that can provide evidence-based care in these settings and reduce disparities in pain management that are pretty prevalent in the patient populations that are served by community health centers.

Adrian Hernandez:

It's interesting you mentioned a telehealth approach. These concepts that you all were putting together were really before the COVID times, before telehealth was really understood as being valuable. Why did you all focus on an approach with telehealth for the management of these problems?

Julie Fritz:

You make a good point about just the timeline and evolution of this project. And the recognition of the potential for telehealth to be a solution to the problem that we were trying to address seemed really the only way we could think of to provide care in places where providers, such as physical therapists or other non-pharmacologic pain providers, just don't exist in very rural communities in the state of Utah, and where also, again, financial barriers become an issue. So, although there were very few models at the time of what that might look like before COVID, we weren't the only people seeing telehealth as a way to potentially address disparities in underserved communities even before COVID. Obviously, what happened during COVID has brought telehealth to the forefront in a lot of areas, including rehabilitation, and what seemed like a daunting and novel approach now seems like something that is much more mainstream and at least familiar to providers and patients.

Adrian Hernandez:

Employing these kinds of methods, before it was so called primetime cool. Now give us a little background about the setting here with Utah. Many of us may have certain views of Utah, but it'd probably be helpful to correct those in terms of what Utah is like and the diversity in the state.

Julie Fritz:

Yeah, there's a few things that are particularly relevant to our projects. So one, Utah by geography is a very large state in terms of square miles, but there's very few people in most of the areas of the state except for concentrations, primarily in Salt Lake City. So we have a lot of very rural remote communities. The other thing to say about Utah is although it's not a state that's really well known for its diverse population, we do have a sizeable and growing population of Hispanic and Latino residents, and many people from that background receive care in community health centers. In our state, about half of adult patients who receive care in community health centers have a Hispanic Latino background, and roughly half of those individuals need to communicate in Spanish to receive their care. So managing our project, knowing that these are the populations that we're serving, really was at the forefront of our mind in developing our strategies in terms of implementing telehealth.

Adrian Hernandez:

Now that we have that kind of background, tell us a little bit about BeatPain. What was the goals for the study and the basic design?

Julie Fritz:

Obviously a pragmatic clinical trial. We've designed it as a hybrid type one trial where our primary aims are looking at the effectiveness of two different delivery strategies for physical therapist led telehealth. We have an adaptive group where we provide a brief care and then a more intensive care for people who don't have a positive response to the briefer care. And then we have a, we call it a sequenced intervention where we just provide the whole thing all at once. Stepped care management is something that's talked about and implemented a lot in pain care in places like the VA so one of our treatment arms really takes that approach. And then the other strategy is just to look at providing, really, the entire treatment in the first phase of care. So as a hybrid type one trial, our primary outcomes relate to pain and the impact of pain on people's ability to function.

And then our secondary aims are focused on how do you implement these procedures. And there's really two processes where we knew the implementation would be different for the groups that are involved. So one is the referral process from clinics to a decentralized group of physical therapists here in Salt Lake City. So that really required a lot of informatics expertise and technical support to work through the EHR and figure out how to, one, technically do that and, two, embed it in a workflow in under-resourced clinics. And then the second implementation effort that we were very attentive to is the connection to the patient for telehealth. And the patient populations that we're serving, there's some unique challenges and barriers in individuals who are lower income, less health literacy, have technology challenges so that implementation piece of our study was also something we were very attentive to and continue to monitor so that we can see if we're really reaching patients to the extent that we can.

Adrian Hernandez:

And it seems like underlying all this is this concept of sociotechnical theory. Can you give a little explanation of that? It's very interesting. I mean, I think there's always this idea that there's an app or a technology that can solve that, but without context, it may not work.

Julie Fritz:

Yeah. It's a concept that, for myself, the real key importance of thinking both of the social and the technical sides of implementing these strategies was not something that was front of mind to me. My background's a physical therapist. I'm not an informatics IT specialist person, but my colleagues really impressed on me the need to think of not just the technology that was necessary to make this happen, but how people interact with that technology. And that's really born out in, particularly, our preparation for this trial. It's one thing to think of just how to solve the problem in terms of resources, but how people interact in their daily work is really critical. And I think that really got amplified because we were implementing both the telehealth and the referral processes during successive COVID waves where additional factors going on, particularly in the healthcare clinics that we're working with, made our ability to implement a new workflow really challenging.

Adrian Hernandez:

Well, certainly we'll see how these things turn out. What have you all learned so far from the study?

Julie Fritz:

A couple things really come to mind. One is it's actually possible to make this happen, which at times I wondered. So in terms of the technology of the two-way communication, it actually can be done. The importance of building trusting relationships with the providers in the clinics, in the community health centers was something certainly I was aware of, but the critical nature of that has really come through, that there's a strong bond of trust between patients and their providers who receive care in CHCs. I think that's probably a statement that applies in these settings quite a bit. We're asking these providers to send us their patients, and we really have to build trust with them that we're going to do everything we can in the interest of those patients and then communicate back to the providers what's happening. And that really has been even clearer to me of how critical that is that we communicate well and really put the patient's interests first.

Adrian Hernandez:

What's next? This certainly seems like a model that could go into different directions.

Julie Fritz:

With respect to our trial, we're still in the midst of recruitment, so that obviously is a large focus of our activities. But I think as is true of many, if not most, pragmatic trials the idea of how to sustain a process after the trial ends is becoming increasingly front of mind I think for our entire team. It's something that providers ask us as we build these relationships and seek referrals to a new resource for them, making sure that it's not just going to go away is something that is important for all of us to be thinking of as the trial moves closer to the end than the beginning of the patient recruitment phase.

Adrian Hernandez:

Well, this has been a great discussion, Julie, so I really appreciate you sharing what you all are doing around trying to generate better evidence for pain management and testing a new model, not only in terms of doing so, but also how clinical trials can be done.

Julie Fritz:

Thanks. And yeah, we're looking forward to see, ultimately, the lessons that we learn.

Adrian Hernandez:

Thanks for joining today's NIH Collaboratory Grand Rounds podcast. Let us know what you think by rating this interview on our website, and we hope to see you again on our next Grand Rounds, Fridays at 1:00 PM Eastern Time.