Talking to Change: An MI Podcast

Glenn Hinds and Sebastian Kaplan

Episode 27: Telehealth and MI, with Jordan Braciszewski, PhD

Sebastian Kaplan:

Hello, everybody. And welcome to another episode of Talking to Change: A Motivational Interviewing podcast. My name is Sebastian Kaplan. I'm based in Winston-Salem, North Carolina in USA. And joined as always by my good friend, Glenn Hinds from Derry, Northern Ireland. Hello, Glenn.

Glenn Hinds:

Hey Seb, how you doing man?

Sebastian Kaplan:

Hanging in there Glenn, hanging in hoping for another interesting conversation today, which we've been having these during this period of pandemic sheltering at home, hoping that today's conversation will be directly relevant to the experience of a lot of healthcare practitioners out there listening.

Glenn Hinds:

No doubt.

Sebastian Kaplan:

Both now and of course, into the future, as things will likely stay somewhat how they are now, even though our life is much different than it was before. Before we get into that topic and we meet our guest, Glenn, can you orient people to our various social media platform?

Glenn Hinds:

Sure. Twitter is @changetalking, our Facebook is talking to change, our Instagram is talkingtochangepodcast and our email link is podcast@glennhinds.com, G-L-E-N-N-H-I-N-D-S.com

Sebastian Kaplan:

As always. We appreciate feedback, rates and reviews. Without further ado, we'll transition to hearing from our guests and talking about telehealth or teletherapy, depending on your role and our guest today is Jordan Braciszewski. Welcome to the podcast, Jordan.

Jordan Braciszewski:

Thanks for having me honored to be here.

Sebastian Kaplan:

Like we said, this is a very relevant topic for many of us. Wanting to hear a bit about you just to give the audience a sense of who you are and where you come from professionally and then getting into your experience with MI.

Jordan Braciszewski:

Sure thing. Again, thanks for having me. I'm a huge fan of the podcast. Pretty glad to be here. My name's Jordan Braciszewski. I'm a clinical psychologist by training and I am in Detroit, Michigan USA. Michigan's located in the Midwest of the United States, primarily I'm a research scientist in the center for health policy and health services research at Henry Ford Health System in Detroit, Henry Ford is a large integrated healthcare system serving sort of all areas of health from outpatient, primary care, behavioral health, psychiatry, addictions treatment, multiple hospitals, a very large health system throughout Michigan.

And most of my work there focuses on substance use research and particularly developing new ways to get empirically supported treatments and prevention programs to patients and families that may not be able to access those in traditional ways, for whatever reasons. A lot of times that's transportation and geography for other reasons as well, trying to link folks who aren't linked into the healthcare system, or are only coming in cases of emergencies to able to get them very good treatments and other programs. A part of my time at Henry Ford is also devoted to MI training. I train our psychiatry residents. In motivational interviewing. I often train other providers, medical students, clinicians who are serving on intervention grants. I do most of my training at Henry Ford. And then I also spend a little bit of time as a practicing clinical psychologist doing psychotherapy at Monarch Behavioral Health, which is in the suburbs of Detroit. That's an outpatient psychotherapy clinic owned by my wife.

Glenn Hinds:

So, you're a busy man.

Jordan Braciszewski:

Yeah, I suppose so. I also have two young ones they keep me pretty busy.

Glenn Hinds:

Your primary role is focused on making services accessible to people and recognizing the limitations of people's circumstances and how you as a provider can extend the reach into where they are so that their health has maintained so that it's not getting to crisis as often as perhaps it was in the past.

Jordan Braciszewski:

Definitely. When I was in graduate school, I worked a lot with families and young people who were homeless. So, getting them services that they need, not just mental health services, but any services that they might be able to need while they're also maybe only having 30 days within a shelter before they have to move to another shelter. That's sort

of where I started to begin to think about how to get empirically supported treatments that I knew about as a graduate student to a population that is sort of constantly mobile. And that's just sort of translated over the last 20 years to other populations as well. Henry Ford serves a pretty large either non-insured or government insured population. Those folks tend to have fewer means, more difficult to access to transportation, especially in Michigan. Being able to let them and give them access to the same means that other folks have, has always been sort of a social justice bug that I've been trying to meet.

Sebastian Kaplan:

So the particular barrier for many people of the physical location of where the healthcare provider is. If we can remove that as a barrier, you now have the provision of healthcare be with the patient or the client is and that wouldn't take away all barriers of course, but a large barrier would be lifted. And theoretically, anyway we'll end up talking about the specifics of how telehealth has been effective and shown to be effective, but theoretically, that would enhance care for a lot of people that couldn't otherwise get it.

Jordan Braciszewski:

Yeah, definitely. I also think in addition to transportation, one thing that I see, like I said, I work a decent amount with families. If one partner in the home is working and the other partner is not, but it's also caring for one or two or three kids and that partner who stays at home needs care. How do you do that? And also take care of one or two or three kids? What do you do with them if they're young and so on? So, if I get something to you that's in your home or something that augments what you're already able to do. Maybe, maybe you can only come in, try to be mindful of this. My bias is a lot of my analogies go to psychotherapy because I'm a therapist, but if you can only come in for therapy once a month or every other week, well, is there something else that we can do with you that augments what we're doing in-person?

So whether that is a video visit or using some sort of computer based technology and app based technology, a text message based technology to keep things going in place of the one hour a month or two hours a month, you're spending in a session with me.

Glenn Hinds:

Really tapping into the technological resources, available to you again to expand the reach for people and responding to people's needs taken into account of social circumstances, family life or finances or work responsibilities prevents them from committing to what would traditionally be, what we'd be expecting. And again, it's back to that flexibility that you have been working very hard to achieve and recognizing that there are people with limited choices and we can either let them drift or to do what you've been doing for the last 20 years, which is to respond with, a very compassionate way of thinking, which has going, ‘These people need taken care of, what can we be doing differently?’ What was it first attracted you to do that? And in what ways, and did that lead you towards motivational interviewing?

Jordan Braciszewski:

I think they mesh very well. Technology, at least my view of how technology can be important and telehealth can be important for folks who need care, whether it's psychotherapy or physical therapy or nutrition or whatever it is they need for their health. It meets people where they're at, maybe at this point in their lives right now, which I know is something you all talk about on the pod quite a bit. This is what you can do right now. This is what you have the capacity for right now. That's obviously an important concept in MI and technology is a way to do that. If I just sat back and said, “Well, the only way that I see people in terms of psychotherapy is if you can come in once a week and if you can't come in once a week, then sorry.” That's not meeting people where they're at.

I think tech and MI is a really nice mix in that case, we can meet people with where they're at and what they can do for now. And the hope is that maybe later they have the capacity to do more. I'll probably say it more than once the disclaimer that I certainly don't think that technology or telehealth is replacing psychotherapy or any other type of provider. I don't think telehealth is for everybody, but we had a lot of people that need care. And if they can't come in anyway, I think giving them something that works quite well, even if it's not the gold standard is better than them never coming in at all. And this sort of gets back to how I got into MI. Although I'm a clinical psychologist, my background is in community psychology.

The first time I ever did a workshop, which was with Sylvie Naar everything really fit that she was talking about because a lot of the values of motivational interviewing are the values of community psychology, sort of meeting people where they're at understanding that when you come into a neighborhood or a church or any sort of context, that you're not a part of understanding that you're not a part of that context, you would never necessarily tell people in that context, what is best for them. And that it's extraordinarily important and essential to understand where they're coming from and what their history is, so that you can use your expertise to work with them and what they know about their community or their neighborhood or their church or their school to find what works best for them. Again, just sort of meeting people where they're at and using their expertise. I think that, again, that's sort of what attracted me to MI.

And that Sylvie's workshop that I did was in my, I think my second year of graduate school, where I had my first therapy placement at a methadone clinic and for those who aren't familiar, methadone is a medication treatment for opioid use disorder and so at this clinic, I think the average age of patients was 50 or 55. They were predominantly African American. They had been using opioids, mostly heroin at that time, prescription medications weren't as big of a deal back when I was working there, they'd been using for an average of 25 or 30 years. And then I come in as a 24, 25 year old Caucasian with no substance use history from the suburbs and I'd sat down and sort of said, “Okay, well I know cognitive behavioral therapy for substance use disorders. Let's do that.”

Of course, I wasn't connecting with them and wondering why they wouldn't fill out the thought records that I wanted them to fill out. The offer to take Sylvie's workshop came at a perfect time where I was really struggling to understand where people were coming from and meet them where they were at and provide them with the comfort and knowledge that this 25 year old kid might be able to connect with them and help them out. MI I was sort of a saving grace for me early on as a therapist.

Sebastian Kaplan:

It's always so interesting to hear people's versions of this story and how early in one's career or training you had some of the tools that are empirically validated and would be theoretically helpful for another person. And MI seem to offer a way of connecting with people of course, on a human level, but also delivering that tool that was known to be effective, but also just bridging divides that could be quite large. And you listed three; an age divide, an experience divide not coming in with substance use history and racial ethnic divide and finding that MI was a way to bridge all of that and connect to people that otherwise you wouldn't have.

Jordan Braciszewski:

You're right on. And going back to telehealth, I have a thing that I think will be helpful for you and MI is the means through which we can make that happen. And once I had some of those tools and subsequently a lot of us know what we could get out of one workshop, but I mean, that really lit the fire and then I was able to get subsequent training after that and become a member of the MINT. But through all of that MI training, it just really enhanced my ability to meet the needs of a population I really wanted to work with in a way that worked for them and that just continued to snowball as I got more into technology and with another population that had its own unique barriers that would young people exiting the foster care system

Glenn Hinds:

So Motivational Interviewing allowed you to articulate your desire to be helpful. It was a language that allowed you to say what was needed to be said in a way that people felt connected to you, that they felt valued, that they felt understood, they had choice. And that bridged the gap that you identified earlier in your career that allowed you then to get on with doing what most purposeful for you, which is to connect to people who were struggling and aware that they would find helpful. Interesting you're describing then we're most interested in today is that idea then that haven't bridged some of those gaps that say up at identified, you identified other difficult is a gap to overcome, which was the telehealth aspect of that.

And I'm wondering, can you just lead us on to that transition from the traditional face to face, and then you're beginning to use telehealth and the sense of way you've kept using it. Because again, what most people will be interested in today, given the situation we found ourselves in the world that people are finding themselves transitioning, not by choice in many ways, these have been imposed upon. And lots of people are saying, “You know what? We're discovering. We can have meetings that we used to have face to face.” But you been doing this for years and maybe you can guide us into the future about how we might choose when the pandemic is over about how to tap into these resources in a way that will be efficient effective, and useful for everybody.

Jordan Braciszewski:

I think the situation that we find ourselves in is obviously pushing everybody to use telehealth. At Henry Ford, thankfully our behavioral health department was a little bit ahead of the curve and we had been pushing, we call it virtual care or teletherapy in what

we're doing right now, using video to conduct psychotherapy sessions, virtual care was being pushed out throughout our health system in all areas. I actually just did my first video primary care appointment a few weeks ago. It was wonderful. I was in my bedroom. I still had my pajamas on, I didn't have to drive anywhere. It was fantastic. And I waited in a virtual waiting room for two minutes. I saw my provider, she was wonderful. We figured out what was going on and that was it.

And I was still home. It was wonderful. But like I said, behavioral health has been a bit ahead of the curve relative to other areas of our health system. And so within about a week, we were able to convert almost all of our behavioral health sessions. And I think we serve maybe a 100,000 people or so to virtual within a week or two. And we can get more into this a little later, but we've seen some pretty fantastic upsides to doing so. It's come of course whether people were reluctant to do it before the pandemic or not. Well now they sort of have to do it because that's really the only way currently that we're able to offer care, taking it back to where my start with all of this came is one silver lining maybe from having to sort of force everybody to do telehealth, is that I'm wondering if now folks will be a little more open to doing other forms of technology too, as I was talking about before augment what it is that they're already doing.

So the way that I got my start in utilizing tech to be able to find and help more people, I was starting my postdoctoral fellowship and I needed to come up with in the first two or three months of postdoc. I needed a grant idea because I needed to start writing a grant. That was the purpose of our fellowship, was learning how to write grants and get one out by the end of your first year. As I said, my graduate school time was working with families and young people who were homeless. And we saw that a lot of folks, once they left the foster care system would end up homeless in the United States.

For those who aren't aware of foster care is similar to child welfare. The government has taken sort of guardianship over for a young person because of circumstances that happened in the biological family home, but in the United States, once they hit a certain age, they're no longer a part of that system they have to go. And so when that happens, a good number of those young people have a lot of negative consequences. Many of them end up homeless within a couple of years of exiting the system and substance use kind of goes through the roof.

I was doing a substance use postdoc. I needed to do a substance use grant. I thought, “Okay, what if we did an MI intervention for these young people in their substance use? So, after they leave it doesn't go through the roof.” I did some focus groups with foster care administrators, foster care parents, and foster care staff. And I had these two ideas I set up, what if I taught … At this point, I was already a member of the MI and I was training people in MI. And I said, “Well, what if we trained nurses and doctors to do motivational interviewing with these young people?” And they said, “Yeah, that'll never work.” And I said, “But that's the hot thing right now is you teach providers how to do MI and they do it in substance use goes down.”

And they said, “But a lot of these young people don't go to the doctor, for those that do, they don't necessarily trust providers to tell them about their substance use, because there are some circumstances in which if these young people report substance use, they lose access to services that they have.” And I thought, well, okay, I got to come up with something else. But I saved my second idea, which I thought was way better for

the second idea. I said, “Okay, well, what if we taught former foster youth to do motivational interviewing and they'll do a brief intervention with these young people.” And I sat back and waited for them to tell me how smart I was.

And then they said, “Yeah, that's a terrible idea. How long is the intervention?” And for the audience that isn't aware, there's a large research literature on doing brief interventions, one or two sessions using motivational interviewing to decrease a number of behaviors, whether it's substance use or getting people to exercise more. But the idea that you can do it in a brief fashion, one session, 20 to 40 minutes, I said, “Well it's one session.” And they said, “Well, what happens afterwards?” I said, “Well, that's it. It's just the one session. And then substance use goes down.” And they said, “Yeah, it's not going to work. You're linking these two people together and getting them to have a relationship that is trusting enough to confide in the former young person who was in foster care and then you're bringing that person out of their life. That's, what's been happening these kids' whole lives, they form a bond with someone and then that person leaves. And then they form a bond with a new person and that person leaves.”

And I said, “Oh my gosh, I'm such an idiot. How did I not think of that?” But it was wonderful to hear because then I had to really say, “Okay, well, how do I take an empirically supported intervention, motivational interviewing for substance use delivered in a brief format to a population that many of whom don't go to the doctor. Training medical providers or anybody like that is out and trust is a big issue for this population. What if we use technology?” And that's sort of where it all started. Then I partnered with Steve Ondersma, who is one of our co-MINTies who had developed a computerized intervention to deliver motivational interviewing, using an animated narrator. And I combined that with a text messaging approach to deliver to these young people.

So that was maybe 12 years ago or something like that. And then it's sort of been off and running since then. How can we continue to find ways to take technology? Because at that time video conferencing wasn't necessarily a big thing back then people were doing more telephone based MI and what is that compared to in-person? So it went telephone, technology, telehealth and video conferencing over time and so it's sort of been off and running since then.

Sebastian Kaplan:

If you didn't know before you certainly realize after that experience a level of persistent creativity on your part, as you proposed an idea that you were excited about and got shut down, propose another idea you're excited about and get shut down. And even with the level of internal like, “Why didn't I think of that,” kind of thinking and persistence led you to use the cliche, I guess, outside the box and really think about how can we adapt MI in this pretty unique context, this unique relationship context that exists to make it worthwhile.

Still thinking also about the people that are now adopting telehealth. Hopefully can get into the different versions of that and how that would look, people are forced to do it and so maybe they're undoing some of their preconceived notions about what telehealth is all about, but just wondering what, in your experience or in your work with other colleagues, what are some of them initial barriers or hoops or hurdles, I guess from a provider standpoint, to then open up to the idea that maybe I'm not going to change

everything that I do, and maybe in-person therapy is going to continue as a major part of the field, but what do you think again, either in your experience or your colleagues experience with how they moved past some of those initial hurdles?

Jordan Braciszewski:

That's a good question. In many ways, it reminds me of being anxious about any new circumstance or anything. I've been doing something a certain way for so long. And now you're telling me, I either have to, or I'm being encouraged to do it in this different way. Well, what will it look like and how will it go? And there's no way I'll be able to do it exactly the same way. Therefore, it probably won't work. It's stuff. It's the same dialogue that we hear from clients when we ask them to, I know you've been interacting with your partner or your child, or whoever in this way, but why don't you try it this different way? And then you spend maybe the next three sessions talking about and using MI about what might be the pros and cons of trying that out? So at least when I talk to folks about their ambivalence about using tech or telehealth, I'm using some of the same strategies that I might use with a client about their ambivalence, about any other behavior.

So what are some concerns for you about using telehealth? One of the big ones that comes to mind for people is, well, the way that I do therapy or the way that I provide whatever health service that I provide. It won't be the same. Then it's a lot of, we talk about in cognitive behavioral therapy, all or nothing thinking if I can't do it exactly how I've been doing it, then I might as well not do it at all. We talked through, what will you be able to do? And hopefully that sort of evokes a lot of change, talk about how this will go well, and then what are some of the things you, you may not be able to do? And then we were troubleshooting barriers. How do we get past some of those barriers?

Well, I generally like to, if my clients are getting emotional, I might like to offer them a Kleenex and I can't offer them a Kleenex over Skype. Okay. Well, yeah, certainly you can't. How might you be able to express empathy and compassion to them in words, or in your facial expression in lieu of being able to offer them a Kleenex? So I think that's where it starts is talking with whether it's my supervisees or colleagues about how are you doing this, having an open conversation with them about their own ambivalence and pointing out that … Because certainly as I think about the writing reflex and especially being a researcher, my writing reflex is to say, “Well, let me just show you all these articles that show you that teletherapy is just as effective as in-person treatment.”

And then when you tell me that you don't know if you can create an alliance over Skype or whatever it is that you're using, I'll show you these other articles that show that therapist rated and patient rated therapeutic alliance is just as good over video, but that's not going to be helpful for people the same way. It's not going to be helpful to tell people why stopping drinking is going to be helpful for them. You need to explore their ambivalence and help them figure out what will work for them.

Glenn Hinds:

The expertise that you bring, is that you know what this research shows you have the evidence, but as well as that, you've also got the experience you've experienced telehealth work, but what you're offering to your trainees and your staff is the opportunity to explore their experience of making this transition. And two things are happening in that

moment. One is that you can help them reflect on that experience to aid their empathy with other people who are going through transitions for other reasons, but also to experience themselves resolving whatever the challenges are in a way that works for them in the context of their lives. And again, that's very consistent with the spirit of motivation that leads, guides, supports someone to discover these things for themselves.

And again, I guess the fact that you've been doing this for 20 years is itself a statement of confidence in this approach and a confidence in telehealth. Before we came on air. Part of what I've exploring with you is the fact that your research and I guess people are interested as the lesson to is what evidence does exist, Jordan, to say telehealth in whatever forms, works?

Jordan Braciszewski:

That's a great question. And certainly folks will be wondering about that. And most of the research shows that when you sort of pit in-person cognitive behavioral therapy for depression versus video conference, cognitive behavioral therapy for depression, it looks about the same now, of course, just like with any research literature that is sort of earlier on, there are caveats to that. It doesn't work for everybody. There are still a number of research design limitations to some of those studies. There are more nuance things that need to be explored. We need to make sure that the process of how therapy is working, not necessarily that it's the same, but that we sort of know why it is that it's working over video conferencing. I'm not sure we know that yet, but I'm the whole sort of omnibus test of does this work versus in-person? It does and it seems to work just as well for a number of issues, not just mental health issues, but also nutrition issues, more general health issues, diabetes, obesity.

And as I sort of alluded to a minute ago, ratings of satisfaction among patients are very high for doing this, that speaks to being able to meet people where they're at and ratings of therapeutic alliance. Again, when you pit in-person versus video ratings of therapeutic alliance, particularly on the part of the patient, there's some research to suggest that clinicians are still a bit more ambivalent about how the alliance is going, but patients rate therapeutic alliance very similarly, I mean, not significantly different between in-person and video.

Sebastian Kaplan:

So a lot of promising preliminary research in a relatively new field, even just thinking about the adjustments that we're making here in the clinic that I work in and imagining questions that people might have just to see if there is any research evidence for, or against other kinds of applications, which of course it may not have been tested yet. And one of the things we might expect going forward is an exponential growth in research, looking at telehealth. I imagine that much of what you're describing is telehealth versus in-person in a one to one kind of context and anything that you've seen or been familiar with in terms of working with families or, or perhaps group therapy. That's one question then the other is in those studies that have the tele versus in-person design, did the tele include any in-person, like was the intake in-person, but then the subsequent sessions were tele or was it just purely, never in the same room together versus always in the same room together.

Jordan Braciszewski:

Great question. Take the second one first, it's something I've been thinking about quite a bit lately, from what I remember of the studies and reviews that I know about, it's generally all tele versus all in-person, but I think you bring up an important distinction. Again, as also we transition from in-person to doing teletherapy and in this time it's made me wonder about the ease with which people transition. I already know you, you know, we already have a relationship, you and I client. Now we're just going to do what we've been doing in a different way. And perhaps that's a much easier transition than doing an intake. I would imagine it is. At least it's been my anecdotal experience that starting a new over telehealth brings up probably heightened reluctance or ambivalence on the part of both parties when we're meeting for the first time over telehealth versus I've known you for a month or a year, and we're just continuing what we've always done. And we're just sort of adapting.

We have a history together. So, I already know a lot of your non-verbals. I already know. A lot of the way when you look off to the left that I know your tells or so on. And so when I have a history with you, it's I think a lot easier to make that transition. Not that it obviously can't be done from starting with the intake doing teletherapy, but at the same time that you are, are dealing with all of the ambivalence and difficulty of or challenges of meeting a new person in treatment, you're also dealing and with their ambivalence about the method with which you are doing that. Do I have the camera straight? Am I supposed to look at you? Is it okay if I look the other way? This is sort of maybe what the client is thinking, or maybe what the provider's thinking if they're sort of new to this.

And so you're dealing with all the technical issues you're dealing with, how the person feels about their background and by background. I mean, like literally the background behind their camera are my kids going to run into the room, all of those kinds of things on top of I'm meeting you for the first time and everything that comes with that. I mean, that's a, that's a new, maybe a new research question for us to look at is just looking at the process of intakes and just the first few sessions and what that looks like different than doing in-person. Going back to your first question about families and groups. There's certainly less literature on that. I know at Henry Ford, we're trying to start doing group virtual care. We're just sort of ironing out some details, but it certainly makes things a little more difficult.

In substance use treatment that is generally a big mode of care. It's intensive outpatient programs or day treatment that are 5, 10. Certainly I've been a part of treatment programs where there's 15 or 18 people in the room and I'm on conference calls all day with 15 and 20 and 25 people. That's a challenge to do for sure, to keep everybody's attention, to make sure everybody is heard and so on. So, I think there are some distinct challenges with group telehealth, and I don't know that we have a good chunk of the answers quite yet.

Glenn Hinds:

So again, it’s that environmental shift, as you say that, part of what I was struck by is I knew some people here in Ireland here in AA, and I know a couple of people in America and they say they are have AA meetings online. So, it sounds like the human resourcefulness and the human creativity is people's responses to the circumstances, we

can see it all around us. Very, very quickly after the outbreak of the pandemic, I noticed here in Derry how quickly community groups developed in response to community need. And I'm just wondering, is it a generational issue? And I wonder Jordan, if you noticed it, but the people that you work with are the younger people that have been offered services quicker to adapt or quicker to engage with this type of resource than people of our age?

Jordan Braciszewski:

I haven't seen that as much, not at least you get to … I see a few people who are, or have seen, I'm not seeing any right now over video, but I've seen in the past clients who are over 75 years old. I'd have to talk with a few of my colleagues that work with geropsychology, older adult population to see what their experience has been. But for the most part, I sort of see people between the ages of 12 and 65. I'll see people like sometimes a little younger, a little older, for the most part. They're at 12 to 65 and I have not really noticed a big difference across that group. And so going back to some of your other questions about what should clinicians that you all are working with, be thinking about in terms of them trying to treat their population, that maybe not having the stereotype that older folks aren't as interested in this.

Again, in the same way that you talk about any sort of ambivalence with somebody, if you're ambivalent about talking to them about it, they'll sense that ambivalence and then sort of take that on themselves. If I have a 60-year-old client and say, "Well, we could do this telehealth, but I don't know if that's really for you." And so then they might say like, “Oh yeah, you're right. Maybe that's not for me.” And capitalize on some of their feelings of anxiety around using technology. We just finished a survey of folks who are on government insurance in our health system. It's relatively small set. We've got about 100 people in this survey, but we're seeing if folks who are on government insurance, they smoke cigarettes at a much higher rate than the general population in the United States.

And we're trying to reduce that health disparity by offering a technology-based intervention to that group. And of course, one of the questions is, okay, well maybe 18 to 40-year-olds would be interested in a technology-based intervention for smoking cessation, but I don't know about 40 to 55-year-olds. And it turns out there are no differences across age. Everybody is interested in doing a computer-based thing at the same rates. They're interested in doing a text message-based thing. They're interested in doing video conferencing all at the same rates regardless of age. That's been pretty interesting to find. I would imagine on the whole, there's maybe a tiny bit more ambivalence or definitely less experience at older ages, but I've not seen it be as big of a barrier as it seems folks posit about.

Sebastian Kaplan:

So, I've plug for a colleague of mine here at Wake Forest University School of Medicine. Is a geriatric psychologist named Gretchen Brenes, B-R-E-N-E-S who has been studying telephone-based cognitive behavioral therapy for, I believe generalized anxiety disorder in older adults with promising findings. And she's still going through her studies with that, one mentioning of some promising advances in terms of use of telephone anyway, with an older population. Also, making me think about the breadth of what is considered tele.

And so there's a lot of the video visits now over the internet using computers or phones and that kind of thing. There's of course, telephone, literally doing it over the phone.

You also mentioned the use of text messaging with the use of avatars and that sort of thing. Really when we use the term telehealth, we're talking about all of these methods of technology as the conduit of healthcare. Wondering if there are any others that you're familiar with, any other modes of tele health. And also if there are any interesting findings from a research standpoint, or maybe if there are some limitations in a particular field where there's still a lot of work needed to advance tele in a particular setting or with a particular population.

Jordan Braciszewski:

Certainly a big challenge moving forward is reimbursement. Not all of these forms of technology are reimbursable. As far as I'm aware in the United States, there is only one app for substance use that has been approved by the FDA and you can get reimbursed for. Despite loads of research on the efficacy of app-based mental health and physical health care, again, whether it's smoking cessation, nutrition, diet and exercise, weight management, medication adherence, there are a ton of studies to show whether it's apps or text messaging or computer-based, they increase access to care. They do just on the whole, just as good of a job as in-person. You're reaching more people, but none of them are reimbursable right now. You're relying on the suggestion of therapists or others to, “Hey, you should give this a try. I think it will be helpful. And if you do it on your own, great. If not, great. Nobody's getting paid for it.”

Even telehealth, whether we continue to get reimbursed or reimbursed at the same rates from health insurance companies in the United States for video conferencing, after the pandemic is over, we don't know, it may stay the same. It may go away. Certainly getting reimbursed for these sorts of thing, unfortunately financial incentives are a big driver of behavior change in healthcare. If we're not going to get reimbursed for it, people aren't going to do it sadly, whether it works or not. And of course a barrier continues to be access to technology. We've been talking for the last several minutes about the benefits of telehealth, but this all assumes that people have access. I don't want to go the other way and say that, “Hey there's a gigantic swab.”

More people have access to tech, than I think others are aware. Again, in this survey of folks who are certainly having government-based insurance in the United States as a proxy for not having adequate financial resources. And so folks would often think, “Well, poor folks don't have access to technology.” And we're finding through a lot of our surveys, they do. And then the next question, “Well, they don't have smartphones.” “Well, it seems like 95% of the folks that we talk to do.” “Well, they don't have internet at home.” “Well, 88% of them do.” A lot more folks have it than don't, but there's still a huge population that doesn't have access. And so, one thing that certainly myself and my colleagues are thinking about is, as this pandemic forces us to shift, to using more tele-based systems of care, whatever that is, is that there will now just be a new gap in the haves and the have-nots in terms of access to care.

Now, I would hope that on the whole, it gets better because going back to the beginning of our conversation, I think more people have a smartphone and can do a video visit, than can drive an hour to come to a therapy appointment. Hopefully that's still the

case, but of course they'll still be folks I think, left behind. If you're in a country that doesn't have large access to fast internet. In terms of, part of your question was also what other approaches are there? I see a lot of combinations of things. Your basic ones are an app, computer-based or a lot of people call it internet-based, text messaging using the old phone and video conferencing, but I've certainly seen combinations or augments of those. There are people starting to use artificial intelligence and chat bots to be able to have conversations with people.

You might have an app on your phone that asks you or prompts you to do a depression screen every week. And if you meet a certain threshold, there's a chat box in the app that will then talk to you about your depression and sort of assess whether an advanced level of care is needed, or maybe just at least suggest that to you. It may have a couple of back and forth with you. And then the chat bot might say it might be worthwhile to reach out to a loved one or to a professional. I think the more advanced artificial intelligence gets, the more we'll be able to leverage that using technology, not to replace therapists. Ever since graduate school, it's really stuck in my head this idea of, we only see people at least in psychotherapy for an hour a week, and there's a lot of other hours in the week.

How can we help folks continue to think about their health when they're not sitting in the chair across from me for those 45 minutes or so? And I think that's where tech can be extraordinarily helpful. The other thing I'd say that comes to mind when you ask about what other modalities are there that I've seen that I think are promising is, I've seen a few studies where the clinician on this study will host weekly or monthly ask-the-doctors sessions. You're getting a technology-based approach that's very individualized, tailored, but then once a week, or once a month, you enter a chat room where folks who are also in the study can ask questions of the physician or the nurse or the clinical psychologist or whomever, is sort of a licensed person.

And it's sort of for an hour, “Ask me anything and respond.” What's nice is not only people can get their questions answered, but it's kind of in a group format that you begin to see some group dynamics, people can learn from each other and so on. I think all of that are different ways to augment what we might be doing that's more traditional in ways that expand access to care for folks.

Glenn Hinds:

You're describing, like it's almost like there's going to be four layers, or they're currently is, and they're going to just become sharper, which is, you have your traditional in-person, then you have the augmented, which is in-person with some telehealth and then a virtual, this type of conversation. And then there's the automated. As we talk about this, I'm just thinking that for the next generation that just talking to Siri or talking to Alexa about their medical or mental health will be normal. And there will be either an augmented support mechanism and just the potential of that, even just recognizing the developments with an artificial intelligence, that we can be talking to a robot or an automated computer and they can reflect, and they can express empathy in such a way that we, as human beings feel supported. And they will be listening out for certain phrases to go, “Okay, we need to escalate this and let a real person come and speak to this person.” And it's almost like a screening process, the internet or the artificial intelligence will offer.

Jordan Braciszewski:

I like that you framed it as a screening process because I think a natural response to what you're saying is either, I'm going to get replaced by Alexa or I'm never going to get replaced by Alexa, what you're talking about is junk. And I keep again, coming back to how many people are out there not seeing therapists right now. I'm not as focused on Alexa replacing me for the patients that I already see. I'm interested in how tech and other ways to reach people, reaches people who would not otherwise be coming in. The estimates in the US are that almost 50 million people have a mental health disorder, certainly many more than that have the need for the sort of sub-threshold from that. Maybe there are 100 million people that could use something, some sort of support, some sort of help.

I don't know how with 600,000 mental health care workers in the US we're going to treat 100 million people. Again, I like the way that you said, it's sort of a screening process, where there are probably loads of people who could be helped with this sort of low intensity, high frequency approach that tech can offer. And then a subsection of them, we can identify as you need a level up. Tech can be very smart about who needs that. I've seen a group that I'm a part of and another group have been working on lately. These papers have come out recently in the literature using machine learning and other sort of advanced stats and programming to use electronic health records, to predict who is at most risk of attempting and succeeding at committing suicide.

Veterans' Healthcare in the United States that healthcare system and some of our healthcare systems are starting to use this to reach out to people who very infrequently touch the healthcare system, reaching out to them and helping them and saving lives by using this machine learning. We're reaching out to people who again, are not coming in anyway, using tech to identify and screen them and saying, "Hey, we noticed this sort of amalgamation of things that you have going on and sort of pointing to, maybe we could be of some help to you." Yeah. I really liked the way you framed it as tech as a way to screen and identify.

Yes, some people we can help with tech, but using tech as an identification process is certainly where we would get a lot of bang for our buck, but doing so in a way, as you were talking about Alexa using reflections or so, doing so in a way that still meets people where they're at. That's some of the work that I've been doing for quite a while, and especially using Steve Ondersma's software. And I do this through some text messaging pieces, delivering MI through tech, which helps become more engaged in what it is that they're doing with the tech and then hopefully more likely to seek traditional treatment.

Sebastian Kaplan:

Just to clarify a term that you used, the chat bot that's B-O-T like a robot, but a chat bot. Okay.

Jordan Braciszewski:

Yeah.

Sebastian Kaplan:

Make sure people got that. You're really emphasizing and inviting people to consider that while there's certainly a lot of probably reasonable concern in other professional communities about technology replacing human beings, the automation of certain professions, probably well-documented and across economies. That's not what you're anticipating from a healthcare standpoint, that the advancement of technology would serve to augment what's already existing and also offer people an option that wasn't there for them. And for many of those people, the existing human options, in essence, weren't there for them either, maybe because of their own choice and they didn't feel comfortable with it, or because of all the societal barriers that might exist, that technology isn't viewed, at least from your perspective, as a replacement of human providers, really way to augment it, dress gap.

And then getting closer to like the MI-specific terrain here, like empathy. I mean, that's a very common thing, even when you brought that up and I've heard it brought up before, about electronic reflections or Alexa making reflection. I know even for myself, I have an immediate level of like, “Ha, come on. There's no way that Alexa can do a reflection.” I need to be careful in my own assumptions about that because it's the same kind of assumptions that we were talking about earlier with telehealth in general.

And so I guess I wonder what your thoughts are about starting to get into some of the more specifics, although empathy is a pretty broad part of MI of course, but something as broad as empathy or something as specific as the skill of reflective listening or an affirmation or something like that. Your thoughts or some of the findings you might have about the use of those MI skills or the concept of empathy in the context of tele.

Jordan Braciszewski:

Obviously the more tech it gets, not video therapy or video chats as we're doing, but the more technology it gets, can you express accurate empathy? Can you provide autonomy? Can you give a reflection? Can a text message demonstrate MI spirit? The more abstract the MI concept, the bigger challenge for tech to be able to address that. I think the place where I continued to see it working best is Steve Ondersma software. For those that aren't aware, Steve Ondersma is a researcher at Wayne State University in Detroit, Michigan. He has created this software, which has been used by a number of folks. I actually think Sylvie Naar had talked about it on the pod with you guys.

There's an animated narrator that you can program. He's emotionally expressive, and you can program the animated narrator to make different gestures and say different things depending on what the client or the research participant has said. And continually, no matter whether it's Steve's research or my research or anybody else that has used this software, participants continue to give high empathy ratings to the narrator, just extraordinarily high. And then in interviews afterwards, they say that in most cases, people use, there's a choice of animated narrators, most of the time people use this parrot named Peedy, the parrot. They say that they really felt like Peedy understood them and that they felt like he cared.

It's a really interesting phenomenon. And when I heard you say the first thought is, there's no way that Alexa can either do a reflection like I can, or they're going to understand me, I would agree. And then what I think happens when people fire up Peedy in the first minute or so, they might think, “This is kind of silly. I'm interacting with this bird.

He's trying to do therapy with me." But then by the time you get to minute four, you're just in it, having this interaction in a very … We set up the interaction to be as adherent to MI as possible. So, we can program how judgemental Peedy is and hopefully not judgemental. We program him to do reflective listening, depending on people's statements, we can make him do different animations that express empathy. And then, like I said, on the other end, people end up saying, "I felt really heard."

And then as I mentioned in a couple of my studies, I've tacked on text messaging to that, so people interact with Peedy for 5 minutes, 10 minutes, 20 minutes. And then they get text messages after that, that are written according to somebody's level of readiness to change. I put people into categories; they're not ready, they're on the fence, they are ready. And the text messages they get are written for someone at that level. Every week, we ask them again about their readiness. If they change levels, we change what kind of texts they're getting. And then when we interview people afterwards, they say one day they stopped getting the messages. And they were sad. They thought, "Well, wait, what happened?" And that they sort of identified the text messages with Peedy.

I've heard this dozens and dozens of times. It's not like one participant telling me this, they'll say like, "Peedy is out of my life. What happened? That was something I was looking forward to everyday for him to talk to me about what I had going on. I miss him." Or, "That was a really big part of my life." Or particularly with young people exiting the foster care system, they'd say things like, "Peedy was really my only support. He was the only one there for me." These automated text messages that were written mostly by youth and foster care and partly by myself and my coworkers, they are automated text messages written by some people delivered by a computer. And then months later our participants are, saying, "Hey, I miss Peedy. What happened to Peedy? He was my only support."

It's interesting that over time people start ascribing these human characteristics to the automated settings and an automated delivery of messages.

Glenn Hinds:

It sounds like what's happening there is that the individuals who are meeting Peedy, whether he is a cartoon parrot or a text messages, the experience that they're having is of the purest form of helping, which is they're only receiving empathy. They're only receiving reflective listening. They're only receiving consideration. That the practitioner who's delivering it, isn't contaminated by the human condition. And therefore can just give their full attention to what it is that we know human beings thrive upon, which is attention, support, choicefulness, and people respond. And that what they're identifying is what they're looking for to identify when they're with us.

In many ways, what we've got to consider is what is Peedy's doing, because that's what we need to be doing because people love it. People appreciate it. And again, it's back to, in many ways that Peedy's manifesting the Spirit of Motivation Interviewing, or Peedy's manifesting the spirit of good helping, and people tap into it. What's interesting as well, I'm conscious of our time. I'm also really conscious of the individuals who'll be listening to this, that the idea of a text message. What is it that Peedy is doing? Or what is it a good practitioner is doing that when they're constructing a text message, what is it they need to be doing to construct a useful, helpful text message rather than just, "Oh my

God, whatever.” I'm just wondering what thoughts or ideas you've got about how to help guide people in the construction of good help and statements, whether it be in text, in email, escalate it to telephone, escalate it up to video, escalate it up to face-to-face.

Jordan Braciszewski:

I think a lot of it comes from, or at least where our success has been getting that messaging from the population to whom you're delivering it. I learned my lesson from those focus groups that I was talking about. And when I designed the original intervention that I'm talking about, I first went to the population and internally I said, “I'm not going to tell them anything about what I want to do. I'm just going to ask them what they would want.” And what they talked about was we feel incredibly judged. These are young people in foster care. What we heard in the focus groups with the young people was we constantly get judged by everybody. Every decision we make, people are telling us, we make the wrong decision. Could you please just trust us to make a decision? Even if we fail, just let us fail on our own, not just tell us not to do something.

And the other thing was meeting, they said, “We need an intervention that meets us where we're at. Don't tell me what to do if I'm not ready. And if I am ready, help me out, but when I ask for help." When we heard that, we thought, “Okay, well, what we're thinking about designing this MI-based computer thing, I think this will work well.” And then getting back to the text messaging, sort of move forward, then when we were designing the text messaging for that I said, “You know what? I recognize that I am not smart enough or cool enough to write text messages for young people. I'm going to have them come in and help me write them.” And so we taught these young people very briefly about motivational interviewing and said, “Okay, given what we just taught you, how would you write these text messages?”

And so the majority of the text messages that we send in those studies are written by the people or from the population that we're sending it to. And I think that really fits quite well and they hear it more. Going back to clinicians, of course clinicians don't have time to survey or run focus groups with a bunch of people to get messaging, but it could be worthwhile to maybe over a series of, if you see 20 people in a week, maybe over a month's time, you just might ask, “Could I take a second to ask you? I don't know if I'm going to do this yet, I'm thinking about it, I heard it might be helpful. If I was going to send you a message, what kind of messages would you want to hear?”

Again, just the same, I'm thinking of this sort of classic slide in MI trainings about the breakdown of communication. When we assume what it is that our clients want to hear, whether it's a verbalization or a text message, decent chance we're going to get it wrong. Why not just ask them, “What is it that you would like to hear? How is it that you would like me to reach out to you?” Then I'd also underscore again, maybe provide … Now, this is all, we haven't even talked about, and certainly we don't have time to get into the privacy and safety of utilizing technology and making sure that people are doing it in a safe way, in a confidential way. It reminds me one of the strongest suicide prevention interventions are these thoughtful postcards.

They're called Caring Contacts for those who aren't familiar. And it started off as just when people exit inpatient for a suicide attempt, you just send them a postcard every once in a while. “Hi, it's Dr. So-and-So. We're just thinking about you. Want to make sure

you're okay. Please feel free to reach out if you need anything." And that simple act alone is one of the strongest suicide prevention techniques that exists. And it's a postcard. As I think about again, providers who might be like, "I don't know. What's a text message going to do," or whatever, the caring contact literature shows us that it can actually go quite a long way.

I guess those are the two things that I would think about that brief communications can be incredibly helpful. And that as you start to think about what you would say, ask people about what they'd want to hear.

Sebastian Kaplan:

Thinking again about the different assumptions that we as human beings make about the work that we do and the way that we do it, this is the way that works and we know what works for people. It's the way I do it. And not that we should stop thinking that way because that's not going to happen, but the challenge, at least the challenge for me is to be aware when I'm thinking that. And then anytime I say to myself, "I know," fill in the blank and ask myself, "Do I know? How do I know?" And with anything that we're talking about regarding patient care, similarly, it doesn't really matter what we say. What matters most is, what do the patients think? How do the patients respond? It might sound completely crazy for Peedy, the parrot to really connect with somewhat at a human level.

It doesn't matter if I think it's crazy. Do the receivers of Peedy, do they? How do they feel about it? And does it help them? And if the answer is yes, and it seems like it is, then the problem is me. If I'm so stuck on the fact that there's no way Peedy, the parrot can be helpful and that I need to increase my awareness, openness, flexibility, whatever it might be.

Glenn Hinds:

Given the time we're at, we always do this at this stage of the podcast, Jordan is we invite our guests to consider what's going on at the minute, not necessarily to do with motivation interviewing it might be something else, but really just something that's currently capturing your attention. And we'd just like to hear you tell us about it.

Jordan Braciszewski:

The first thing that comes to mind that that I'm currently inundated with is trying to school my children. As I mentioned, I'm a dad of two. My, wife and I have a five-year-old and an eight-year-old. Michigan's, the schools are closed for the rest of the year and trying to achieve. Work-life balance is hard enough as it is, no matter what, whether you're a clinician, a researcher. Whatever you're doing work-life balance is always very difficult.

So, managing that in these kinds of crazy times, while also parenting and being a kindergarten and third grade teacher is certainly at the top of my mind, but also obviously because I'm getting sort of, everybody's being flooded with it right now, just continuing to think more about telehealth and virtual care and how we can take something that I think will be really helpful for a lot of people and move it forward once we come out of this, opening people's minds to how this can be helpful and how we can reach more people, hopefully how we can reduce disparities among folks in terms of their access to treatment.

I know at Henry Ford we've seen a tremendous decrease in our no-show rate. Now, that we've transitioned to virtual care, very dramatic drops in no-show rate and that's here. If you see somebody weekly, but they only come two or three times out of the four in a month, that's going to have a drastic impact on their wellness. And doesn't matter whether you have a small or a big practice, it also has a huge financial impact. That's certainly something I've been thinking about as well. And also just trying to stay sane during these times, mostly stuck in my house.

Sebastian Kaplan:

Yeah. No matter where we are in the world, I'm sure that there's going to be some similarities in our experience the requests, the pressures to stay in and adaptations school-wise and such. Jordan, another question we ask our guests at the end is, if people have any interest in reaching out to you and to ask you questions directly, would you be okay with that? And if so, how could they reach you?

Jordan Braciszewski:

Definitely. Two ways, I'm on Twitter. My Twitter handle is J like Jordan M like Michael, B-R-O-C-K-P-H-D. So, jmbrockphd. You can also email me at J-B-R-A-C like cat I-S like Sam and the number one @hfhs like HenryFordHealthSystem.org.

Glenn Hinds:

As we always do, we will be tweeting about this episode and we'll tag you in alongside of that and invite people to follow you. I imagine this is in many ways, well it's challenging as an individual and as a dad and as a practitioner because of the circumstances of this enclosure forced upon us. I imagine there must be a degree of real excitement about the consequence of also having this time together and spend so much been introduced to telehealth or telecommunication. And the possibility that more people will turn to the likes of yourself. And to be curious, what is it you can teach us? What is it we can learn that can now expand? Now that we've all been introduced, the nuts been cracked, and it happened because we had to. Had the pandemic not happened, then chances are a lot of people wouldn't still be using video contact with their mom, but they are now.

And industry wouldn't be thinking, “You know what, we don't necessarily have to be flying everywhere. We can be doing teleconferencing.” And it's just that developing relationship, as you say, the augmentation of our previous lives with this existing technology, ultimately like anything, it can be used for the good or the ill, it's the person that does it. Made me think of a few years ago, I took my kids to a festival and there was a person selling magic wands. And I asked, “Is this for good magic or bad magic?” And she says, “It's the magician, it's the wizard that decides. It's not the wand.” It's like any skill that we have, we can use it for good or ill. It's our intention that informs that.

And it sounds like what has been driving you for all these years, Jordan has been the desire to make support available to as many people as possible. And one of the things that you discovered was technology is one of those bridges, and you've brought it to this place, and we are so grateful for your time today, and so grateful for your insights. We wish you every success in the future.

Jordan Braciszewski:

Thank you very much. It's been a pleasure.

Sebastian Kaplan:

Well, Glenn, last reminder about social media.

Glenn Hinds:

Of course. Our Twitter, changetalking. Our Facebook, Talking to Change. Instagram, Talking to Change Podcast. Direct email podcast@glennhinds.com.

Sebastian Kaplan:

Well, again, Jordan, thanks so much for joining us. Glenn, till next time.

Glenn Hinds:

In deed.